NOTICE OF A
REGULAR MEETING OF THE
CALOPTIMA BOARD OF DIRECTORS

OCTOBER 7, 2021
2:00 P.M.

505 CITY PARKWAY WEST, SUITE 108
ORANGE, CALIFORNIA 92868

BOARD OF DIRECTORS

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

Supervisor Lisa Bartlett, Alternate

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

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

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

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

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

1) **Listen to the live audio at or +1 (415) 930-5321 and Access Code: 361-600-647 or**
2) **Participate via Webinar at https://attendee.gotowebinar.com/rt/973201248127155724 rather than attending in person. Webinar instructions are provided below.**

CALL TO ORDER

PRESENTATIONS/INTRODUCTIONS

MANAGEMENT REPORTS

1. Chief Executive Officer Report
   a. National Committee for Quality Assurance Rating
   b. Medi-Cal Medical Audit
   c. California Advancing and Innovating Medi-Cal (CalAIM) Stakeholder Meeting
   d. COVID-19 Vaccination Efforts, Incentive Program
   e. CalFresh Collaboration
   f. Federally Qualified Health Centers Legislation
   g. Program of All-Inclusive Care for the Elderly Month
   h. Community Alliances Forum
   i. Social Determinants of Health Learning Collaborative
   j. Behavioral Health Incentive Program Workgroup
   k. Media Coverage

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

PUBLIC COMMENTS

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

CONSENT CALENDAR

3. Minutes
   a. Approve Minutes of the September 2, 2021 Regular Meeting of the CalOptima Board of Directors
   b. Receive and File Minutes of the May 19, 2021 Regular Meeting of the CalOptima Board of Directors' Quality Assurance Committee; the Minutes of the May 20, 2021 Regular Meeting of the CalOptima Board of Directors' Finance and Audit Committee; the Minutes of the April 27, 2021 Regular Meeting of the CalOptima Board of Directors' Whole Child Model Family Advisory Committee; the Minutes of the June 24, 2021 Regular Meeting of the CalOptima Board of Directors' OneCare Connect Member Advisory Committee; the Minutes of the August 12, 2021 Regular Meeting of the CalOptima Board of Directors' Provider Advisory Committee; the Minutes of the August 12, 2021 Regular Meeting of the CalOptima Board of Directors' Member Advisory Committee

4. Consider Approval to Extend the Behavioral Health Applied Behavior Analysis Pay for Value Performance Program for Calendar Year 2022

5. Consider Accepting and Receiving and Filing Fiscal Year 2020-21 CalOptima Audited Financial Statements

6. Consider Adopting Resolution No. 21-1007-01, Authorizing the Execution of Contract MS-21-22-41 with the California Department of Aging in order to Continue Operation of the Multipurpose Senior Services Program

7. Consider Approval of Modifications to CalOptima PACE Policy PA.1002 Mandatory Medical Equipment and Supply Requirements

8. Consider Authorizing and Directing Execution of Amendments to CalOptima's Primary and Secondary Agreements with the California Department of Health Care Services

9. Consider Authorizing Execution of an Amendment(s) to CalOptima's Primary Medi-Cal Agreement with the Department of Health Care Services Related to Enhanced Care Management, In Lieu of Services, and Additional Covered Aid Codes

10. Consider Appointment of Whole-Child Model Family Advisory Committee Vice Chair

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

REPORTS/DISCUSSION ITEMS

ADMINISTRATION

12. Consider Authorizing Contract with Health Management Associates for Consulting Services to Assist in Preparation for the Department of Health Care Services Routine Medical Audit Scheduled for January 2022, and Authorize Expenditures from Existing Reserves for Such Services

13. Consider Ratifying Salary Schedule Adopted on September 2, 2021 and Actions to Amend the Chief Executive Officer's Employment Agreement and Adjust the Base Salaries of Executive Level Positions to at Least the Minimums of the New Salary Ranges included in Salary Schedule

14. Consider Approval of Program Year 1 CalAIM Performance Incentive Payment Methodology

15. Consider Authorization of Unbudgeted Expenditures for Various Capital Improvements

16. Consider Authorizing Extension of Contracts Related to CalOptima's Key Operational Systems

CLINICAL OPERATIONS

17. Consider Authorizing Kaiser Foundation Health Plan, Inc.'s Collaboration in Mutually Identified Quality Initiatives Including Participation in CalOptima's Quality Improvement Committee

18. Consider Approving an Exemption to the Required Submission of the Seniors and Persons with Disabilities (SPD) Tracking Log (Medi-Cal) Report for Kaiser Foundation Health Plan, Inc.

PUBLIC AFFAIRS

19. Consider Authorizing Contract and Funding with Miller Geer & Associates for External Communications Support Services

20. Consider Appropriation of Funds and Authorization of Unbudgeted Expenditures and Other Actions as Necessary to Implement the All-Plan Letter (APL) 21-010: Medi-Cal COVID-19 Vaccination Incentive Program

ADVISORY COMMITTEE UPDATES

21. OneCare Connect Member Advisory Committee Update

22. Whole-Child Model Family Advisory Committee Update

23. Provider Advisory Committee Update

24. Member Advisory Committee Update

BOARD MEMBER COMMENTS AND BOARD COMMITTEE REPORTS

CLOSED SESSION

CS1. Pursuant to Government Code section 54956.9, subdivision (d)(2), CONFERENCE WITH LEGAL COUNSEL, Anticipated Litigation (Number of Potential Cases: 1)

ADJOURNMENT

How to Join

1. Please register for Regular Meeting of the CalOptima Board of Directors on October 7, 2021, 2:00 PM PDT at: **https://attendee.gotowebinar.com/rt/973201248127155724**

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

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

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

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

   TO USE YOUR COMPUTER'S AUDIO:

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

   --OR--

   TO USE YOUR TELEPHONE:

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

   United States: +1 (415) 930-5321

   Access Code: 361-600-647

   Audio PIN: Shown after joining the webinar

MEMORANDUM

DATE:	September 29, 2021
TO:	CalOptima Board of Directors
FROM:	Richard Sanchez, Chief Executive Officer
SUBJECT:	CEO Report — October 7, 2021, Board of Directors Meeting
COPY:	Sharon Dwiers, Clerk of the Board; Member Advisory Committee; Provider Advisory Committee; OneCare Connect Member Advisory Committee; and Whole-Child Model Family Advisory Committee

a. National Committee of Quality Assurance (NCQA) Rates CalOptima Among Top Plans

On September 15, the NCQA released its Medicaid health plan ratings for the first time since the beginning of the pandemic. CalOptima was named one of the top-rated Medi-Cal health plans in California — for the seventh year in a row — receiving a rating of 4 out of 5 for services delivered in 2020. Only 16 Medicaid plans of the 185 reviewed nationwide scored higher, and no other Medi-Cal plan in California earned higher than 4 out of 5. Thank you to your Board for the guidance that supports CalOptima's consistently outstanding quality performance. The agency has shared the great news with employees, providers, stakeholders and the public.

b. Medical Audit of CalOptima Medi-Cal Planned for January

CalOptima received notice that the Department of Health Care Services (DHCS) will conduct a medical audit of the Medi-Cal plan virtually January 24–February 4, 2022. Staff expects the formal audit document request on October 8. It is estimated that the review period will be from February 1, 2020–December 31, 2021. Preparations are already underway, and a COBAR at the October Board meeting will recommend engaging a consulting firm for audit support.

c. California Advancing and Innovating Medi-Cal (CalAIM) Stakeholder Meeting Welcomes Input in Preparation for Launch in 2022

On September 22, 44 participants attended CalOptima's CalAIM event for stakeholders, including health networks, Whole Person Care providers, Orange County Health Care Agency, OC Housing, hospital representatives and community-based organizations. The event included an overview presentation by CalOptima staff and breakout sessions to review the proposed workflows for the two new benefits: Enhanced Care Management and Community Supports (formerly known as In Lieu of Services). The general themes from each session were:

- Having a common system to coordinate members care and share data
- Making enhancements to the referral forms and authorization timing and process
- Training providers on the new workflows
- Collaborating to avoid duplication of services
- Exploring future community support services

Attendees expressed that the event was productive and agreed to meet on a regular basis to continue collaborating on transition readiness and beyond. CalOptima's Program Implementation team will schedule a series of meetings and lead those future discussions.

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d. CalOptima Making Progress on Vaccination Efforts, Joins State Incentive Program

CalOptima enters the fall season with increasing rates of vaccinated members and will be working to grow the number even more through the state incentive program. Below are updates in several areas of pandemic response:

- *Vaccination Rates:* As of September 28, CalOptima has 409,008 vaccinated members, which is 62% of members age 16 and older and 61% of members age 12 and older.
- *DHCS Vaccine Incentive Program (VIP):* On September 9, DHCS approved CalOptima's proposed VIP plan, and staff has begun working on implementation. To that end, your October Board meeting will include a COBAR requesting budget support for the upfront costs to implement the VIP, with state incentive dollars to be awarded at a later date after CalOptima meets milestones.
- *Member Texting Program:* CalOptima's successful member texting program has received recognition by fellow health plans and was discussed as a best practice during a "Reimagining Health Engagement" conference presented by mPulse, the texting vendor. CalOptima Director of Population Health Management Pshyra Jones spoke on September 30 about the contribution of the texting program to CalOptima's high member vaccination rates.
- *Booster Vaccine:* On September 22, the U.S. Food and Drug Administration authorized a Pfizer-BioNTech COVID-19 single booster dose for those over the age of 65 and high-risk individuals. CalOptima is working on a plan to reach eligible members with information about obtaining a booster shot.

e. CalFresh Collaboration Moves Forward With Data Sharing Approval

As part of efforts to address Social Determinants of Health, CalOptima has been meeting regularly with the Orange County Social Services Agency (SSA) to discuss CalOptima member enrollment in CalFresh. During a September 20 meeting, SSA staff were pleased to announce that DHCS recently approved SSA's request to share data with CalOptima regarding members likely eligible for but not yet enrolled in CalFresh. SSA is finalizing household and member-specific data that CalOptima staff will use to develop a targeted engagement strategy. In addition, SSA will be providing two in-service presentations about CalFresh in the next few months that will be open to CalOptima staff and community stakeholders.

f. Federally Qualified Health Centers (FQHCs) Legislation Blocked

On June 3, your Board approved CalOptima's formal support of Senate Bill (SB) 316, which would have allowed FQHCs to be reimbursed for two separate visits providing physical health and behavioral health services to the same person on the same day. DHCS announced its opposition to the bill on August 12, citing significant cost increases, current reimbursement options, and its ongoing efforts to establish an alternative payment methodology for FQHCs. This resulted in the bill's inability to pass the State Assembly before the end of the 2021 legislation session. Staff will continue to monitor SB 316 in the event it is amended and reconsidered in 2022.

g. CalOptima Promotes National Program of All-Inclusive Care for the Elderly (PACE) Month in September

CalOptima PACE celebrated National PACE Awareness Month throughout September, offering tours to elected officials and posting special website and social media content. California Assemblywoman Cottie Petrie-Norris and Alexander Kim, her district director, toured

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CalOptima PACE and met with me, PACE Director Monica Macias and Government Affairs Manager Jackie Mark. Ms. Macias provided an update about PACE operations during the pandemic, including the extensive telehealth services that have been deployed for participants. Assemblywoman Sharon Quirk-Silva joined CalOptima's Go Purple for PACE campaign on her social media sites, posting a picture of herself wearing purple and sharing a supportive statement about CalOptima PACE. Additionally, CalOptima PACE will be celebrating its eighth anniversary on October 1 with a drive-thru celebration and resource fair for participants.

h. CalOptima Community Alliances Forum (CAF) Focuses on Health Equity

More than 120 guests attended the virtual CAF on September 14, which focused on countywide efforts to address health equity. Speakers included Marie Jeannis, CalOptima Executive Director, Quality & Population Health Management; Hieu Nguyen, Director of Population Health & Equity, Orange County Health Care Agency; José Pérez, Community Services Superintendent, City of Anaheim; and Larry Wanger, Executive Director, The Dayle McIntosh Center. Ms. Jeannis highlighted CalOptima's latest health equity-related activities, including:

- Improving COVID-19 vaccine access for homebound members
- Coordinating WIC and diaper bank services for Bright Steps participants
- Collaborating with SSA to improve CalFresh benefits awareness
- Improving access to mammography for Korean and Chinese members
- Developing a produce delivery service for members with poorly controlled diabetes

i. CalOptima Joins Social Determinants of Health (SDOH) Learning Collaborative

Starting this fall, CalOptima is part of a 20-week SDOH learning collaborative hosted by the Association for Community Affiliated Plans. CalOptima staff from Customer Service, Population Health Management and Strategic Development are participating. The collaborative will provide opportunities to engage with experts and member plans about best practices and lessons learned.

j. Student Behavioral Health (BH) Incentive Program Workgroup Formed

CalOptima's BH Integration department is participating in a Student BH Incentive Program Workgroup facilitated by DHCS. With input from managed care plans, schools and county BH representatives, this new workgroup will meet throughout the fall to support development of the BH Incentive Program design. To boost local collaboration, CalOptima BH staff met last month with the Orange County Department of Education (OCDE) to discuss the incentive program. Further, staff are analyzing data to identify CalOptima membership among school districts and plans to share that information with OCDE.

k. Media Coverage Highlights CalOptima Efforts in CalAIM, Homeless Health

CalOptima was mentioned and quoted in two recent articles covering CalAIM and homeless health. On September 7, a Kaiser Health News reporter published an article that addressed CalAIM policy and implementation. The piece featured interviews and information from Medi-Cal managed care plans from across the state. Read the piece in California Healthline or the Los Angeles Times. On September 17, the Orange County Register ran an article about a new provider and new legislation in the homeless services area. Positive data from CalOptima's Homeless Response Team and Clinical Field Teams was shared, showing improvements in ER visits, hospitalization, specialty visits and primary care for members experiencing homelessness.

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Better. Together.

COVID-19 Update

Board of Directors Meeting
October 7, 2021

Emily Fonda MD MMM CHCQM
Chief Medical Officer

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Latest Data as of 9/24/21

Membership and COVID-19 Case

- CalOptima has **855,852** members (673,494 age 12 and older)
- **5.2%** members tested positive for COVID-19 (0.2% expired)

COVID-19 Vaccination

- **409,007** members are vaccinated
- **378,016** members are eligible for incentives
- **62%** members 16 years and older received at least one dose of vaccine
- **61%** members 12 years and older received at least one dose of vaccine

Vaccine Incentives

- More than **197,040** gift cards processed for general members
- **1,595** gift cards distributed to members experiencing homelessness

Covid Case Source: CalOptima Claims & Encounters
Vaccine Source: CalOptima Claims & Encounters, CAIR2, CAIRs, CMS, DHCS, HN Submissions

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Latest Data as of 9/24/21 (cont.)

Whole-Child Model

- Vaccination rate: **~58%**

Age 65 and Older

Overall vaccination rate**: ~77%**
- LTC members vaccination rate: **~94%**
- PACE participants vaccination rate: **~99.5%**

By Cities

- Vaccination rates highest in Irvine, Garden Grove and Westminster: **~67-72%**

By Ethnicity

- Highest: Asian population **79%** vaccinated
- Lowest: Black population **44%** vaccinated

Covid Case Source: CalOptima Claims & Encounters
Vaccine Source: CalOptima Claims & Encounters, CAIR2, CAIRs, CMS, DHCS, HN Submissions

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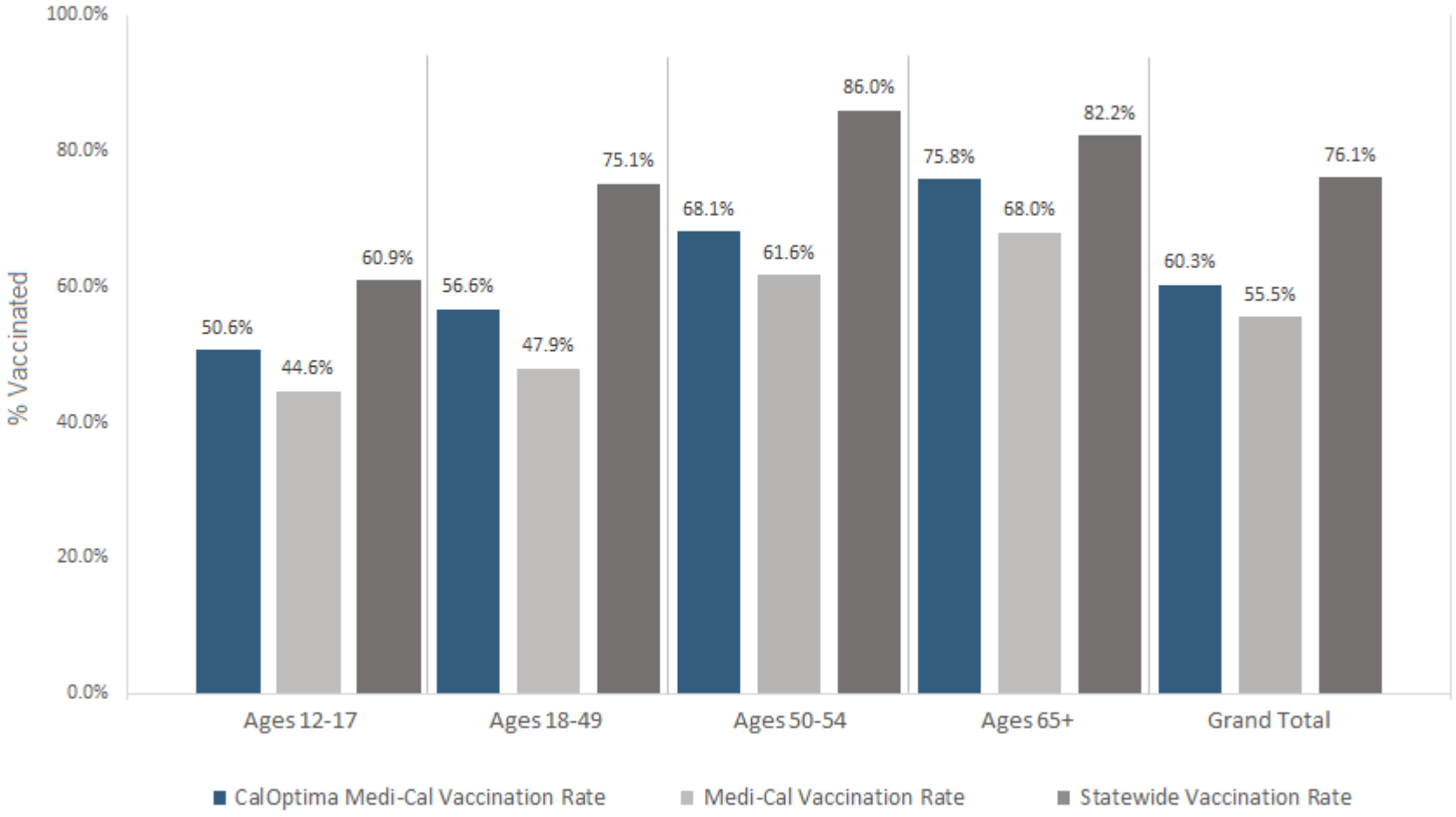
Vaccination Rates Comparison*



*DHCS data as of 9/5/21; CalOptima data as of 9/24/21

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DHCS Vaccine Incentive Plan

- On August 13, 2021, DHCS released All Plan Letter 21-010: Medi-Cal COVID-19 Vaccination Incentive Program
  - Allocation of up to $350 million to incentivize COVID-19 vaccination efforts for service period of September 1, 2021, through February 28, 2022
- Members are eligible if not fully vaccinated against COVID-19
  - Members ages 12 years and older
  - Focus Populations:
    - Homebound and unable to travel to vaccination sites
    - 50-64 years of age with multiple chronic diseases
    - Self-identify as persons of color
    - Youths ages 12-25 years

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DHCS Vaccine Incentive Plan (cont.)

- CalOptima developed a Vaccine Response Plan and submitted to DHCS on September 1, 2021
- Received DHCS approval on September 9, 2021
- Implemented Vaccination Response Plan:
  - Data analysis to identify members in populations of focus
  - Leveraging current vaccination strategies to support member outreach, address vaccine hesitancy and increase access (texting, social media, member education, trusted messenger and vaccine events)
  - Collaboration with county, health networks, providers, community partners and CBOs
  - Establishing DHCS monthly reporting

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Most Recent Vaccine Events

August 28

On-site Vaccine Event

- 245 individuals vaccinated
- 146 gift cards distributed
- Total: **5,318** individuals vaccinated, and **2,486** gift cards distributed through these events

9/11/21
Back-to-School Immunization Event

- Collaborated with Boys & Girls Clubs of Garden Grove, CHOC, Health Smiles and Families Together of Orange County
- Provided routine vaccines, COVID-19 vaccine, health screenings, groceries, giveaways and haircuts

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Our Mission

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

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MINUTES

REGULAR MEETING
OF THE
CALOPTIMA BOARD OF DIRECTORS

September 2, 2021

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

ROLL CALL

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

Members Absent: None

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

PRESENTATIONS/INTRODUCTIONS

None.

MANAGEMENT REPORTS

1. Chief Executive Officer Report

Richard Sanchez, Chief Executive Officer, highlighted several items from his report, including the completion of the Centers for Medicare & Medicaid Services (CMS) audit of CalOptima's Medicare programs. Mr. Sanchez noted we are waiting on the final results of the CMS audit. He also reported that the Department of Health Care Services (DHCS) notified CalOptima that it will be conducting an audit of CalOptima's Medi-Cal program in December 2021.

2. Chief Medical Officer Updates

Emily Fonda, M.D., Chief Medical Officer, provided an update on CalOptima's COVID-19 vaccination efforts. Dr. Fonda reported that as of August 30, 2021, 60% of CalOptima members aged 16 and over, and 58% of CalOptima members aged 12 and over, have received at least one dose of a COVID-19 vaccine. Dr. Fonda also reported that another 245 CalOptima members were vaccinated last weekend at another CalOptima hosted event in collaboration with the Orange County Health Care Agency and other community partners.

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3. OneCare Connect Transition

Ladan Khamseh, Chief Operating Officer, provided an update on the OneCare Connect (OCC) transition, with the Cal Medi-Connect program ending in December 2022. CalOptima members enrolled in Cal Medi-Connect programs will need to select a new Medicare plan and luckily for CalOptima OCC members an option that offers very similar benefits is CalOptima's OneCare Medicare Advantage Special Needs Plan. The intent is to transition OCC members who choose the OneCare Program effective January 2023.

To ensure minimal disruption to members, CalOptima staff has been meeting with health networks and other providers to ensure a smooth transition.

4. Strategic Plan Update

Rachel Selleck, Executive Director, Public Affairs, provided an update on the Strategic Plan and provided a refresher on the three-year cycle plan. Ms. Selleck noted that, staff has been meeting with CalOptima's Advisory Committees and during those meetings, a common theme is the need for education and awareness of the types of services CalOptima offers. This includes education for both members and providers. CalOptima staff continues to develop communication campaigns to address heath equity and the social determinates of health, and will bring updates to the Board at future meetings.

PUBLIC COMMENTS

There were no requests for public comment.

CONSENT CALENDAR

5. Minutes

a. Approve Minutes of the August 5, 2021 Regular Meeting of the CalOptima Board of Directors
b. Receive and File Minutes of the June 10, 2021 Regular Meeting of the CalOptima Board of Directors' Member Advisory Committee; the Minutes of the June 10, 2021 Regular Meeting of the CalOptima Board of Directors' Provider Advisory Committee

6. Consider Authorizing Expenditures in Support of CalOptima's Participation in a Community Event

7. Consider Ratifying a Revised Amendment to CalOptima's Primary Medi-Cal Agreement with the California Department of Health Care Services (DHCS) Related to Coordinate Care Initiative (CCI) Rate Changes

8. Consider Authorizing and Directing Execution of Amendment(s) to CalOptima's Primary Medi-Cal Agreement with the California Department of Health Care Services Related to Base Medi-Cal Classic, Affordable Care Act (ACA) Optional Expansion (OE) and Pharmacy Rate Changes

9. Receive and File:

a. July 2021 Financial Summary
b. Compliance Report
c. Federal and State Legislative Advocates Reports
d. CalOptima Community Outreach and Program Summary

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Action: ***On motion of Vice Chair Corwin, seconded and carried, the Board of Directors approved Consent Calendar as presented. (Motion carried 8-0-0)***

REPORTS/DISCUSSION ITEMS

ADMINISTRATIVE

10. Consider Authorizing Employee and Retiree Group Health Insurance and Wellness Benefits for Calendar Year 2022

Director Schoeffel did not participate in this item due to potential conflicts of interest.

Action: ***On motion of Vice Chair Corwin, seconded and carried, the Board of Directors: 1.) Authorized the Chief Executive Officer (CEO), with the assistance of Legal Counsel, to enter into contracts and/or amendments to existing contracts, as necessary, to continue to provide group health insurance, including medical, dental, and vision for CalOptima employees and eligible retirees (and their dependents), and basic life, accidental death and dismemberment, short-term disability (STD) and long-term disability (LTD) insurance, an employee assistance program, and flexible spending accounts, for Calendar Year (CY) 2022 in an amount not to exceed $23.0 million which includes: a.) An increase in employer contributions (based on the percentage of premium the employer pays for each plan), as a result of an 8.13% increase in premium rates, increasing costs to CalOptima for CY 2022 in an amount of $1,589,845; b.) A continuation of employer contributions for CY 2022 in an estimated amount of $196,250 to fund the Health Savings Accounts (HSA) monthly for employees currently enrolled in the Cigna High Deductible Health Plan (HDHP); c.) A buy-up option in the vision plan to enhance contact lens and/or frames benefits. The buy-up option is voluntary at the employee's discretion and cost; and 2.) Authorize the receipt and expenditures for CalOptima staff wellness programs from $20,000 in funding received from the Cigna Wellness/Health Improvement Fund for CY 2022. (Motion carried 7-0-0; Director Schoeffel absent)***

11. Consider Authorizing Executive Recruitment Incentives and Appropriation of Funds and Authorization of Unbudgeted Expenditures to Fund Recruitment Incentives and Talent Sourcing Services

Action: ***On motion of Director Corwin, seconded and carried, the Board of Directors: 1) Authorized the Chief Executive Officer (CEO) to offer recruitment incentives in an amount not to exceed $50,000 per executive or chief level position to entice executive level candidates to join CalOptima and appropriate funds and authorize unbudgeted expenditures in an amount up to $250,000 from existing reserves to***

fund recruitment incentives for executive and chief level positions through June 30, 2022; and 2.) Appropriated funds and authorized unbudgeted expenditures in an amount up to $500,000 from existing reserves to fund talent sourcing services through June 30, 2022. (Motion carried 8-0-0)

12. Consider Adoption of Resolution Approving and Adopting Updated CalOptima Policy GA.8058: Salary Schedule; Appropriation of Funds and Authorization of Unbudgeted Expenditures and Other Actions as Necessary to Implement Updated Compensation Practices and Proposed Salary and Salary Range Changes, Including Authorizing an Amendment to the Chief Executive Officer's Employment Contract; and Authorization of Independent Employee Compensation Study

Action: ***On motion of Director Schoeffel, seconded and carried, the Board of Directors: 1.) Adopted Resolution Approving Updated CalOptima Policy GA.8058: Salary Schedule and Attachment A; 2.) Authorized the Board Chair to execute an amendment to the Chief Executive Officer (CEO) employment agreement to increase his base salary to at least the minimum of the proposed salary range and authorize unbudgeted expenditure in an amount up to $177,000 from existing reserves for this purpose through June 30, 2022; 3.) Authorized the CEO to administer CalOptima compensation practices in accordance with CalOptima policies and authorize unbudgeted expenditures in an amount up to $189,000 from existing reserves to fund moving affected employees to the minimum of the proposed salary range through June 30, 2022; 4.) Authorized the CEO to administer CalOptima compensation practices in accordance with CalOptima policies and authorize unbudgeted expenditures in an amount up to $1,500,000 from existing reserves for market adjustments in Fiscal Year (FY) 2021-22; 5.) Appropriated funds and authorize unbudgeted expenditures in an amount up to $476,000 from existing reserves to fund the salaries and benefits for the upgrade of Executive Director Behavioral Health Integration and new Executive Director Finance positions through June 30, 2022; and 6.) Appropriated funds and authorize unbudgeted expenditures of up to $500,000 from existing reserves to fund a comprehensive independent compensation study of CalOptima's pay policies, practices, and market competitiveness. (Motion carried 8-0-0)***

Chairman Do noted for the record that he would not be participating items 13, 14, and 15 due to conflicts of interest under the Levine Act based on campaign contributions and passed the gavel to Vice Chair Corwin.

13. Authorize Medi-Cal Health Network Capitation Rate Increases for the Period of September 1, 2021, through December 31, 2021, due to COVID-Related Expenses

Director Schoeffel did not participate in this item due to potential conflicts of interest. Director Shivers did not participate in this item due to her affiliation with UnitedHealth Group and Optum.

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Action: ***On motion of Director Tran, seconded and carried, the Board of Directors: 1.) Authorized resuming Health Network Medi-Cal capitation rate increases for contracted Physician Hospital Consortia (PHC), Shared Risk Group (SRG), and Health Maintenance Organizations (HMO), except Kaiser Foundation Health Plan, Inc. (Kaiser), on Child, Adult and Seniors and Persons with Disabilities (SPD) Categories of Aid (COA), by 7.5% from current levels for the period from September 1, 2021, through December 31, 2021; 2.) Authorized unbudgeted expenditures up to $10.4 million from existing reserves to provide funding for Health Network capitation rate adjustments; and 3.) Authorized the Chief Executive Officer (CEO), with the assistance of Legal Counsel, to amend the Medi-Cal PHC, SRG, and HMO Health Network contracts, except Kaiser, to implement the Health Network capitation rate adjustments. (Motion carried 5-0-0; Chairman Do abstained; Directors Schoeffel and Shivers absent)***

14. Consider Authorizing a Temporary, Short-Term Supplemental Payment Increase for Certain Contracted CalOptima Fee-for-Service Providers due to COVID-Related Expenses for Services Provided to CalOptima Community Network and CalOptima Direct-Administrative Medi-Cal Members

Director Schoeffel did not participate in this item due to potential conflicts of interest. Director Tran did not participate in this item due to his service as a specialist physician serving CalOptima members.

Action: ***On motion of Director Shivers, seconded and carried, the Board of Directors: 1.) Authorized resuming a temporary, short-term supplemental payment increase of 5% from current levels, for compliant, contracted Medi-Cal Fee-for-Service (FFS) Primary Care, Specialist and Ancillary Providers, for certain medically necessary services provided to CalOptima Community Network (CCN) and CalOptima Direct-Administrative (COD-A) Medi-Cal Members on dates of service September 1, 2021, through December 31, 2021; 2.) Authorized resuming a temporary, short-term supplemental payment increase of 5% from current levels, for compliant, contracted Medi-Cal FFS Behavioral Health Providers to include all CalOptima Medi-Cal members; and 3.) Authorized unbudgeted expenditures up to $5.5 million from existing reserves to provide funding for the recommended supplemental payment increases. (Motion carried 5-0-0; Chairman Do abstained; Directors Schoeffel and Tran absent)***

15. Consider Authorizing a Temporary, Short-Term Supplemental Payment Increase for Contracted Medi-Cal Fee-for-Service Community Health Centers due to COVID-Related Expenses for Services Provided to CalOptima Community Network and CalOptima Direct Medi-Cal Members

Director Schoeffel did not participate in this item due to potential conflicts of interest. Director Becerra did not participate in this item due to her affiliation with the Orange County Coalition of Community Health Centers.

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Action: ***On motion of Director Giammona, seconded and carried, the Board of Directors: 1.) Authorized resuming a temporary, short-term supplemental payment increase of 5% from current levels, for compliant, contracted Medi-Cal Fee-for-Service (FFS) Community Health Centers, for certain medically necessary services provided to CalOptima Community Network (CCN) and CalOptima Direct (COD) Medi-Cal members on dates of service from September 1, 2021 through December 31, 2021; and 2.) Authorized unbudgeted expenditures up to $150,000 from existing reserves to provide funding for the supplemental payment increase to Medi-Cal FFS Community Health Centers. (Motion carried 5-0-0; Chairman Do abstained; Directors Becerra and Schoeffel absent)***

16. Consider Authorizing a Temporary, Short-Term Supplemental Payment Increase for Contracted Medi-Cal Fee-for-Service Hospitals due to COVID-Related Expenses for Services Provided to CalOptima Community Network and CalOptima Direct Medi-Cal Members

Director Schoeffel did not participate in this item due to potential conflicts of interest.

Action: ***On motion of Director Corwin, seconded and carried, the Board of Directors: 1.) Authorized resuming a temporary, short-term supplemental payment increase of 5% from current levels, for claims for members associated with compliant, contracted Medi-Cal Fee-for-Service (FFS) Hospitals for certain medically necessary services provided to CalOptima Community Network (CCN) and CalOptima Direct-Administrative (COD-A) Medi-Cal members between September 1, 2021 and December 31, 2021; and 2.) Authorized unbudgeted expenditures up to $3.6 million from existing reserves to provide funding for the supplemental payment increase to Medi-Cal FFS hospitals (Motion carried 7-0-0; Director Schoeffel absent)***

17. Consider authorizing the preparation and release, subject to the Legal Ad Hoc's ("Ad Hoc") review, of Requests for Proposal ("RFP") for an outside law firm to serve as the agency's general counsel ("GC") to augment, and integrate with, the legal services currently provided by the agency's employed and contracted lawyers

Chairman Do provided an update on the work of the Legal Ad Hoc comprised of himself, Director Schoeffel and Director Giammona. He noted that the Ad Hoc believes it would be beneficial to the agency to have an outside general counsel. He also noted that the outside general counsel will review the current structure of the Legal department and identify the strengths and weaknesses and provide recommendations to the Board. Chairman Do thanked Directors Giammona and Schoeffel for their service on the Ad Hoc.

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Action: ***On motion of Chairman Do, seconded and carried, the Board of Directors authorized the preparation and release, subject to the Ad Hoc's review, of an RFP for an outside law firm to serve as the agency's GC to augment, and integrate with, the legal services currently provided by the agency's employed and contracted lawyers. (Motion carried 8-0-0)***

CLINICAL OPERATIONS

18. Consider Authorizing Contract and Funding with Push Media, Inc. (dba Gleeson Digital Strategies) to Provide Consulting Services Regarding CalOptima's California Advancing and Innovating Medi-Cal (CalAIM) Initiative

Action: ***On motion of Supervisor Chaffee, seconded and carried, the Board of Directors: 1.) Authorized the Chief Executive Officer (CEO), with the assistance of Legal Counsel, to execute a contract with Push Media, Inc. (dba Gleeson Digital Strategies) effective July 19, 2021, for consulting services regarding CalOptima's CalAIM implementation for the current fiscal year and include an additional one-year extension option exercisable at CalOptima's sole discretion; and 2.) Authorized unbudgeted expenditures from existing reserves in an amount not to exceed $225,000 to fund this contract through June 30, 2022. (Motion carried 8-0-0)***

ADVISORY COMMITTEE UPDATES

19. Member Advisory Committee Update

Christine Tolbert, Member Advisory Committee (MAC) Chair, provided an update on the MAC's Recent and upcoming activities.

20. Provider Advisory Committee Update

Dr. Junie Lazo-Pearson, Provider Advisory Committee (PAC) Chair, provided an update on the PAC's recent and upcoming activities.

BOARD MEMBER COMMENTS AND BOARD COMMITTEE REPORTS

Director Chau expressed an interest in attending a future Member Advisory Committee and Provider Advisory Committee meetings, depending on his schedule.

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Hearing no further business, Chairman Do adjourned the meeting at 3:18 p.m.

ADJOURNMENT

/s/ Sharon Dwiers
Sharon Dwiers
Clerk of the Board

Approved: October 7, 2021

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MINUTES

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

CALOPTIMA
505 CITY PARKWAY WEST
ORANGE, CALIFORNIA

May 19, 2021

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

Chair Mary Giammona, M.D., called the meeting to order at 3:01 p.m. and welcomed Director Nancy Shivers to the Quality Assurance Committee (QAC) as its newest member. Director Shivers led the Pledge of Allegiance.

PUBLIC COMMENTS
There were no requests for public comment.

CALL TO ORDER

Members Present: Mary Giammona, M.D., Chair; Nancy Shivers, R.N.; Trieu Tran, M.D. (at 3:07 p.m.) (all members participated via teleconference)

Members Absent: None

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

CONSENT CALENDAR

1. Approve the Minutes of the February 25, 2021 Special Meeting of the CalOptima Board of Directors' Quality Assurance Committee

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

REPORTS

2. Consider Recommending the Continued Use of the Methodology Previously Approved for the Distribution of OneCare Connect Quality Withhold Payments to Contracted Health Networks in Demonstration Years 2 Through 5 for Distribution of Such Payment for Demonstration Years 6 Through 8

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Kelly Rex-Kimmet, Director, Quality Analytics introduced this item.

Action: ***On motion of Director Tran, seconded and carried, the Committee recommended Board of Directors approval of the continued use of the methodology previously approved for the distribution of OneCare Connect quality withhold payments to contracted Health Networks (including the CalOptima Community Network (CCN)) in Demonstration Years (DY) 2-5 (Calendar Years 2016-2019) for the distribution of such payment for DY 6-8 (Calendar Years 2020-2022). (Motion carried 3-0-0)***

3. Consider Recommending Authorization of a Diabetes Mellitus Program to Improve Health Care Quality for Medi-Cal Members with Poorly Controlled Diabetics

Emily Fonda, M.D., Chief Medical Officer, presented an overview of the proposed Diabetes Mellitus (DM) Program. Dr. Fonda noted that, based on the Centers for Disease Control and Prevention's 2017 data, diabetes is the most expensive chronic health condition in the United States, and the total annual expenditures on diabetes care was $327 billion in that year. Mirroring this national trend, she noted that CalOptima is seeing the high cost of diabetes for our CCN Medi-Cal members. Based on claims data from July 2019 through June 2020, approximately $247 million was spent on diabetic care for these members.

Food insecurity is "a lack of consistent access to enough food for an active, healthy life." This is an issue that touches people of all ages with all types of diabetes. With the proposed DM program, CalOptima will offer a $25 gift incentive to encourage CalOptima CCN Medi-Cal Members with diabetes to complete HbA1c tests on an annual basis. For those members with poorly controlled HbA1c levels, staff recommends providing $50 health rewards for reducing HbA1c levels by a full percentage point, for example, from HbA1c 10 to 9 (eligible twice a year, totaling up to $100 for qualifying members). For the 6,270 CalOptima CCN Medi-Cal members who have not had a HbA1c test, an estimated 9% (564) of this population may be identified as having poorly controlled diabetes.

The Committee recommended revising the target number of poorly controlled diabetes from greater than 8 on the HbA1c test rather than 9 to broaden the impact of the DM Program. The Committee also had several other suggestions for staff to include prior to bringing the proposed DM Program to the full Board for consideration.

Dr. Fonda clarified that the proposed DM Program includes a contract with a vendor to deliver fresh produce to qualifying members to encourage them to make healthier meal choices that will directly assist them in controlling their diabetes. Dr. Fonda also noted that staff may need to come back to the Board to request additional funding for the DM Program, if it is highly successful and larger than anticipated numbers of qualifying members participate.

Action: ***On motion of Director Shivers, seconded and carried, the Committee recommended that the Board of Directors: 1.) Authorize the Chief Executive Officer (CEO), with the assistance of Legal Counsel, to implement a two-year pilot Multidisciplinary Approach to Improving Care in Poorly Controlled Diabetics, hereinafter referred to as "the diabetes mellitus (DM) program," for CalOptima Community Network (CCN) Medi-Cal members; 2.) Authorize the allocation of Intergovernmental Transfer (IGT) 10 funds in***

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an amount not to exceed $3.6 million for program expenses for the DM program; 3.) Authorize funding for staffing resources and program design expenses for the DM program prior to CalOptima's receipt of IGT 10 funds from the State of California; and 4.) Authorize the CEO, with the assistance of Legal Counsel, to execute a contract with a selected vendor through the Request for Proposal process to provide fresh produce delivery services. (Motion carried 3-0-0)

INFORMATION ITEMS

4. Pay for Value Program Overview

Ms. Rex-Kimmet, Director, Quality Analytics, responded to the Committee member questions regarding payment amounts health networks receive for the various levels of performance under CalOptima's Pay for Value Program, noting that at the highest level of performance, a health network would receive an additional $5 per member per month.

5. PACE Member Advisory Committee Update

Monica Macias, PACE Director, provided a brief overview the PACE Member Advisory Committee (PMAC) activities.

The following items were accepted as presented.

6. Quarterly Reports to the Quality Assurance Committee
   a. Quality Improvement Committee Report
   b. Program of All-Inclusive Care for the Elderly Report
   c. Member Trend Report

COMMITTEE MEMBER COMMENTS

The Committee members thanked staff for their work.

ADJOURNMENT

Hearing no further business, Chair Giammona adjourned the meeting at 4:06 p.m.

/s/ Sharon Dwiers
Sharon Dwiers
Clerk of the Board

Approved: September 8, 2021

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MINUTES

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

CALOPTIMA
505 CITY PARKWAY WEST
ORANGE, CALIFORNIA

May 20, 2021

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

CALL TO ORDER
Chair Isabel Becerra called the meeting to order at 2:00 p.m. Director Schoeffel led the Pledge of Allegiance.

Members Present: Isabel Becerra, Chair; Clayton Corwin; Victor Jordan (at 3:07 p.m.); Scott Schoeffel (all Members at teleconference locations)

Members Absent: None

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

Chair Becerra announced that she was reordering the agenda to hear Information Item 10., Moss Adams 2021 Financial Audit Planning, after the Consent Calendar and before the Report Items.

PUBLIC COMMENTS
There were no requests for public comment.

MANAGEMENT REPORTS
1. Chief Financial Officer Report
Nancy Huang, Chief Financial Officer, provided a brief summary on Governor Newsom's May Revise of the state's proposed FY 2021-2022 budget that was released last Friday. Ms. Huang noted that the May Revise includes several items that impact the Medi-Cal program and CalOptima, including an increased caseload from the current fiscal year based largely on Medi-Cal eligibility expansion. Ms. Huang also noted that proposed changes in the May Revise align closely with CalOptima staff's proposed budget assumptions for the upcoming fiscal year.

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INVESTMENT ADVISORY COMMITTEE UPDATE

2. Treasurer's Report

Ms. Huang presented the Treasurer's Report for the period of January 1, 2021 through March 31, 2021. As reported to the Board of Directors' Investment Advisory Committee, she noted that all investments were compliant with Government Code section 53600 *et seq.*, and with CalOptima's Board-approved Annual Investment Policy during that period.

CONSENT CALENDAR

3. Approve the Minutes of the February 18, 2021 Regular Meeting of the CalOptima Board of Directors' Finance and Audit Committee; Receive and File Minutes of the January 25, 2021 Regular Meeting of the CalOptima Board of Directors' Investment Advisory Committee

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

INFORMATION ITEMS

10. Moss Adams 2021 Financial Audit Planning

Ms. Huang introduced independent auditor, Moss Adams' audit partner, Stacy Stelzriede, who provided a brief overview of the audit planning process and introduced audit manager Aparna Venkateswaran. Ms. Venkateswaran reviewed the significant audit areas that Moss Adams will be reviewing, which include medical claims liability and claims expense, capitation revenue and receivables, amounts due to the State of California or the Department of Health Care Services (DHCS), pension and OPEB liabilities, and the impact of COVID-19. Ms. Venkateswaran reviewed the timeline for this audit for the Fiscal Year ending June 30, 2021, noting that Moss Adams' staff met with CalOptima management back in April to discuss the financial audit plan. In July, Moss Adams will return to start the final fieldwork procedures with the goal of wrapping up and presenting the audit results at the September 16, 2021 FAC meeting.

REPORTS

4. Consider Recommending Board of Directors Approval of the CalOptima Fiscal Year 2021-22 Operating Budget

Ms. Huang reviewed the proposed Fiscal Year (FY) 2021-22 Operating Budget starting at a consolidated level and then presented a detailed review by line of business. Ms. Huang noted that enrollment is the largest single driver for changes in next year's operating budget that include increases in revenue as well as in medical costs and administrative expenses. She also noted that staff is proposing a less than break even budget to ensure that adequate resources are available so that members receive the care they need and that CalOptima is sufficiently resourced to meet regulator and program management requirements. Ms. Huang also noted that for FY 2020-21, CalOptima had budgeted a deficit of $41 million; however, due to the pandemic and reduced utilization for non-COVID-19 related services, operating results are expected to be favorable.

Following Ms. Huang's presentation, and extended committee discussion on the various elements of the proposed budget, the following action was taken.

Action: ***On motion of Director Corwin, seconded and carried, the Committee recommended that the Board of Directors: 1.) Approve the CalOptima Fiscal Year (FY) 2021-22 Operating Budget; and 2.) Authorize the expenditures and appropriate the funds for items listed in Attachment B: Administrative Budget Details, which shall be procured in accordance with CalOptima Policy GA.5002: Purchasing Policy. (Motion carried 4-0-0)***

5. Consider Recommending Approval of the CalOptima Fiscal Year 2021-22 Capital Budget

Action: ***On motion of Director Jordan, seconded and carried, the Committee recommended that the Board of Directors: 1.) Approve the CalOptima Fiscal Year (FY) 2021-22 Capital Budget; and 2.) Authorize the expenditures and appropriate the funds for the items listed in Attachment A: Fiscal Year 2021-22 Capital Budget by Project, which shall be procured in accordance with CalOptima Board-approved policies. (Motion carried 4-0-0)***

6. Consider Recommending Reappointment to CalOptima Board of Directors Investment Advisory Committee

Action: ***On motion of Director Schoeffel, seconded and carried, the Committee recommend Board of Directors reappoint Rodney Johnson to the CalOptima Board of Directors' Investment Advisory Committee for a two-year term beginning on June 7, 2021. (Motion carried 4-0-0)***

7. Consider Recommending Authorization of Contracts with Investment Managers for CalOptima's Operating, Tier One and Tier Two Investment Accounts; Authorize Allocation of these Assets Amongst the Recommended Investment Managers

Director Schoeffel did not participate in this item due to potential conflicts of interest.

Action: ***On motion of Director Corwin, seconded and carried, the Committee recommended that the Board of Directors 1.) Authorize the Chief Executive Officer (CEO), with assistance of Legal Counsel, to enter into contracts with MetLife Investment Management and Payden & Rygel for investment manager services, with each contract for a three-year term, with two one-year extension options, each extension option exercisable at CalOptima's sole discretion; and 2.) Authorize the allocation of management responsibility for the Operating, Tier One and Tier Two investment accounts on a 50%/50% basis between the two selected investment managers. (Motion carried 3-0-0; Director Schoeffel absent)***

8. Consider Recommending Board of Directors Ratification of Finance Policy and Procedure

Action: ***On motion of Director Corwin, seconded and carried, the Committee recommended that the Board of Directors ratify CalOptima Policy MA.3003: Medicare Shared Risk Pool. (Motion carried 4-0-0)***

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9. Consider Recommending Board of Directors' Approval of Extension of Reimbursement for Necessary Business Expenditures Incurred by Employees on Temporary Telework Due to the Coronavirus (COVID-19) Pandemic

Action: ***On motion of Director Schoeffel, seconded and carried, the Committee recommended that the Board of Directors 1.) Approve extension of reimbursement at a flat rate of $45 per month per temporary teleworker, continuing July 1, 2021 on a month-to-month basis through December 31, 2021 for necessary business expenditures incurred by regular full-time and part-time employees on temporary telework due to the COVID-19 pandemic; and 2.) Authorize the Chief Executive Officer (CEO) to extend the flat rate reimbursement on a month-to-month basis from July 1, 2021 through December 31, 2021 for employees on temporary telework. (Motion carried 4-0-0)***

INFORMATION ITEMS

11. March 2021 Financial Summary

Ms. Huang briefly reviewed the March 2021 financial summary.

The following Information Items were accepted as presented.

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

COMMITTEE MEMBER COMMENTS

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

Hearing no further business, Finance and Audit Committee Chair Becerra adjourned the meeting at 4:07 p.m.

/s/ Sharon Dwiers
Sharon Dwiers
Clerk of the Board

Approved: September 16, 2021

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MINUTES

REGULAR MEETING OF THE CALOPTIMA BOARD OF DIRECTORS' WHOLE CHILD MODEL FAMILY ADVISORY COMMITTEE

April 27, 2021

A Regular Meeting of the CalOptima Board of Directors' Whole-Child Model Family Advisory Committee (WCM FAC) was held on April 27, 2021, CalOptima, 505 City Parkway West, Orange, California and via teleconference (Go-to-Webinar) in light of the COVID-19 public health emergency and consistent with Governor Newsom's executive orders EO-N-25-20 and EO-N-29-20, which temporarily relax the teleconferencing limitations of the Brown Act.

CALL TO ORDER

Kristen Rogers, WCM FAC Chair called the meeting to order at 9:35 a.m. and led the Pledge of Allegiance.

ESTABLISH QUORUM

Members Present: Kristen Rogers, Chair; Brenda Deeley, Vice Chair; Maura Byron; Cathleen Collins; Jacqui Knudsen; Kathleen Lear; Monica Maier; Malissa Watson

Members Absent: Sandra Cortez-Schultz

Others Present: Ladan Khamseh, Chief Operations Officer; Emily Fonda, M.D., Chief Medical Officer; Belinda Abeyta, Executive Director, Operations; Rachel Selleck, Executive Director, Public Affairs; Tracy Hitzeman, Executive Director, Clinical Operation; Thanh-Tam Nguyen, M.D., Medical Director; Kris Gericke, Director, Pharmacy Management; Albert Cardenas, Director, Customer Service; Debra Kegel, Director, Strategic Development; Andrew Tse, Associate Director, Customer Service; Claudia Magee, Manager, Strategic Development; Vy Nguyen, Manager, Customer Service; Jackie Mark, Sr. Policy Advisor, Government Affairs; Cheryl Simmons, Staff to the Advisory Committees; Jorge Dominguez, Lead Customer Service Representative, Customer Service

PUBLIC COMMENT

There were no public comments

MINUTES

Approve the Minutes of the February 23, 2021 Regular Meeting of the CalOptima Board of Directors' Whole-Child Model Family Advisory Committee

Action: ***On motion of Member Maura Byron, seconded and carried, the WCM FAC Committee approved the minutes of the February 23, 2021 meeting. (Motion carried 8-0-0; Member Sandra Cortez-Schultz absent)***

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REPORTS

Consider approval of the WCM FAC FY 2021-2022 Meeting Schedule

WCM FAC members reviewed the proposed FY 2021-2022 meeting schedule and opted to continue with their bi-monthly meeting schedule and continue with a 9:30 AM start time.

Action: ***On motion of Member Maura Byron, seconded and carried, the Committee approved the WCM FAC FY 2021-22 Meeting Schedule. (Motion carried 8-0-0; Member Sandra Cortez-Schultz absent)***

Consider Recommendation of WCM FAC Slate of Candidates

Chair Kristen Rogers reviewed the recommendations of the WCM FAC Ad Hoc Committee which consisted of Chair Kristen Rogers, Vice Chair Brenda Deeley and Member Maura Byron. The ad hoc committee met via Teams on April 22, 2021 to review the applications received from the recent recruitment to fill the five expiring WCM FAC seats for three Authorized Family Members and two Community Based Organization or Consumer Advocate Representatives.

The ad hoc committee recommended the following applicants for the three expiring Authorized Family Member Representative seats: Kathleen Lear (new appointment), Monica Maier (reappointment) and Malissa Watson (reappointment). The committee also recommended Sandra Cortez-Schultz (reappointment) as a Community Based Organization Representative.

Action: ***On motion of Vice Chair Brenda Deeley, seconded and carried, the Committee approved the WCM FAC Slate of Candidates. (Motion carried 8-0-0; Member Sandra Cortez-Schultz absent)***

Consider Recommending Adding a WCM FAC Orange County Health Care Agency Representative

Chair Kristen Rogers reviewed the recommendation to add an Orange County Health Care Agency Representative standing seat to the committee.

Action: ***On motion of Member Maura Byron, seconded and carried, the Committee approved the recommendation to add an Orange County Health Care Agency Representative . (Motion carried 8-0-0; Member Sandra Cortez-Schultz absent)***

CEO AND MANAGEMENT REPORTS

Chief Operating Officer Update

Ladan Khamseh, Chief Operating Officer announced that Emily Fonda, M.D. has accepted the Chief Medical Officer position at CalOptima. Ms. Khamseh also updated the committee on the current status of the draft policy intended to address health network model changes that was discussed at the August 2020 Board meeting. Ms. Khamseh noted that the policy included draft language that is intended to define the criteria and provided the process for health networks to

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submit requests for contract model changes. She also noted that staff plans to prepare and submit this policy for board consideration at the May 6, 2021 Board meeting. Ms. Khamseh also updated the committee on the status of the Qualified Medicare Beneficiary annual outreach to members.

Chief Medical Officer Update

Emily Fonda, M.D., Chief Medical Officer, provided a COVID-19 update and discussed the on-going vaccine efforts that were currently in progress. Dr. Fonda noted that over 71K members who had been vaccinated. She discussed how the incentive gift cards had been distributed to CalOptima members as an incentive for getting their vaccine. Dr. Fonda also discussed the vaccine initiatives for those members who are homeless and addressed the myths that were circulating about the vaccines.

INFORMATION ITEMS

Whole-Child Model Member Updates

Chair Kristen Rogers notified the members that the annual committee accomplishments were being developed and to submit any items they would like to add to Cheryl Simmons, Staff to the Committees. She noted that the committee will approve these accomplishments at their June 22, 2021 meeting and that they would be submitted to the Board as an informational item.

CalOptima 2020-2022 Strategic Plan Discussion

Rachel Selleck, Executive Director, Public Affairs, jointly presented with Debra Kegel, Director, Strategic Development and Claudia Magee, Manager, Strategic Development the feedback they received on the FY 2020-2022 Strategic Plan that was presented at the advisory committees joint meeting March 11, 2021. WCM FAC members provided additional feedback on Health Equity, Social Determinants of Health, Service Delivery Model and Behavioral Health as well as other service categories during the meeting.

California Advancing and Innovating Medi-Cal (CalAIM) Update

Pallavi Patel, Director, Process Excellence provided a California Advancing and Innovating Medi-Cal (CalAIM) presentation. She noted that this overview had been presented to the Board at their April meeting. Ms. Patel noted that a final plan will be presented to the Board at their June 3, 2021 meeting with submission of deliverables to the Department of Health Care Services (DHCS) on or before July 1, 2021.

Federal and State Legislative Update

Jackie Mark, Sr. Policy Advisor, Government Affairs provided an update on several legislative items of interest to the committee and referred the committee to the handout that they had received in their meeting materials including the CalOptima's Legislative Platform and Legislative Priorities.

Medi-Cal Rx Update

Kristin Gericke Pharm.D, Director, Pharmacy Management provided a verbal update on the Medi-Cal Rx transition to Magellan Health Care and noted that it again had been delayed due to Magellan being purchased by Centene and due to conflict of interest. Dr. Gericke noted that meetings had been postponed indefinitely by the Department of Health Care Services.

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Family Support Network

Maura Byron, Executive Director, Family Support Network and current WCM FAC member presented on how the Family Support Network offered resources and advocacy for families and children with social, emotional, intellectual and physical needs so they could achieve their full potential by offering programs to empower families to be the best versions of themselves.

ADJOURNMENT

Chair Rogers reminded the committee members that the next meeting would be on June 22, 2021 at 9:30 a.m.

Hearing no further business, Chair Rogers adjourned the meeting at 11:18 a.m.

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

Approved: August 24, 2021

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MINUTES

REGULAR MEETING OF THE CALOPTIMA BOARD OF DIRECTORS' ONECARE CONNECT CAL MEDICONNECT PLAN (MEDICARE-MEDICAID PLAN) MEMBER ADVISORY COMMITTEE

June 24, 2021

A Regular Meeting of the CalOptima Board of Directors' OneCare Connect Member Advisory Committee (OCC MAC) was held on June 24, 2021, CalOptima, 505 City Parkway West, Orange, California and via teleconference (Go-to-Webinar) in light of the COVID-19 public health emergency and consistent with Governor Newsom's executive orders EO-N-25-20 and EO-N-29-20, which temporarily relax the teleconferencing requirements of the Brown Act.

CALL TO ORDER

Chair Patty Mouton called the meeting to order at 3:01 p.m. and led the Pledge of Allegiance.

ESTABLISH QUORUM

Members Present: Patty Mouton, Chair; Keiko Gamez, Vice Chair; Meredith Chillemi; Gio Corzo (3:15 PM); Sandra Finestone (3:15 PM); Sara Lee; Mario Parada; Donald Stukes

Members Absent: Josefina Diaz; Eleni Hailemariam, M.D. (non-voting)

Others Present: Ladan Khamseh, Chief Operating Officer; Emily Fonda, M.D. Chief Medical Officer; Belinda Abeyta, Executive Director, Operations; Tracy Hitzeman, Executive Director Clinical Operations; Albert Cardenas, Director, Customer Service; Edwin Poon, Ph.D., Director, Behavioral Health Services; Jackie Marks, Sr. Policy Advisor, Government Affairs; Cheryl Simmons, Staff to the Advisory Committees; Jorge Dominguez, Lead Customer Service Representative, Customer Service.

MINUTES

Approve the Minutes of the April 22, 2021 Special Meeting of the CalOptima Board of Directors' OneCare Connect Member Advisory Committee (OCC MAC)

Action: ***On motion of Member Meredith Chillemi, seconded and carried, the Committee approved the minutes of the April 22, 2021 meeting by a roll call vote. (Motion carried 6-0-0; Voting Member Gio Corzo, Josefina Diaz and Sandy Finestone absent)***

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PUBLIC COMMENT

There were no requests for public comment

REPORTS

Consider Approval of FY 2020-2021 OneCare Connect Member Advisory Committee Meeting Accomplishments

Action: ***On motion of Member Mario Parada, seconded and carried, the Committee approved the FY 2020-2021 Accomplishments by a roll call vote. ((Motion carried 6-0-0; Voting Members Gio Corzo, Josefina Diaz and Sandy Finestone absent)***

Chief Operating Officer Report

Ladan Khamseh, Chief Operating Officer, updated the OCC MAC on the vaccination events that had taken place in CalOptima's parking lot and noted that over 800 individuals received vaccines. She thanked the Orange County Health Care Agency for their partnership in this endeavor. Ms. Khamseh also notified the committee that CalOptima had received notice that Centers for Medicare and Medicaid (CMS) would be auditing the OneCare and OneCare Connect program. The audit is anticipated to begin July 16, 2021 and conclude August 6, 2021 and will be conducted virtually. Ms. Khamseh asked the committee to review the CalOptima COVID-19 Provider Toolkit that was included in their materials and to let staff know if they had any questions.

Chief Medical Officer Report

Emily Fonda, M.D. Chief Medical Officer, provided a COVID-19 update and discussed COVID-19 vaccine efforts that were currently in progress. Dr. Fonda noted that over 56,000 gift cards had currently been sent to members as an incentive for getting vaccinated of which approximately 1200 gift cards had been given to homeless individuals for obtaining their vaccines as part of CalOptima's collaboration with the Orange County Health Care Agency(OCHCA) and Federally Qualified Health Centers (FQHC) such as AltaMed, Families Together, Korean Community Services and Share Our Selves Clinics. The gift cards were provided on-site after the individual received the COVID-19 vaccine dose. She also noted that the OCHCA and the FQHCs sent in weekly reports to CalOptima on the vaccine initiative.

INFORMATION ITEMS

OCC MAC Member Updates

Chair Patty Mouton notified the Committee that the Board at their June 3, 2021 meeting had approved the reappointments of Josefina Diaz, Sandy Finestone and Sara Lee. Chair Mouton noted that this would be the last meeting for Mario Parada whose term expires on June 30, 2021 and thanked him for his service on the OCC MAC. Member Parada served as the In-Home Supportive Services Representative and CalOptima staff is continuing the recruitment for this seat.

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At this time, Chair Patty Mouton rearranged the agenda to hear Item VII.E Ombudsman Report before continuing with the agenda.

Ombudsman Report

Sara Lee, Supervising Attorney Health Consumer Action Center of Community Legal Aid SoCal (CLA SoCal) provided the Ombudsman Update. Ms. Lee, who is also the OCC MAC Representative for Members of Ethnic and Cultural Communities reviewed how the CLA SoCal has been assisting dual eligible consumers during the pandemic with share of cost affordability issues such as: whether the share of cost determination is correct and whether the member was placed in the correct Medi-Cal Aid Code for OneCare Connect enrollment. Ms. Lee will continue to update the committee with regular Ombudsman reports.

OneCare Connect Transition Planning Update

Ravina Hui, Director, Program Implementation provided an update on the transition of the OneCare Connect Program to the OneCare Program once the Cal MediConnect program expires on December 31, 2022.

Behavioral Health Update

Edwin Poon, Ph.D., Director, Behavioral Health Services provided a verbal update on CalOptima's Behavioral Health programs. Dr. Poon also discussed the Behavioral Health Integration Incentive Program (BHIIP) with the committee and noted that CalOptima would be working with seven entities to assist with twelve project. He also provided an update on the Applied Behavioral Analysis (ABA) Pay for Value (P4V) program to support the ABA programs at CalOptima.

Federal and State Legislative Update

Jackie Mark, Sr. Policy Advisor, Government Affairs provided an update on several legislative items of interest to the committee and referred the committee to the handout that they had received in their meeting materials including the CalOptima's summary on the Governor's May Revise to the California State Budget.

ADJOURNMENT

Chair Mouton reminded the members that the next regular OCC MAC meeting is scheduled for August 26, 2021 at 3:00 p.m.

Hearing no further business, the meeting adjourned at 4:06 p.m.

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

Approved: August 26, 2021

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MINUTES

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

August 12, 2021

A Regular Meeting of the CalOptima Board of Directors' Member Advisory Committee (MAC) was held on August 12, 2021, CalOptima, 505 City Parkway West, Orange, California and via teleconference (Go-to-Webinar) in light of the COVID-19 public health emergency and consistent with Governor Newsom's executive orders EO-N-25-20 and EO-N-29-20, which temporarily relax the teleconferencing limitations of the Brown Act.

CALL TO ORDER

Chair Christine Tolbert called the meeting to order at 3:01 p.m. and led the Pledge of Allegiance.

ESTABLISH QUORUM

Members Present:	Christine Tolbert, Chair; Pamela Pimentel, Vice Chair (3:12 p.m.); Linda Adair (3:30 p.m.) Maura Byron; Meredith Chillemi; Sandra Finestone; Connie Gonzalez; Hai Hoang; Sally Molnar; Kate Polezhaev (3:15 p.m.); Sister Mary Therese Sweeney; Steve Thronson;
Members Absent:	Jacqueline Gonzalez; Patty Mouton; Melisa Nicholson;
Others Present:	Ladan Khamseh, Chief Operating Officer; Emily Fonda, M.D. Chief Medical Officer; Michelle Laughlin, Executive Director, Network Operations; Albert Cardenas, Director, Customer Service; Ravina Hui, Director, Program Implementation; Debra Kegel, Director, Strategic Development; Jackie Mark, Manager, Government Affairs; Cheryl Simmons, Staff to the Advisory Committees; Jorge Dominguez, Lead Customer Service Representative, Customer Service.

Chair Tolbert welcomed Meredith Chillemi to the MAC as the Seniors Representative.

MINUTES

Approve the Minutes of the June 10, 2021 Regular Meeting of the CalOptima Board of Directors' Member Advisory Committee

Action: ***On motion of Member Steve Thronson, seconded and carried, the MAC approved the minutes as submitted. (9-0-0, Members Adair, J. Gonzalez, Mouton, Nicholson, Pimentel and Polezhaev absent)***

PUBLIC COMMENT

Steve McNally, Costa Mesa Resident – Oral Re: Behavioral Health Services in Orange County.

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CEO AND MANAGEMENT REPORTS

At this time, Chair Tolbert rearranged the agenda to hear the Item V.C Chief Medical Officer Report before continuing with the remainder of the agenda.

Chief Medical Officer Report

Emily Fonda, M.D. Chief Medical Officer, provided a COVID-19 update and discussed COVID-19 vaccine efforts that were currently in progress. Dr. Fonda noted that over 368,000 members had received vaccinations and noted that the Whole-Child Model program was doing well with a 46 percent vaccination rate. She also noted that 197,000 gift cards had been sent to members as an incentive for getting vaccinated. She noted that CalOptima ranked sixth out of the 24 managed care plans in California. She also noted the vaccine events held by CalOptima and the Orange County Health Care agency during July in which 5,073 individual were able to receive vaccines with 2,340 gift cards provided to CalOptima members.

Chief Operating Officer Report

Ladan Khamseh, Chief Operating Officer, provided an update on improvements to provider communications. She noted that recently CalOptima transitioned over 8,600 (90% of CalOptima Community Network (CCN) providers) from fax-based provider alerts, updates and newsletters to electronic mail. This functionality will give providers instant access to links, websites and other documents which could not be achieved with blast-faxes. She also noted that the next steps will include gathering email addresses from health networks exclusive providers who do not currently participate with CCN. Ms. Khamseh also provided an update on the Centers for Medicare and Medicaid Services (CMS) audit of CalOptima's OneCare and OneCare Connect programs that had just been completed. Ms. Khamseh also notified the MAC that Michael Herman had accepted the position as the Interim Executive Director, Program Implementation. Mr. Herman who was previously the Director, IS-Application Development will return to the MAC in September with a CalAIM update.

INFORMATION ITEMS

MAC Member Updates

Chair Christine Tolbert notified the members that during the first week of September they would be receiving an email providing information on how to access the yearly compliance courses that all committee members must take. She noted that the compliance courses would be due in early November and also noted that the modules would be rolled out on a new platform. She asked the members to reach out to Cheryl Simmons should they have difficulty accessing these mandatory courses.

Intergovernmental Transfer Funds (IGT) 10 Update

Debra Kegel, Director, Strategic Development provided an update on the IGT 10. She reviewed the process of securing additional federal revenue from CMS to increase CalOptima's Medi-Cal managed care capitation rates. She noted that the funds must be used for Medi-Cal covered services as outlined in CalOptima's Department of Health Care Services contract for Medi-Cal members.

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Ms. Kegel also explained that IGT 10 will be paid out in two installments. The first installment was received in May 2021 and the second installment expected sometime Fall 2021 for a total of $45.1million in IGT funds. She noted that some of the IGT funds would be used for the Orange County COVID-19 Nursing Home Prevention Program, COVID-19 Vaccination Member Incentive Program for 2021.

OneCare Connection Transition

Ravina Hui, Director, Program Implementation updated the MAC on the CMS transition of the Cal MediConnect program, currently known as CalOptima's OneCare Connect program. She noted that the program will conclude on December 31, 2022. Ms. Hui noted that existing OneCare Connect members would have the option of being moved to CalOptima's OneCare program for 2023.

Healthcare Effectiveness Data and Information Set (HEDIS) MY2020 Results

Irma Munoz, Project Manager Lead, Quality Analytics, gave a brief presentation on CalOptima's annual HEDIS results. Ms. Munoz reviewed DHCS regulatory reporting requirements for Managed Care Plans called the Managed Care Accountability Set (MCAS) and the National Committee for Quality Assurance (NCQA) accreditation scores. Ms. Munoz noted that CalOptima was successful in meeting all the DHCS minimum performance levels.

Member Experience Results

Marsha Choo, Manager, Quality Analytics reviewed the member experience results with the committee. She noted that CalOptima fields annual member experience surveys for the Medi-Cal adult and pediatric populations using the Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey during the period of February – May 2021. She also noted that there was an approximately 20% decrease in the response rate for this year with an average of 17.56% adults and 18.88% children that is likely a result of the current pandemic.

Federal & State Legislative Update

Jackie Mark, MPP, Manager, Government Affairs presented on several legislative items of interest to the MAC and referred the committee to the Legislative Matrix that they had received as part of their meeting materials.

ADJOURNMENT

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

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

Approved: September 9, 2021

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MINUTES

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

August 12, 2021

A Regular Meeting of the CalOptima Board of Directors' Provider Advisory Committee (PAC) was held on August 12, 2021, CalOptima, 505 City Parkway West, Orange, California and via teleconference (Go-to-Webinar) in light of the COVID-19 public health emergency and consistent with Governor Newsom's executive orders EO-N-25-20 and EO-N-29-20, which temporarily relax the teleconferencing requirements of the Brown Act.

CALL TO ORDER

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

ESTABLISH QUORUM

Members Present:	Junie Lazo-Pearson, Ph.D., Chair; John Nishimoto, O.D., Vice Chair; Amin Alpesh, M.D.; Anjan Batra, M.D.; Tina Bloomer, MHNP (8:10 a.m.); Gio Corzo; Andrew Inglis, M.D.; Loc Tran, PharmD.; Alexander Rossel; Jacob Sweidan, M.D.; Christy Ward
Members Absent:	Jennifer Birdsall, Ph.D.; Donald Bruhns; Jena Jensen
Others Present:	Ladan Khamseh, Chief Operating Officer; Gary Crockett, Chief Counsel; Emily Fonda, M.D., Chief Medical Officer; Michelle Laughlin, Executive Director, Network Operations; Mike Herman, Interim Executive Director, Program Implementation; Debra Kegel, Director Strategic Development; Donald Sharps, M.D., Medical Director; Natalie Zavala, Interim Director, Behavioral Health Services; Kelly Rex-Kimmet, Director, Quality Analytics; Paul Jiang, Manager, Quality Analytics; Marsha Choo, Manager, Quality Analytics; Jackie Mark, Manager, Government Affairs; Cheryl Simmons, Staff to the Advisory Committees; Jorge Dominguez, Lead Customer Service Representative, Customer Service

Dr. Lazo-Pearson welcomed Gio Corzo as the Allied Health Representative and welcomed back Jacob Sweidan, M.D. as the Health Network Representative. She noted that Dr. Sweidan had previously served on the PAC as a Physician Representative until 2020.

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MINUTES

Approve the Minutes of the June 10, 2021 Regular Meeting of the CalOptima Board of Directors' Provider Advisory Committee

Action: ***On motion of Member Christy Ward, seconded and carried, the Committee approved the minutes of the June 10, 2021 regular meeting. (Motion carried 10-0-0; Members Jennifer Birdsall; Tina Bloomer; Donald Bruhns; Jena Jensen absent)***

PUBLIC COMMENTS

There were no public comments.

CEO AND MANAGEMENT REPORTS

Chief Operating Officer Report

Ladan Khamseh, Chief Operating Officer, introduced Mike Herman as the Interim Executive Director, Program Implementation. Mr. Herman, previously the Director, IS-Application Development noted that he will return to the PAC in September with a CalAIM update. Ms. Khamseh shared that, in an effort to improve provider communications, CalOptima transitioned over 8,600 (90% of CalOptima Community Network (CCN) providers) from fax-based provider alerts, updates and newsletters to electronic mail. This functionality gives providers instant access to links, websites and other documents which could not be achieved with blast-faxes. She also noted that the next steps will include gathering email addresses from the health networks' exclusive providers who do not currently participate with CCN. Ms. Khamseh also provided an update on the Centers for Medicare & Medicaid Services (CMS) audit of CalOptima's OneCare and OneCare Connect programs that has just been completed. Ms. Khamseh thanked the health networks for all of their assistance with this audit.

Chief Medical Officer Report

Emily Fonda, M.D., Chief Medical Officer, provided a comprehensive COVID-19 update and also updated the PAC on the vaccine status in Orange County and the distribution of the vaccine gift cards for CalOptima members. Dr. Fonda also updated the PAC on the Delta variant of COVID that has been spreading, primarily among unvaccinated individuals. PAC Member Dr. Sweidan asked staff to look into whether CalOptima could consider assisting the health networks with the cost of back-to-school COVID testing for school-aged CalOptima members.

INFORMATION ITEMS

Intergovernmental Transfer Funds (IGT) 10 Update

Debra Kegel, Director, Strategic Development provided an update on IGT 10. She reviewed the process of securing additional federal revenue from CMS to increase CalOptima's Medi-Cal managed care capitation rates. She noted that the funds must be used for Medi-Cal covered services included in CalOptima's Department of Health Care Services (DHCS) contract for Medi-Cal members. Ms. Kegel also explained how the IGT 10 funds would be paid out in two

installments, with the first installment already having been received in May 2021 and the second expected sometime in the Fall of 2021 for a total of $45.1 million. She also noted that some of the IGT funds will be used for the Orange County COVID-19 Nursing Home Prevention Program and for the COVID-19 Vaccination Member Incentive Program for 2021.

Healthcare Effectiveness Data and Information Set (HEDIS) MY 2020 Results

Kelly Rex-Kimmet, Director, Quality Analytics and Paul Jiang, Manager, Quality Analytics, provided the Annual Health Effectiveness Data and Information Set (HEDIS) 2020 results. Ms. Rex-Kimmet along with Mr. Jiang both reviewed the DHCS regulatory reporting requirements with the committee members and noted that CalOptima had been successful in achieving all the DHCS minimum performance levels.

Member Experience Results

Marsha Choo, Manager, Quality Analytics reviewed the member experience results with the committee. She noted that CalOptima fields annual member experience surveys for the Medi-Cal adult and pediatric populations using the Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey during the period of February – May 2021. She noted that there was an approximately 20% decrease in the response rate for this year with an average of 17.56% Adults and 18.88% Children and noted that this could be due to the on-going pandemic.

Behavioral Health Update

Donald Sharps, M.D., Medical Director, Behavioral Health Services and Natalie Zavala, Interim Director, Behavioral Health Services provided a verbal updates on CalOptima's Behavioral Health programs. Dr. Sharps also discussed the Behavioral Health Integration Incentive Program (BHIIP) and an update on the Applied Behavioral Analysis (ABA) Pay for Value (P4V) program to support the ABA programs at CalOptima.

Federal and State Legislative Update

Jackie Mark, MPP, Manager, Government Affairs presented on several legislative items of interest to the committee and referred the committee to the Legislative Matrix handout that they had received in their meeting materials.

PAC Member Updates

Chair Dr. Lazo-Pearson requested assistance from the PAC with the recruitment of a Physician Representative to fulfill the remainder of a term which runs through June 30, 2022. Dr. Lazo-Pearson also notified the members that during the first week of September they would be receiving an email providing information on how to access the yearly compliance courses that all committee members must take. She also noted that the compliance courses would be due in early November and that the modules would be rolled out on a new platform. She asked the members to reach out to Cheryl Simmons should they have difficulty accessing their courses.

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ADJOURNMENT

Chair Dr. Lazo-Pearson reminded the PAC that the next meeting would be on September 9, 2021 at 8 a.m. Hearing no further business, Dr. Lazo-Pearson adjourned the meeting at 9:38 a.m.

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

Approved: September 9, 2021

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken October 7, 2021
Regular Meeting of the CalOptima Board of Directors

Consent Calendar

4. Consider Approval to Extend the Behavioral Health Applied Behavior Analysis Pay for Value Performance Program for Calendar Year 2022

Contacts

Emily Fonda, M.D., MMM, CHCQM, Chief Medical Officer, (714) 246-8887
Donald Sharps, M.D., Medical Director, Behavioral Health Integration, (714) 246-8737

Recommended Action

Extend the approved Behavioral Health Applied Behavior Analysis (ABA) Pay for Value (P4V) Program for the calendar year January 1, 2022–December 31, 2022.

Background

During the October 2020 Board of Directors Meeting, the Board approved the "Report Item #22 — Consider Recommending Board of Directors' Approval of the Calendar Year 2021 Behavioral Health Applied Behavior Analysis (ABA) Pay for Value (P4V) Performance Program (Attachment 1).

The program targets ABA services by incentivizing ABA providers to improve quality outcomes by focusing on supervision and utilization of one-on-one (1:1) services. The Behavioral Health Integration (BHI) department completed the implementation design for the program and launched the program in January 2021. The baseline period for the program metrics is calendar year (CY) January 1–December 31, 2020, and the measurement period is from January 1–December 31, 2021. The ABA provider groups' incentive payout is targeted for the end of Quarter 1 2022. CalOptima is utilizing a report card style format to send the ABA provider groups their individual monthly results for each performance metric:

- Metric 1 — ABA Utilization (ABAU): Percentage of 1:1 hours utilized vs. authorized
- Metric 2 — ABA Supervision Hours (ABAH): Percentage of supervision hours completed by a Board Certified Behavior Analyst (BCBA) or a Behavior Management Consultant (BMC)

Discussion

The ABA P4V Program was designed to improve quality of care, result in better individualized treatment recommendations, consistent treatment delivery, and decrease member grievances. To fully evaluate the performances comprehensively, the program requires additional time to mature and be analyzed for program continuance. The BHI department has received ABA provider support for the program. As anticipated, ABA providers will continue to provide valuable feedback as they use their internal systems to track their performance.

The current trend reflects the measurement period year-to-date:

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	CY 2020 (Baseline)	YTD 2021 (Measurement period)
Metric ABAU	59.33%	34.66%
Metric ABAH	50.38%	49.51%

To earn the incentive, during the first year (CY 2021), the ABA provider group needed a baseline for calendar year 2020. During the program's second year (CY 2022), new ABA provider groups who did not have a baseline for 2020, must have a baseline for 2021. The incentive payout for the first year of the program is planned for end of Quarter 1 2022.

When the incentives are calculated, the ABA provider groups will need to have reached the target goals for each performance metric set at four incentive levels. The maximum combined incentive for the two-performance metrics will be no more than 4% of the provider's annual claims payment. The incentive will be calculated based on the level they reach, with a corresponding percent of annual claim paid amount:

- Level 1 — 0.5% of annual claims paid incentive payout
- Level 2 — 1.0% of annual claims paid incentive payout
- Level 3 — 1.5% of annual claims paid incentive payout
- Level 4 — 2.0% of annual claims paid incentive payout

A report card was designed to send to each ABA provider group to monitor their progress. The frequency to send report cards to the ABA provider groups will change from monthly to quarterly beginning January 2022.

Fiscal Impact

The recommended action to extend the approved Behavioral Health Applied Behavior Analysis (ABA) Pay for Value (P4V) Program for CY 2022 is a budgeted item under the CalOptima Fiscal Year 2021–22 Operating Budget approved by the CalOptima Board of Directors on June 3, 2021. Funding is estimated not to exceed $1.5 million.

Rationale for Recommendation

By selecting two measurable performance metrics, the BHI P4V program will reflect improvement in quality by incentivizing ABA providers to:

1. Increase BCBA supervision of ABA services and move toward a two-tier supervision model.
2. Increase the percentage of necessary and authorized ABA hours that members receive.

Concurrence

Board of Directors' Quality Assurance Committee
Gary Crockett, Chief Counsel

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Attachments

1. Board Action Dated October 1, 2020: Consider Recommending Board of Directors' Approval of the Calendar Year 2021 Behavioral Health Applied Behavior Analysis (ABA) Pay for Value (P4V) Performance Program
2. Presentation: Behavioral Health Applied Behavior Analysis Pay for Value Performance Program Update

/s/ Richard Sanchez *09/29/2021*
Authorized Signature **Date**

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken October 1, 2020
Regular Meeting of the CalOptima Board of Directors

Report Item
22. Consider Approval of the Calendar Year 2021 Behavioral Health Applied Behavior Analysis Pay for Value Performance Program

Contacts
David Ramirez, M.D., Chief Medical Officer, (714) 246-8400
Betsy Ha, R.N., Executive Director, Quality and Population Health Management, (714) 246-8400
Edwin Poon, Ph.D., Director, Behavioral Health Services, (Integration) (714) 246-8400

Recommended Action
Recommend Approval of the Behavioral Health Applied Behavior Analysis (ABA) Pay for Value (P4V) Program for the Measurement Period effective January 1, 2021 through December 31, 2021.

Background
Behavioral Health Treatment (BHT) is a Medi-Cal covered service under the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit for members under 21 years of age. From 2014 to 2017, CalOptima Medi-Cal Behavioral Health (BH) benefits, including BHT services, were delegated to a Managed Behavioral Health Organization (MBHO). In 2018, CalOptima integrated Medi-Cal BH benefits within CalOptima internal operations. Currently, approximately 3,000 CalOptima Medi-Cal members receive BHT services each year.

Applied Behavior Analysis (ABA) is a type of BHT service. It has been identified as an evidenced-based approach for preventing or minimizing the adverse effects of behaviors that interfere with learning and social interaction. ABA therapy is intense, with treatment hours averaging 9 to 10 per week. The course of treatment can last for several years or longer. Most of the direct services are rendered by paraprofessionals who are unlicensed and require ongoing supervision. The education requirements for paraprofessionals are high school diploma, a minimum of 40 hours of training, and a demonstrated competency in implementing ABA intervention.

Since the Department of Health Care Services (DHCS) implemented the BHT benefit in 2014, CalOptima has followed the State Plan Amendment (SPA 14-026) regarding the types of providers allowed to supervise paraprofessionals:

1. Board Certified Behavior Analyst (BCBA)
2. Behavior Management Consultant (BMC)
3. Behavior Management Assistant (BMA)
4. Board Certified Assistant Behavior Analyst (BCaBA)

BCBA and BMC are considered the top tier supervisor types, while BMA and BCaBA fall under the mid-tier level. When a paraprofessional is supervised by a mid-tier provider, a BCBA or BMC is still required to oversee the work to ensure quality of care.

In 2018, CalOptima proposed to phase out the mid-tier level (BMAs and BCaBAs) within a one-year period. The rationale for phasing out mid-tier was to raise the overall quality of care and align our approach with most commercial insurance plans and the Regional Center of Orange County. At that time, ABA providers expressed concerns over lack of available BCBAs and the associated cost. As a result, CalOptima has continued to maintain the 3-Tier model approach. Currently, approximately 50% of supervisions are conducted by the mid-tier level supervisors.

During the 2019 DHCS medical audit, file review showed some ABA providers were not providing the hours as stated in individual members' treatment plans. DHCS noted that when ABA providers insufficiently deliver direct service hours, members may not receive effective treatment and consequently, the quality of care may be compromised. DHCS recommended that CalOptima update and implement policies and procedures to monitor and ensure that ABA providers are providing BHT services based upon approved treatment plans, including providing direct service hours as authorized. Since then, CalOptima has developed a monitoring tool to track utilization of ABA direct services. Data reports show that the recommended hours authorized are not being fully utilized. Currently, on average, approximately 41% of authorized hours are being utilized. The DHCS medical audit findings also support the assumption that utilizing only top-tier level for supervision and monitoring of the ABA providers will help promote member and family-centered treatment planning, ensure appropriate utilization of direct service hours, and improve member experience with the ABA services. Currently there are no HEDIS or standardized measures for the quality of BHI ABA services

Discussion

In an effort to improve the quality of ABA services, CalOptima staff proposes to implement a Pay for Value (P4V) program designed to address the quality issues mentioned above. CalOptima has had good success with P4V programs targeting medical care both at the Health Network (HN) and individual provider levels. With CalOptima directly managing BH Services, there is an opportunity to leverage the same P4V program success to improve ABA services.

CalOptima has implemented a comprehensive Health Network P4V Performance Measurement Program consisting of recognizing outstanding performance and supporting ongoing improvement that strengthens CalOptima's mission of providing members with access to quality health care. Annually, CalOptima staff conducts a review of the current measures and their performance over time. A part of this analysis includes evaluating both the overall performance of the measure and the level of improvement left to achieve. In addition, staff analyzes the difficulty of improving a measure due to the size of the eligible population or difficulty in data gathering. Finally, staff evaluates any changes to the specifications of the measures that are important to CalOptima's NCQA Accreditation status and/or overall Health Plan Rating.

The purpose of CalOptima's P4V program for the Health Networks, including the CalOptima Community Network (CCN), is consistent with the P4V programs of the previous years, which remains:

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

With CalOptima directly managing BH services, there is an opportunity to leverage the same P4V program success to improve ABA services.

The BHI ABA P4V Program is designed to improve quality of care, result in better individualized treatment recommendations, consistent treatment delivery, and decrease member grievances. Since there are currently no HEDIS or standardized measures for the quality of BHI ABA services, staff recommends that the program focus on two measurable objectives associated with quality of care:

1. Increase in the percentage of BCBAs supervising ABA services.
2. Increase in the percentage of authorized hours that members receive.

The baseline period will be January 1, 2020 to December 31, 2020 and the measurement period will be January 1, 2021 to December 31, 2021, with providers to be paid within 90 days of the close of the measurement year, by the end of March 2022. To earn the incentive, ABA providers will need to reach the target goals for each measure, which are set at four levels. The incentive will be calculated based on the level they reach, with a corresponding percent of annual claim paid amount. The maximum combined incentive will be no more than 4% of the provider's annual claims payment. Each ABA provider will receive a monthly report during the measurement year to evaluate their progress. Below are the specifications of the two proposed measures:

Measure 1

$$\%\text{ of supervision hours completed by BCBA/BMC} = \frac{\text{Total H0032* HO** hours per month}}{\text{Total H0032 per month}}$$

* H0032 is the CPT code for supervision
** HO is the modifier code for BCBA

Incentive Level	1	2	3	4
Measure Target Goal	50.00%	65.00%	80.00%	95.00%
Incentive by annual claims paid	0.50%	1.00%	1.50%	2.00%

Measure 2

% of authorized 1:1 hours provided = $\frac{\text{Total number of 1:1 claims paid}}{\text{Total number of authorized 1:1 hours}}$

Incentive Level	1	2	3	4
Measure Target Goal	See Table below			
Incentive by annual claims paid	0.50%	1.00%	1.50%	2.00%

			1	2	3	4
Baseline rate			**Target Goal**			
70%	and	up	72.50%	75.00%	77.50%	80.00%
65%	to	69%	68.75%	72.50%	76.25%	80.00%
60%	to	64%	65.00%	70.00%	75.00%	80.00%
55%	to	59%	61.25%	67.50%	73.75%	80.00%
50%	to	54%	57.50%	65.00%	72.50%	80.00%
45%	to	49%	53.75%	62.50%	71.25%	80.00%
40%	to	44%	50.00%	60.00%	70.00%	80.00%
0%	to	39%	46.25%	57.50%	68.75%	80.00%

Incentive Payout Examples:

Provider A: Achieves Measure 1 and 2 target goals

	Measure 1	Measure 2
Y2020 Baseline Rate	40%	38%
Y2021 Measurement Rate	50%	46.25%
Incentive by Annual Claims Paid	**0.50%** (Level 1)	**0.50%** (Level 1)

Provider qualifies for a total of **1%** incentive based on their Y2021 claims $400,000 = payout $4,000 Q1 2022

Provider B: Achieves only one target goal

	Measure 1	Measure 2
Y2020 Baseline Rate	30%	60%
Y2021 Measurement Rate	48%	72%
Incentive by Annual Claims Paid	0% (did not meet target minimum)	**1.00%** (Level 2)

Provider qualifies for a total of **1%** incentive based on their Y2021 claims $400,000 = payout $4,000 Q1 2022

Fiscal Impact
The recommended action to approve the Behavioral Health Applied Behavior Analysis (ABA) Pay for Value (P4V) Program is a budgeted item under the Board-approved Fiscal Year 2020-21 Operating Budget and is estimated not to exceed $600k for the six months of January through June 2021. Management will include expenses related to the remainder of the measurement period in future operating budgets.

Rationale for Recommendation
Based on two measurable performance metrics, the proposed behavioral health P4V program is intended to improve quality by incentivizing applied behavioral analysis (ABA) providers to increase BCBA/BMC supervision of the delivery of ABA services and move toward a two tier supervision model, and ensure that members receive the appropriate number of necessary and authorized ABA hours.

Concurrence
Gary Crockett, Chief Counsel
Board of Directors' Quality Assurance Committee

Attachments
1. ABA P4V Presentation 9/16/2020

/s/ Richard Sanchez *09/23/2020*
Authorized Signature **Date**

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CalOptima

Better. Together.

Behavioral Health Applied Behavior Analysis Pay for Value Performance Program

Quality Assurance Committee Meeting

September 16, 2020

Edwin Poon, Ph.D., Director, Behavioral Health Integration

Donald Sharps, M.D., Medical Director, Behavioral Health Integration

Agenda

- Activities and Timeline
- Background
- Discussion
- Proposed Performance Measures and Rationale
- Framework and Fiscal Impact
- Oversight and Stakeholder Engagement

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Activities and Timeline

- Finance Review — Completed May 26
- P4V Steering Group — Completed June 29
- Executive Staff Meeting — Completed July 14
- Stakeholder Meeting — Completed August 7
- QIC Meeting — August 11
- QAC Meeting — September 16
- BOD Meeting — October 1

Background

- Behavioral Health Treatment (BHT) includes Applied Behavior Analysis (ABA).
  - Under 21 years of age
  - 2014 — Only if diagnosed with Autism Spectrum Disorder (ASD)
  - 2017 — Included non-ASD (typically intellectual disability)
- Board Certified Behavioral Analyst (BCBA) conducts Functional Behavioral Assessment (FBA) and develops treatment plan.
- Paraprofessionals conduct in-home training and behavior intervention services.
- ABA service is an intensive and long-term therapy.
- Service is renewed every six months.

Discussion: Supervision

- Follows the State Plan Amendment (SPA 14-026)
- Types of supervisors:
  - Board Certified Behavior Analyst (BCBA)
  - Behavior Management Consultant (BMC)
  - Behavior Management Assistant (BMA)
  - Board Certified Assistant Behavior Analyst (BCaBA)
- Supervision Models: 2-Tier vs. 3-Tier
  - 9 of 10 Medi-Cal managed care plans allow 3-tier
  - Three of six commercial plans allow 3-tier

Discussion: Supervision (cont.)

- Initially proposed 100% supervision by BCBA or BMC (2-Tier Model)
  - CalOptima accepted 3-Tier Model, if BCBA supervises all cases

2-Tier	3-Tier
BCBA or BMC	BCBA or BMC
Paraprofessional	BMA or BCaBA (mid-tier)
	Paraprofessional

Discussion: Under Utilization

- ABA Utilization vs. Authorization

All ABA Providers

Authorization Start Date : 2019-06 to 2019-11
Claim Date of Service : 01/01/2018 and onwards

Diagnosis	ABA Code Category	Procedure Code	Modifier	Avg. Auth Units Requested	Avg. Auth Units Authorized	Avg. Auth Units Utilized	% of Units Utlilized
non-ASD Dx	One-on-One	H2019		561	561	242	43%
			HM	672	672	0	0%
			HO	957	957	826	86%
ASD Dx	One-on-One	H2019		684	684	373	54%
			HM	1,207	1,207	234	19%
			HO	877	877	394	45%
Average Total				826	826	345	41%

ABA Code Category
- [ ] FBA
- [x] One-on-One
- [ ] Parent Consultation
- [ ] Social Skills
- [ ] Supervision

Diagnosis
- [x] ASD Dx
- [x] non-ASD Dx

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Proposed Performance Measures

- **Metrics**
  - **% of supervision hours completed by BCBAs/BMCs**
  - **% of 1:1 hours provided vs recommended**
- We want to make sure the highest quality of supervision is being provided.
- Data show intervention recommendations and what is delivered are not equivalent.

Rationale for Recommendation

- Metric #1: To increase percentage of BCBAs/BMCs supervising cases
  - ABA providers do use 100% BCBAs for other commercial plans that require this.
  - They may increase number of BCBAs supervising CalOptima cases with incentive.
  - Improve quality, decrease impairments and comply with state plan amendment (SPA).

Rationale for Recommendation (cont.)

- Metric #2: To increase percentage of hours utilized vs authorized
  - ABA providers may increase/maintain paraprofessional staffing as this has been reason given for not utilizing hours authorized.
  - They may more individualize the treatment recommendations rather than literature-based numbers.

ABA P4V Framework

- 81 contracted ABA providers*
- Framework: 4 Tier of Payout
- Measurement year: CY2021
- Payout: Q1 2022

Projected Percent of ABA Cases per Tier

Tier	% of Cases	Payout by Tier	Total Payout
Tier 1	40%	1%	0.4%
Tier 2	30%	2%	0.6%
Tier 3	20%	3%	0.6%
Tier 4	10%	4%	0.4%
TOTAL			**2.0%**

*Exception Kaiser

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ABA P4V Framework (cont.)

- Metric #1: % of supervision hours completed by BCBA/BMC

Annual Percentage P4V			
0.5%	1.0%	1.5%	2.0%
Goal rate for P4V			
50.00%	65.00%	80.00%	95.00%

- Metric #2: % of 1:1 hours provided vs. recommended

Annual Percentage P4V

Base rate			0.5%	1.0%	1.5%	2.0%	Increase to reach next level
			Goal rate for P4V				
70%	and	up	72.50%	75.00%	77.50%	80.00%	2.50%
65%	to	69%	68.75%	72.50%	76.25%	80.00%	3.75%
60%	to	64%	65.00%	70.00%	75.00%	80.00%	5.00%
55%	to	59%	61.25%	67.50%	73.75%	80.00%	6.25%
50%	to	54%	57.50%	65.00%	72.50%	80.00%	7.50%
45%	to	49%	53.75%	62.50%	71.25%	80.00%	8.75%
40%	to	44%	50.00%	60.00%	70.00%	80.00%	10.00%
0%	to	39%	46.25%	57.50%	68.75%	80.00%	11.25%

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ABA P4V Incentive Payout — Example

- Provider A — Achieves Measures 1 and 2 target goals

	Measure 1	Measure 2
Y2020 Baseline Rate	40%	38%
Y2021 Measurement Rate	50%	46.25%
Incentive by Annual Claims Paid	0.50% (Level 1)	0.50% (Level 1)
Provider qualifies for a total of **1%** incentive based on their Y2021 claims $400,000 = payout $4,000 Q1 2022		

ABA P4V Incentive Payout — Example (cont.)

- Provider B — Achieves only one target goal

	Measure 1	Measure 2
Y2020 Baseline Rate	30%	60%
Y2021 Measurement Rate	48%	72%
Incentive by Annual Claims Paid	0% (did not meet target minimum)	1.00% (Level 2)
Provider qualifies for a total of **1%** incentive based on their Y2021 claims $400,000 = payout $4,000 Q1 2022		

Preliminary Fiscal Impact

MAX	4.0%
Projected Payout (of 4%)	50.0%
Annual ABA Spend (~)	$48,000,000
Annual P4V Spend	$960,000
FY21 (6-months Jan–Jun ’21)	**$480,000**

Oversight and Stakeholder Engagement

- Oversight:
  - ABA P4V performance monitoring will fall under the same structure currently designed for Pay for Value
    - Generated Prospective Rate Reports (Dashboard)
    - Providers will be able to track their progress on each Pay for Value measure during performance measuring period.
  - Next steps
    - Determine delivery method and frequency
    - Support for provider inquiries
- Stakeholder Engagement:
  - August 7 — ABA Council
    - Feedback received
  - Q4 ABA Council — TBD

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Behavioral Health Applied Behavior Analysis Pay for Value Performance Update

Quality Assurance Committee Meeting

September 8, 2021

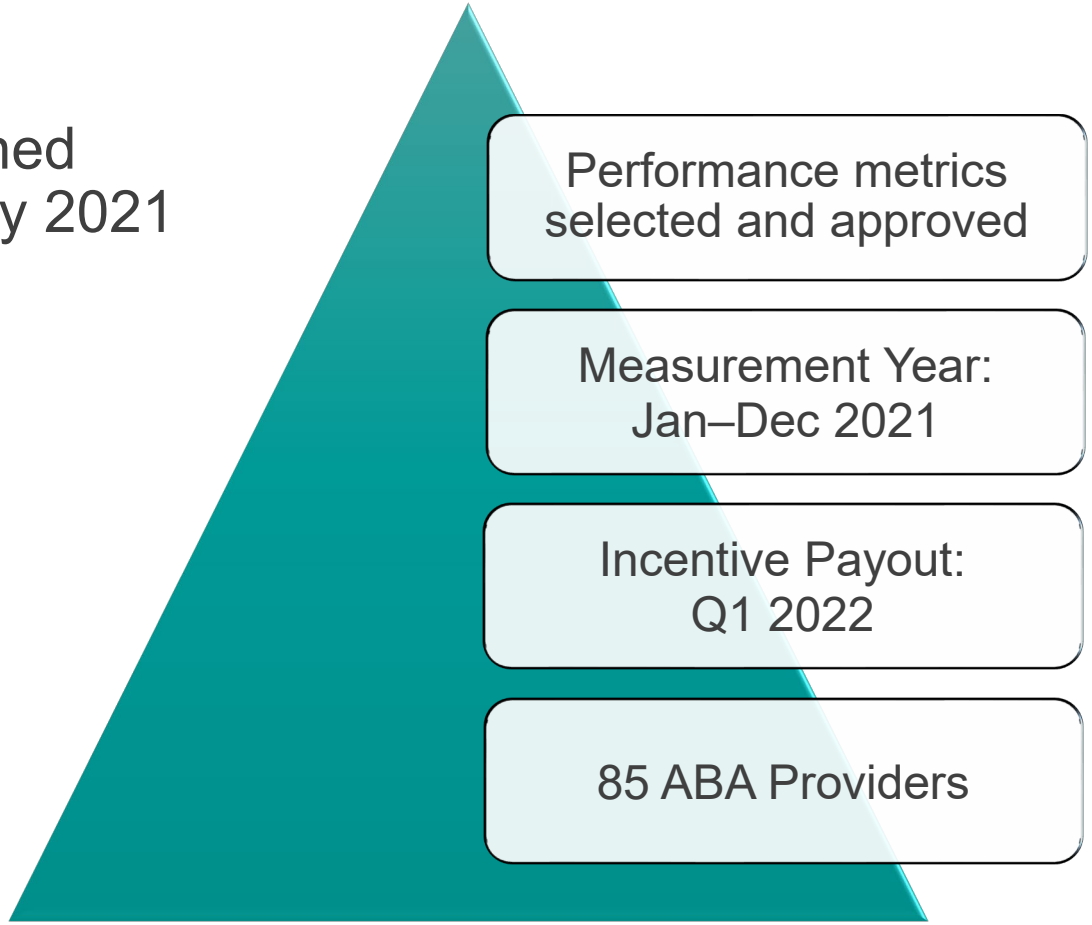
Donald Sharps, M.D., Medical Director, Behavioral Health

Agenda

- Program Background
- Performance Metrics
- Report Card
- Metric Calculations
- Preliminary Data/Outcomes
- Next Steps

Background: ABA P4V Program

- Launched January 2021



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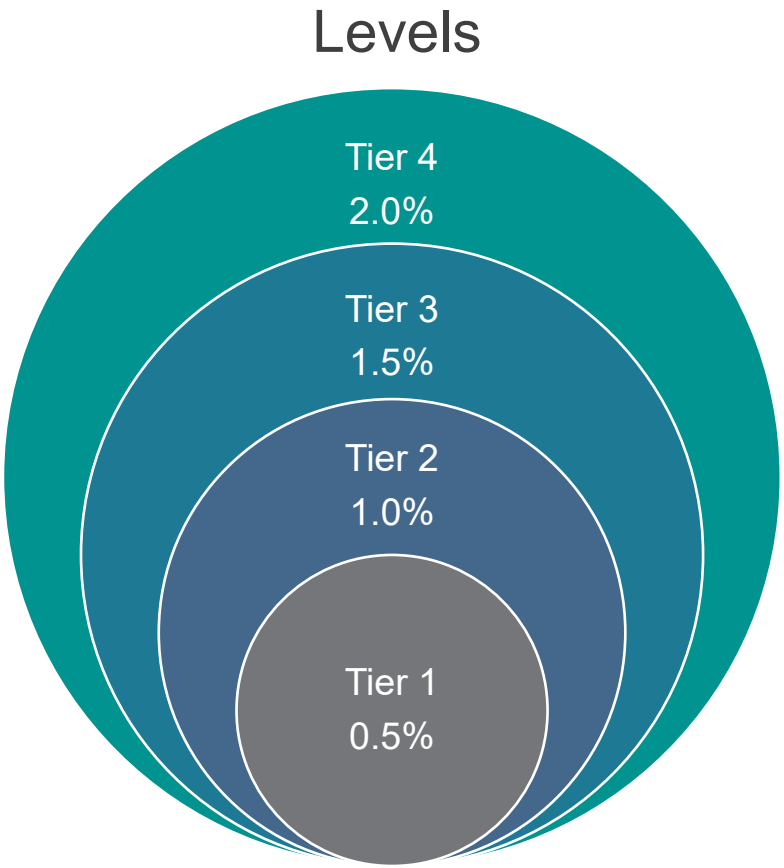
Background: Program Scope

- Each metric required 2020 utilization data to calculate baseline/rate
- To earn the incentive, the ABA provider group needs to reach the target goals for each metric, which are set at four levels
- The maximum combined incentive for the two metrics will be no more than 4% of the provider group's annual claims payment



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Program Performance Metrics

- **Metric 1: ABAU**
  - % of 1:1 hours utilized vs. authorized

			Annual Percentage P4V			
			0.5%	1.0%	1.5%	2.0%
Base rate			Goal rate for P4V			
70%	and	up	72.50%	75.00%	77.50%	80.00%
65%	to	69%	68.75%	72.50%	76.25%	80.00%
60%	to	64%	65.00%	70.00%	75.00%	80.00%
55%	to	59%	61.25%	67.50%	73.75%	80.00%
50%	to	54%	57.50%	65.00%	72.50%	80.00%
45%	to	49%	53.75%	62.50%	71.25%	80.00%
40%	to	44%	50.00%	60.00%	70.00%	80.00%
0%	to	39%	46.25%	57.50%	68.75%	80.00%

- **Metric 2: ABAH**
  - % of supervision hours completed by BCBA /BMC

Annual Percentage P4V			
0.5%	1.0%	1.5%	2.0%
Goal rate for P4V			
50.00%	65.00%	80.00%	95.00%

ABAU – Applied Behavior Analysis Utilization
ABAH – Applied Behavior Analysis Supervision hours

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Program Report Card

- Each ABA provider group receives a report card during the measurement periods

Provider Group: NAME

Tax ID: #

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ABA P4V Monthly Reporting

Metrics	Baseline 2020	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21
ABAU													
ABAH													

Disclaimer: Due to claims lag percentages will adjust as claims are processed

ABAU — 1:1 hours utilized vs. authorized
ABAH — Supervision hours completed by BCBA/BMC

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Program Metric Calculations

- ABAU: The percentage of 1:1 hours utilized vs. authorized
  - SUM of claim units for that month divided by the SUM of total auth units for that month
- ABAH: The percentage of supervision hours completed by Board Certified Behavior Analyst and/or Behavior Management Consultant
  - Total units billed of H0032-HO divided by the units billed of procedure code H0032

Program Preliminary Data/Outcomes

- Year-to-date

	CY 2020 (Baseline)	YTD 2021 (Measurement Period)
Metric ABAU	59.33%	34.66%
Metric ABAH	50.38%	49.51%

- Example of an ABA Provider Group Reporting

2020 Provider Baseline

Provider Name (By Group)		
[redacted]	ABAU	52.74%
	ABAH	31.05%

2021 Provider Metric (By Month)

Provider Name (By Group)		January	February	March	April	May
[redacted]	ABAU (Monthly)	30.93%	36.62%	41.47%	43.29%	20.10%
	ABAH	33.84%	31.58%	32.82%	32.40%	32.27%

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Program Next Steps

- Recommendation to extend program
  - Program is already budgeted
  - Allows the program to mature
  - Ample evaluation period to assess ABA providers' metrics performance
  - Conclude whether to modify the program (e.g., select different metrics)
  - Provides an opportunity window to certify the metrics' logic and reporting are sustainable

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken October 7, 2021
Regular Meeting of the CalOptima Board of Directors

Consent Calendar

5. Consider Accepting and Receiving and Filing Fiscal Year 2020-21 CalOptima Audited Financial Statements

Contact

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

Recommended Action

Recommend that the CalOptima Board of Directors accept and receive and file the Fiscal Year (FY) 2020-21 CalOptima consolidated audited financial statements as submitted by independent auditors Moss-Adams, LLP.

Background

CalOptima has contracted with financial auditors Moss-Adams, LLP since May 21, 2015, to complete CalOptima's annual financial audit. At the May 20, 2021, meeting of the CalOptima Finance and Audit Committee, Moss-Adams presented the FY 2020-21 Audit Plan. The plan includes performing the mandatory annual consolidated financial statement audit and review of relevant internal controls and compliance for CalOptima's major programs.

Discussion

Moss-Adams conducted the interim audit remotely beginning May 17, 2021, and the year-end audit remotely during July to August 2021. This year's significant audit areas that Moss-Adams reviewed included:

- Medical claims liability and claims expense;
- Capitation revenue and receivables;
- Amounts due to State of California or the California Department of Health Care Services;
- Pension and other post-employment benefits (OPEB) liabilities; and
- Impact of COVID-19.

Results from CalOptima's FY 2020-21 Audit were positive.

- The auditor made no changes in CalOptima's approach to applying critical accounting policies;
- The auditor did not report any significant difficulties during the audit;
- And the auditor identified no material misstatements nor control deficiencies.

As such, Management recommends that the Board accept the CalOptima FY 2020-21 audited financial statements, as presented.

Fiscal Impact

There is no fiscal impact related to this recommended action.

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Concurrence
Board of Directors' Finance and Audit Committee
Gary Crockett, Chief Counsel

Attachments
1. FY 2020-21 CalOptima Audited Financial Statements
2. Presentation by Moss-Adams, LLP

/s/ Richard Sanchez *09/29/2021*
Authorized Signature **Date**

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REPORT OF INDEPENDENT AUDITORS
AND FINANCIAL STATEMENTS WITH
SUPPLEMENTARY INFORMATION

ORANGE COUNTY HEALTH AUTHORITY, A PUBLIC AGENCY DBA ORANGE PREVENTION AND TREATMENT INTEGRATED MEDICAL ASSISTANCE DBA CALOPTIMA

June 30, 2021 and 2020

MOSSADAMS

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Orange County Health Authority, a Public Agency/ dba Orange Prevention and Treatment Integrated Medical Assistance/dba CalOptima
Management's Discussion and Analysis

The intent of management's discussion and analysis of CalOptima's financial performance is to provide readers with an overview of the agency's financial activities for the fiscal years ended June 30, 2021, 2020, and 2019. Readers should review this summation in conjunction with CalOptima's financial statements and accompanying notes to the financial statements to enhance their understanding of CalOptima's financial performance.

Key Operating Indicators

The table below compares key operating indicators for CalOptima for the fiscal years ended June 30, 2021, 2020, and 2019:

Key Operating Indicators	2021	2020	2019
Members (at end of fiscal period)			
Medi-Cal program	825,076	742,769	743,936
OneCare	1,934	1,452	1,537
OneCare Connect	14,833	14,358	14,123
PACE	398	391	327
Average member months			
Medi-Cal program	793,023	724,049	751,409
OneCare	1,669	1,463	1,448
OneCare Connect	14,704	14,144	14,398
PACE	389	380	303
Operating revenues (in millions)	$ 4,148	$ 3,833	$ 3,475
Operating expenses (in millions)			
Medical expenses	3,729	3,644	3,217
Administrative expenses	141	142	131
Operating income (in millions)	$ 278	$ 47	$ 127
Operating revenues PMPM (per member per month)	$ 427	$ 432	$ 377
Operating expenses PMPM			
Medical expenses PMPM	384	410	349
Administrative expenses PMPM	15	16	14
Operating income PMPM	$ 29	$ 6	$ 14
Medical loss ratio	90%	95%	93%
Administrative expenses ratio	3.4%	3.7%	4.0%
Premium tax revenue and expenses not included above			
Operating revenues (in millions)	$ 154	$ 67	$ 137
Administrative expenses (in millions)	$ 150	$ 75	$ 137

Overview of the Financial Statements

This annual report consists of financial statements and notes to those statements, which reflect CalOptima's financial position as of June 30, 2021, 2020, and 2019, and results of its operations for the fiscal years ended June 30, 2021, 2020, and 2019. The financial statements of CalOptima, including the statements of net position, statements of revenues, expenses, and changes in net position, and statements of cash flows, represent the accounts and transactions of the five (5) programs – Medi-Cal, OneCare, OneCare Connect, Program of All-Inclusive Care for the Elderly (PACE), and CalOptima Foundation (fiscal year 2019 only).

- The statements of net position include all of CalOptima's assets, deferred outflows of resources, liabilities, and deferred inflows of resources, using the accrual basis of accounting, as well as an indication about which assets and deferred outflows of resources are utilized to fund obligations to providers and which are restricted as a matter of the Board of Directors' policy.

- The statements of revenues, expenses, and changes in net position present the results of operating activities during the fiscal year and the resulting increase or decrease in net position.

- The statements of cash flows report the net cash provided by or used in operating activities, as well as other sources and uses of cash from investing and capital and related financing activities.

The following discussion and analysis addresses CalOptima's overall program activities. CalOptima's Medi-Cal program accounted for 90.1 percent, 90.3 percent, and 90.2 percent of its annual revenues during fiscal years 2021, 2020, and 2019, respectively. CalOptima's OneCare program accounted for 0.6 percent, 0.4 percent, and 0.6 percent of its annual revenues during fiscal years 2021, 2020, and 2019, respectively. CalOptima's OneCare Connect program accounted for 8.3 percent, 8.3 percent, and 8.4 percent of its annual revenues during fiscal years 2021, 2020, and 2019, respectively. All other programs in aggregate accounted for 1.0 percent, 1.0 percent, and 0.8 percent of CalOptima's annual revenues during fiscal years 2021, 2020, and 2019, respectively.

CalOptima Foundation (the "Foundation") was formed as a not-for-profit benefit corporation in 2010 dedicated to the betterment of public health care services in Orange County. During the year ended June 30, 2019, the Foundation was dissolved and all assets were transferred to CalOptima.

2021 and 2020 Financial Highlights

As of June 30, 2021 and 2020, total assets and deferred outflows of resources were approximately $2,540.8 million and $2,256.8 million, respectively, and exceeded liabilities and deferred inflows of resources by approximately $1,308.8 million and $1,025.1 million, respectively.

Net position increased by approximately $283.6 million, or 27.7 percent, during fiscal year 2021 and increased by approximately $89.6 million, or 9.6 percent, during fiscal year 2020.

Table 1a: Condensed Statements of Net Position as of June 30,
(Dollars in Thousands)

Financial Position	2021	2020	Change from 2020 Amount	Change from 2020 Percentage
ASSETS				
Current assets	$ 1,834,119	$ 1,556,053	$ 278,066	17.9%
Board-designated assets and restricted cash	645,979	642,383	3,596	0.6%
Capital assets, net	45,728	46,654	(926)	-2.0%
Total assets	2,525,826	2,245,090	280,736	12.5%
DEFERRED OUTFLOWS OF RESOURCES	14,992	11,661	3,331	28.6%
Total assets and deferred outflows of resources	$ 2,540,818	$ 2,256,751	$ 284,067	12.6%
LIABILITIES				
Current liabilities	$ 1,165,444	$ 1,171,996	$ (6,552)	-0.6%
Other liabilities	62,230	52,947	9,283	17.5%
Total liabilities	1,227,674	1,224,943	2,731	0.2%
DEFERRED INFLOWS OF RESOURCES	4,363	6,677	(2,314)	-34.7%
NET POSITION				
Net investment in capital assets	45,601	46,493	(892)	-1.9%
Restricted by legislative authority	101,509	100,574	935	0.9%
Unrestricted	1,161,671	878,064	283,607	32.3%
Total net position	1,308,781	1,025,131	283,650	27.7%
Total liabilities, deferred inflows of resources, and net position	$ 2,540,818	$ 2,256,751	$ 284,067	12.6%

2021 and 2020 Financial Highlights (continued)

Current assets increased $278.1 million from $1,556.1 million in 2020 to $1,834.1 million in 2021, primarily in cash, investments, and premium receivables. Cash and investments had a net increase of $244.3 million from deferred capitation payments from the State of California (the "State") and Intergovernmental Transfers (IGT). The increase in premium receivables is primarily due to delays in payment of updated premium capitation rates from the State. Current liabilities decreased $6.6 million from $1,172.0 million in 2020 to $1,165.4 million in 2021 due to the release of In-Home Supportive Services liability accrual offset by an increase in payables due to the State for the Gross Medical Expense (GME) risk corridor for the period of July 1, 2019 through December 31, 2020 (i.e., Bridge Period), and the Research and Prevention Tobacco Tax Act of 2016 (Proposition 56) risk corridors for fiscal years 2020 and 2021.

Board-designated assets and restricted cash increased by $3.6 million and $22.0 million in fiscal years 2021 and 2020, respectively. In addition to the existing Board-designated reserve, the Board of Directors designated a $100.0 million of total funding for homeless health initiatives. As of June 30, 2021, the balance of homeless health initiatives was $56.8 million.

The Board of Directors' policy is to augment the rest of Board-designated assets to provide a desired level of funds between 1.4 months and 2.0 months of premium revenue to meet future contingencies. CalOptima's reserve level of Tier One and Two investment portfolios as of June 30, 2021, is at 1.80 times of monthly average premium revenue.

CalOptima is also required to maintain a $300,000 restricted deposit as a part of the Knox-Keene Health Care Service Plan Act of 1975 (the "Act").

2020 and 2019 Financial Highlights

As of June 30, 2020 and 2019, total assets and deferred outflows of resources were approximately $2,256.8 million and $1,957.2 million, respectively, and exceeded liabilities and deferred inflows of resources by approximately $1,025.1 million and $935.5 million, respectively.

Net position increased by approximately $89.6 million, or 9.6 percent, during fiscal year 2020 and increased by approximately $171.1 million, or 22.4 percent, during fiscal year 2019, including the transfer of Foundation assets of approximately $2.9 million.

2020 and 2019 Financial Highlights (continued)

Table 1b: Condensed Statements of Net Position as of June 30,
(Dollars in Thousands)

Financial Position	2020	2019	Change from 2019 Amount	Change from 2019 Percentage
ASSETS				
Current assets	$ 1,556,053	$ 1,279,064	$ 276,989	21.7%
Board-designated assets and restricted cash	642,383	620,445	21,938	3.5%
Capital assets, net	46,654	46,626	28	0.1%
Total assets	2,245,090	1,946,135	298,955	15.4%
DEFERRED OUTFLOWS OF RESOURCES	11,661	11,090	571	5.1%
Total assets and deferred outflows of resources	$ 2,256,751	$ 1,957,225	$ 299,526	15.3%
LIABILITIES				
Current liabilities	$ 1,171,996	$ 965,968	$ 206,028	21.3%
Other liabilities	52,947	48,307	4,640	9.6%
Total liabilities	1,224,943	1,014,275	210,668	20.8%
DEFERRED INFLOWS OF RESOURCES	6,677	7,407	(730)	-9.9%
NET POSITION				
Net investment in capital assets	46,493	46,581	(88)	-0.2%
Restricted by legislative authority	100,574	84,930	15,644	18.4%
Unrestricted	878,064	804,032	74,032	9.2%
Total net position	1,025,131	935,543	89,588	9.6%
Total liabilities, deferred inflows of resources, and net position	$ 2,256,751	$ 1,957,225	$ 299,526	15.3%

Current assets increased $277.0 million from $1,279.1 million in 2019 to $1,556.1 million in 2020, primarily in cash and premium receivables. Cash increased $165.9 million due to delays in the submission, processing, and reimbursement of medical claims during the novel coronavirus (COVID-19) pandemic. The increase in premium receivables is primarily due to unpaid Managed Care Organization (MCO) tax. Current liabilities increased $206.0 million from $966.0 million in 2019 to $1,172.0 million in 2020, primarily due to an increase in payables due to the State for the GME and Coordinated Care Initiative (CCI) risk corridors. The GME risk corridor was enacted on June 29, 2020, through the fiscal year 2020-21 State Budget.

Board-designated assets and restricted cash increased by $22.0 million and $81.9 million in fiscal years 2020 and 2019, respectively. In fiscal year 2019, in addition to the existing Board-designated reserve, the Board of Directors designated $100.0 million of total funding for homeless health initiatives. As of June 30, 2020, the balance of homeless health initiatives was $57.2 million.

2020 and 2019 Financial Highlights (continued)

The Board of Directors' policy is to augment the rest of Board-designated assets to provide a desired level of funds between 1.4 months and 2.0 months of premium revenue to meet future contingencies. CalOptima's reserve level of Tier One and Two investment portfolios as of June 30, 2020, is at 1.96 times of monthly average premium revenue.

CalOptima is also required to maintain a $300,000 restricted deposit as a part of the Knox-Keene Health Care Service Plan Act of 1975.

2021 and 2020 Results of Operations

CalOptima's fiscal year 2021 operations and non-operating revenues resulted in a $283.7 million increase in net position, $194.1 million more compared to a $89.6 million increase in fiscal year 2020. The following table reflects the changes in revenues and expenses for 2021 compared to 2020:

Table 2a: Revenues, Expenses, and Changes in Net Position for
Fiscal Years Ended June 30,
(Dollars in Thousands)

Results of Operations	2021	2020	Change from 2020 Amount	Change from 2020 Percentage
PREMIUM REVENUES	$ 4,148,336	$ 3,833,145	$ 315,191	8.2%
Total operating revenues	4,148,336	3,833,145	315,191	8.2%
MEDICAL EXPENSES	3,729,469	3,644,419	85,050	2.3%
ADMINISTRATIVE EXPENSES	141,166	142,142	(976)	-0.7%
Total operating expenses	3,870,635	3,786,561	84,074	2.2%
OPERATING INCOME	277,701	46,584	231,117	496.1%
NONOPERATING REVENUES AND EXPENSES	5,949	43,004	(37,055)	-86.2%
Increase in net position	283,650	89,588	194,062	216.6%
NET POSITION, beginning of year	1,025,131	935,543	89,588	9.6%
NET POSITION, end of year	$ 1,308,781	$ 1,025,131	$ 283,650	27.7%

2021 and 2020 Operating Revenues

The increase in operating revenues of $315.2 million in fiscal year 2021 is primarily attributable to an increase in enrollment of 9.4 percent resulting in additional revenue of approximately $356.5 million from fiscal year 2020. The increase in revenue is offset by an increase to payables due to the State for the GME and Proposition 56 risk corridors.

2021 and 2020 Medical Expenses

Medi-Cal provider capitation, comprised of capitation payments to CalOptima's contracted health networks, increased by 4.6 percent from fiscal year 2020 to fiscal year 2021. Capitated member enrollment accounted for approximately 75.0 percent of CalOptima's enrollment, averaging 595,103 members during fiscal year 2021, and 74.9 percent of CalOptima's enrollment, averaging 542,204 members during fiscal year 2020. Included in the capitated environment are 192,076 or 32.3 percent and 175,704 or 32.4 percent members in a shared risk network for fiscal years 2021 and 2020, respectively. Shared risk networks receive capitation for professional services and are claims-based for hospital services.

Medi-Cal provider capitation expenses totaled $1,184.9 million in fiscal year 2021, compared to $1,133.1 million in fiscal year 2020. The increase reflects additional capitation expenses primarily due the increase in CalOptima's enrollment.

Medi-Cal claims expense to providers and facilities, including Long-Term Care (LTC) services, decreased by 6.0 percent from fiscal year 2020 to fiscal year 2021 primarily driven by decreased utilization trends due to the COVID-19 pandemic.

Prescription drug costs increased by 12.0 percent in fiscal year 2021 compared to fiscal year 2020 due primarily to a 18.5% unit cost increase from fiscal year 2020.

In addition to items mentioned above, total Quality Assurance Fee (QAF) payments received and passed through to hospitals increased from $154.6 million to $209.1 million from fiscal year 2020 to fiscal year 2021. These receipts and payments are not included in the statements of revenues, expenses, and changes in net position.

2021 and 2020 Administrative Expenses

Total administrative expenses were $141.2 million in 2021 compared to $142.1 million in 2020. Overall administrative expenses decreased by 0.7 percent or $1 million, spread across all expense categories. During fiscal years 2021 and 2020, respectively, CalOptima's administrative expenses were 3.4 percent and 3.7 percent of total operating revenues, respectively.

2020 and 2019 Results of Operations

CalOptima's fiscal year 2020 operations and non-operating revenues resulted in a $89.6 million increase in net position, $81.5 million less compared to a $171.1 million increase in fiscal year 2019. The following table reflects the changes in revenues and expenses for 2020 compared to 2019:

Table 2b: Revenues, Expenses, and Changes in Net Position for
Fiscal Years Ended June 30,
(Dollars in Thousands)

Results of Operations	2020	2019	Change from 2019 Amount	Change from 2019 Percentage
CAPITATION REVENUES	$ 3,833,145	$ 3,474,634	$ 358,511	10.3%
Total operating revenues	3,833,145	3,474,634	358,511	10.3%
MEDICAL EXPENSES	3,644,419	3,216,673	427,746	13.3%
ADMINISTRATIVE EXPENSES	142,142	130,574	11,568	8.9%
Total operating expenses	3,786,561	3,347,247	439,314	13.1%
OPERATING INCOME	46,584	127,387	(80,803)	-63.4%
NONOPERATING REVENUES AND EXPENSES	43,004	43,676	(672)	-1.5%
Increase in net position	89,588	171,063	(81,475)	-47.6%
NET POSITION, beginning of year	935,543	764,480	171,063	22.4%
NET POSITION, end of year	$ 1,025,131	$ 935,543	$ 89,588	9.6%

2020 and 2019 Operating Revenues

The increase in operating revenues of $358.5 million in fiscal year 2020 is primarily attributable to the addition of the new Whole Child Model (WCM) program which began on July 1, 2019, Hospital Directed Payments, IGTs, and expansion of Proposition 56. The increase in revenue is offset by a 1.5 percent GME rate reduction and risk corridor for the Bridge Period, that was approved in the State's fiscal year 2020-21 budget and overall lower enrollment in fiscal year 2020 compared to fiscal year 2019.

2020 and 2019 Medical Expenses

Overall medical expenses increased by $427.7 million or 13.3 percent in fiscal year 2020, totaling $3,644.4 million, compared to $3,216.7 million in fiscal year 2019. CalOptima's medical loss ratio (MLR) increased 2.5 percent to 95.1 percent in 2020 from 92.6 percent in fiscal year 2019.

2020 and 2019 Medical Expenses (continued)

Medi-Cal provider capitation, comprised of capitation payments to CalOptima's contracted health networks, increased by 3.5 percent from fiscal year 2019 to fiscal year 2020. Capitated member enrollment accounted for approximately 74.9 percent of CalOptima's enrollment, averaging 542,204 members during fiscal year 2020, and 76.3 percent of CalOptima's enrollment, averaging 573,455 members during fiscal year 2019. Included in the capitated environment are 175,704 or 32.4 percent and 192,011 or 33.5 percent members in a shared risk network for fiscal years 2020 and 2019, respectively. Shared risk networks receive capitation for professional services and are claims-based for hospital services.

Medi-Cal provider capitation expenses totaled $1,133.1 million in fiscal year 2020, compared to $1,094.3 million in fiscal year 2019. The increase reflects additional capitation expenses relating to WCM and expansion of the Proposition 56 program which authorizes additional supplemental payments to impacted physician services compared to fiscal year 2019.

Medi-Cal claims expense to providers and facilities, including LTC services, increased by 5.3 percent from fiscal year 2019 to fiscal year 2020 primarily driven by increase in price and utilization trends.

Prescription drug costs increased by 24.3 percent in fiscal year 2020, compared to fiscal year 2019. Results from fiscal year 2020 reflect additional prescription drug utilization from the new WCM program.

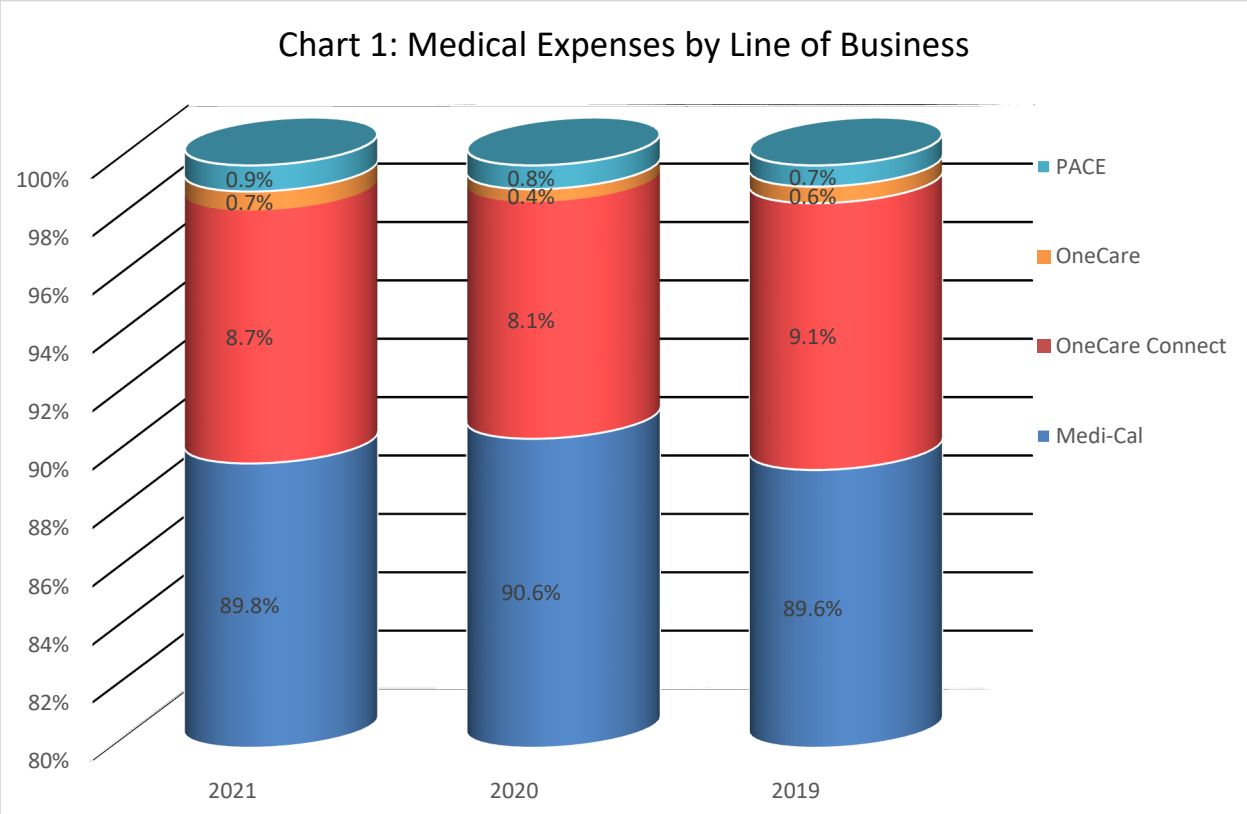
In addition to items mentioned above, total QAF payments received and passed through to hospitals decreased from $297.4 million to $154.6 million from fiscal year 2019 to fiscal year 2020. These receipts and payments are not included in the statements of revenues, expenses, and changes in net position.

2020 and 2019 Administrative Expenses

Total administrative expenses were $142.1 million in 2020 compared to $130.6 million in 2019. Overall administrative expenses increased by 8.9 percent or $11.6 million, corresponding to higher salaries and benefits due additional staffing and California Public Employees Retirement Systems (CalPERS) expense, along with inflation increases in other expense categories. During fiscal years 2020 and 2019, respectively, CalOptima's administrative expenses were 3.7 percent and 4.0 percent of total operating revenues.

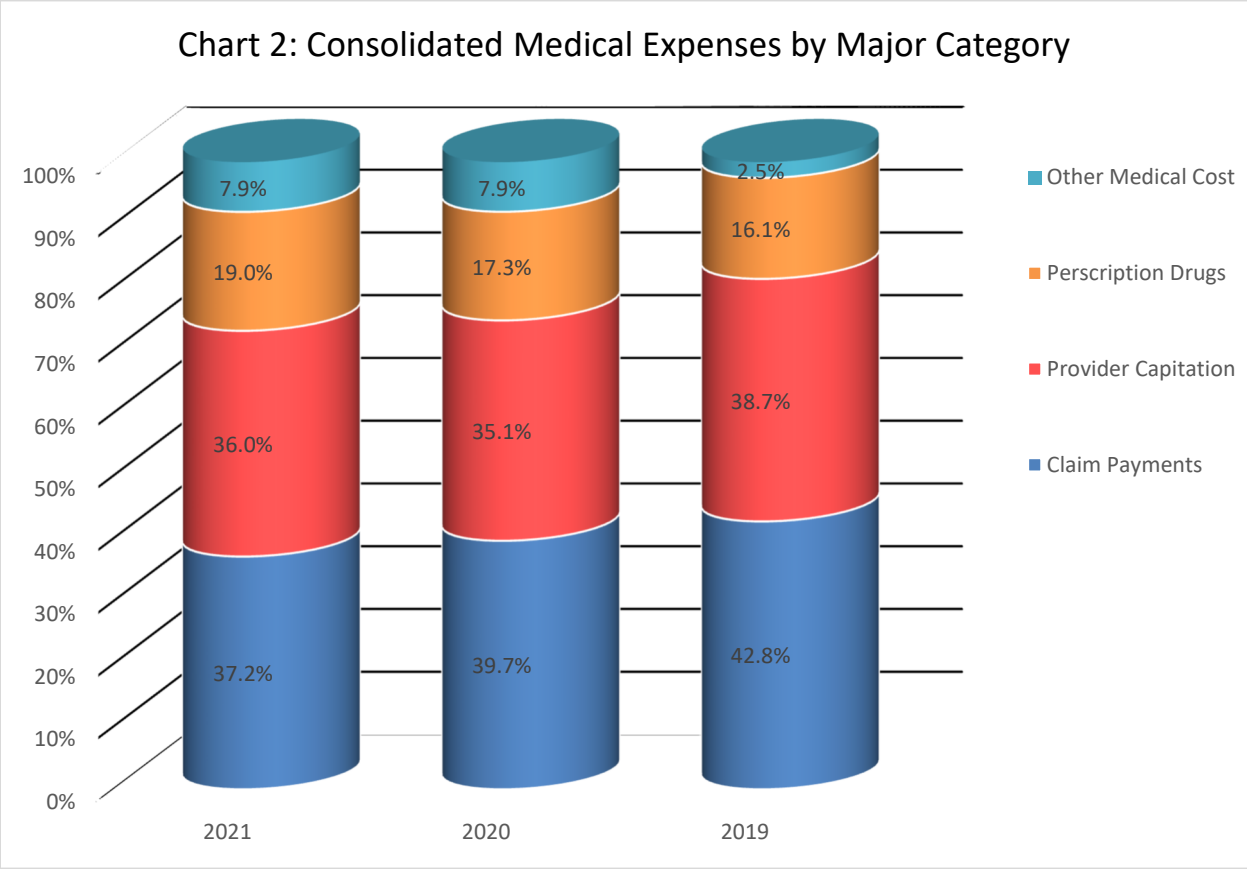
2021, 2020, and 2019 Medical Expenses by Line of Business

Below is a comparison chart of total medical expenses by line of business and their respective percentages of the overall medical expenditures by fiscal year.



2021, 2020, and 2019 Medical Expenses by Major Category

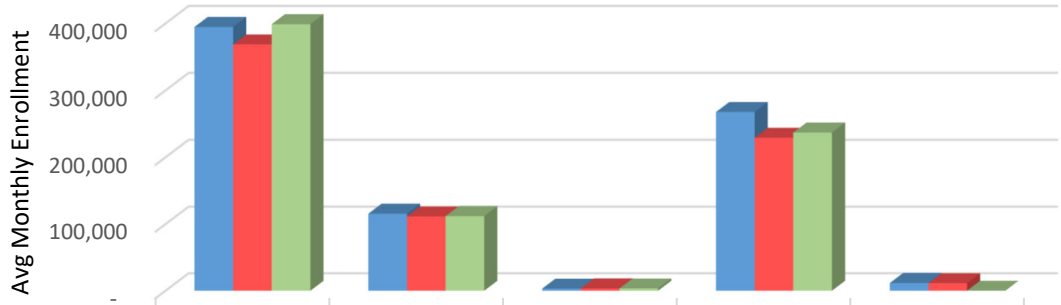
Below is a comparison chart of medical expenses by major category and their respective percentages of the overall medical expenditures by fiscal year.



2021, 2020, and 2019 Enrollment

During fiscal year 2021, CalOptima served an average of 793,023 Medi-Cal members per month compared to an average of 724,049 members per month in 2020 and 751,409 members per month in 2019. The chart below displays a comparative view of average monthly membership by Medi-Cal aid category during 2021, 2020, and 2019:

Chart 3: Medi-Cal Membership by Aid Category
(Shown as Average Member Months)



	TANF	Disabled/ Aged	LTC	MCE	WCM
2021	394,819	115,711	3,158	267,700	11,634
2020	368,614	111,496	3,493	229,196	11,250
2019	398,951	112,089	3,402	236,967	-

Significant aid categories are defined as follows:

Temporary Assistance to Needy Families (TANF) includes families, children, and poverty-level members who qualify for the TANF federal welfare program, which provides cash aid and job-search assistance to poor families. TANF also includes members who migrated from CalOptima, Health Net, and Kaiser Healthy Family programs.

Disabled and Aged includes individuals who have met the criteria for disability set by the Social Security Administration, and individuals of 65 years of age and older who receive supplemental security income (SSI) checks, or are medically needy, or have an income of 100 percent or less of the federal poverty level.

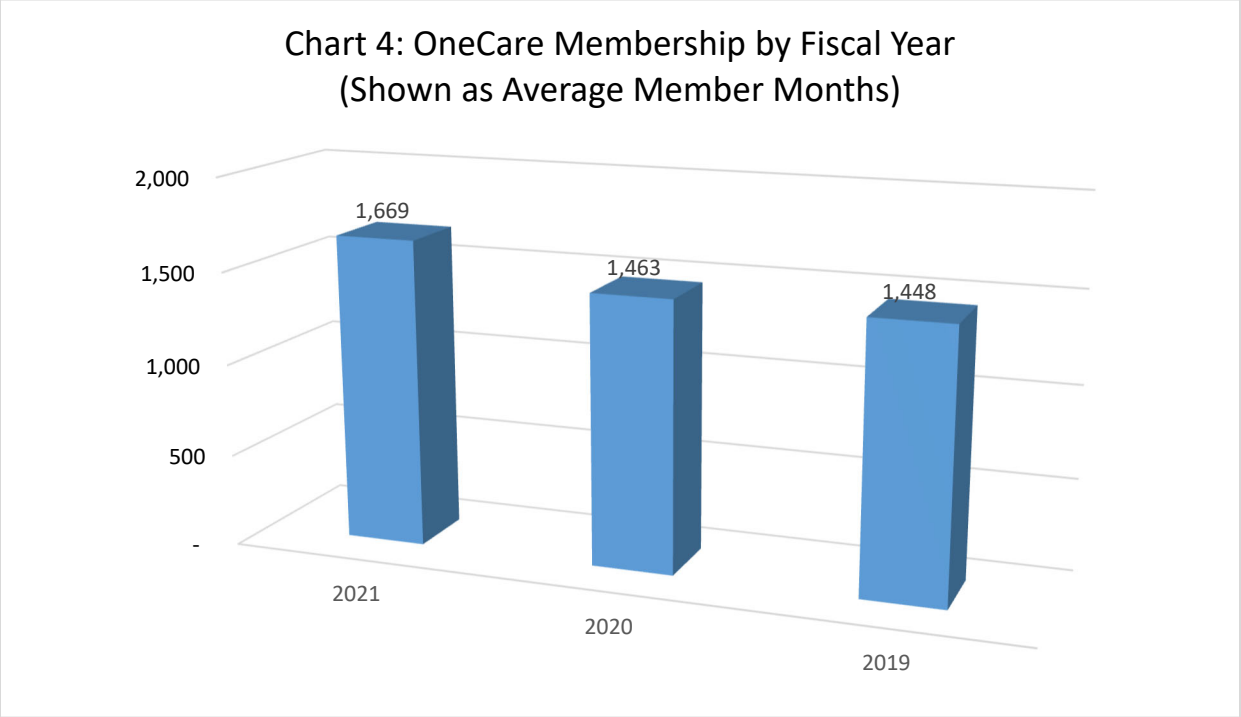
LTC includes frail elderly adults, nonelderly adults with disabilities, and children with developmental disabilities and other disabling conditions requiring long-term care services.

2021, 2020, and 2019 Enrollment (continued)

Medi-Cal Expansion (MCE) program includes adults without children, ages 19–64, qualified based upon income, as required by the Patient Protection and Affordable Care Act (ACA).

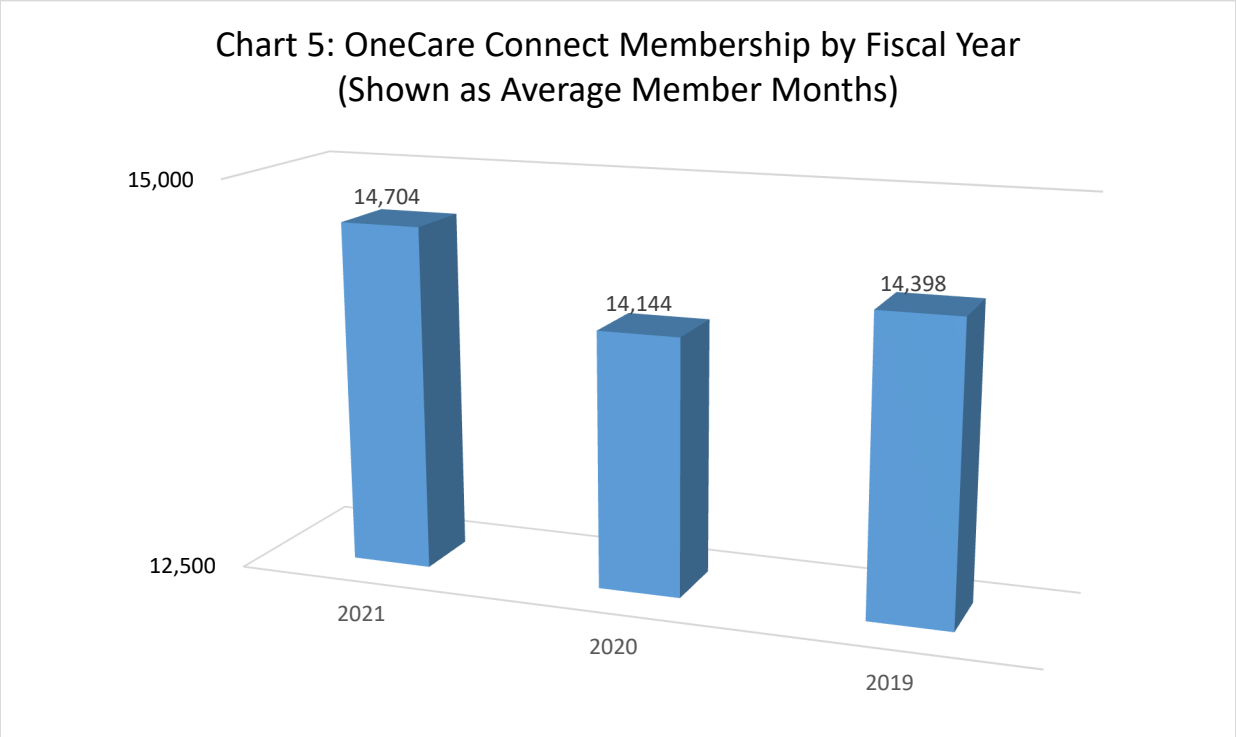
CalOptima's WCM includes children who are California Children's Services (CCS) eligible. These members are receiving their CCS services and non-CCS services under WCM program.

OneCare was introduced in fiscal year 2006 as a Medicare Advantage Special Needs Plan. It provides a full range of health care services to average member months of 1,669, 1,463, and 1,448 for the years ended June 30, 2021, 2020, and 2019, respectively. Members are eligible for both the Medicare and Medi-Cal programs. The chart below displays the average member months for the past three years.



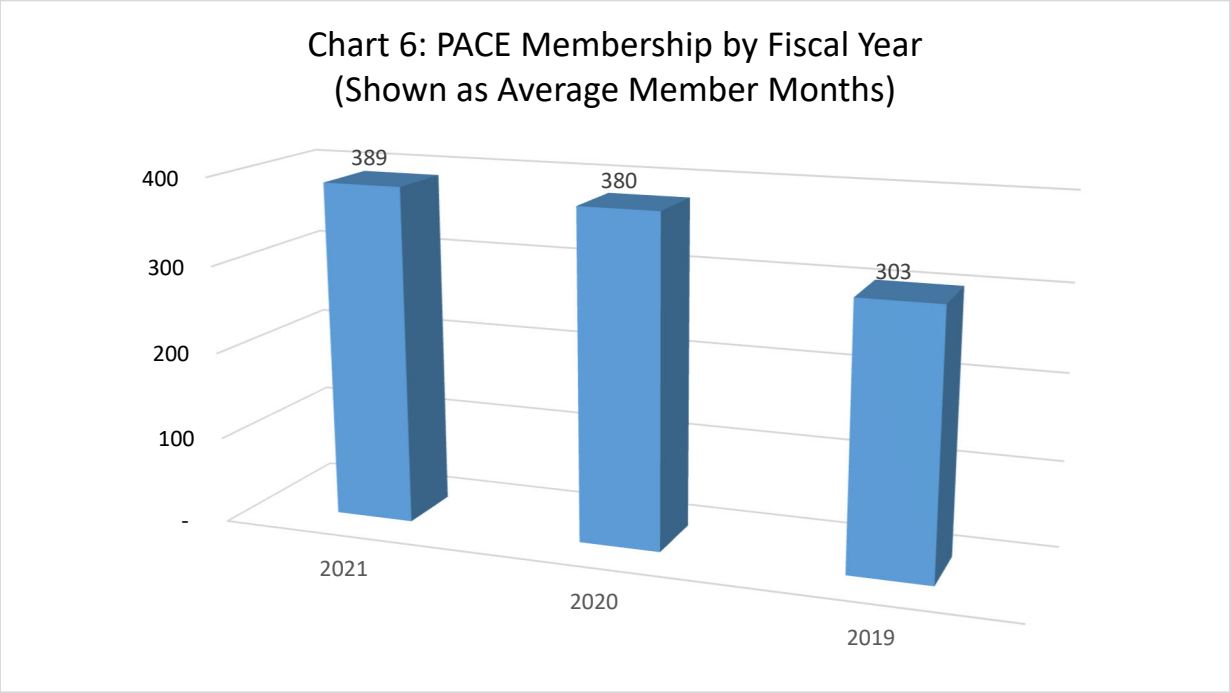
2021, 2020, and 2019 Enrollment (continued)

CalOptima launched the OneCare Connect program to serve dual eligible members in Orange County on July 1, 2015. This program combines members' Medicare and Medi-Cal coverage and adds other benefits and supports. The average member months were 14,704, 14,144, and 14,398 for the years ended June 30, 2021, 2020, and 2019, respectively. The chart below displays the average member months for the past three years.



2021, 2020, and 2019 Enrollment (continued)

PACE began operations in October 2013. It is a community-based Medicare and Medi-Cal program that provides coordinated and integrated health care services to frail elders to help them continue living independently in the community. The average member months were 389, 380, and 303 for the years ended June 30, 2021, 2020, and 2019, respectively. The chart below displays the average member months for the past three years.



Economic Factors and the State's Fiscal Year 2021-22 Budget

On June 28, 2021, Governor Gavin Newsom signed the fiscal year 2021-22 state budget. The budget includes a strong fiscal outlook and addresses the State's efforts to promote economic recovery from the COVID-19 pandemic. It prioritizes one-time spending of discretionary funds over ongoing program commitments, while building reserves and paying down debt obligations.

General Fund spending in the budget package was $196.4 billion, a decrease of $30.4 billion or 18.3 percent from fiscal year 2020-21. The budget included $26.9 billion in General Fund spending for the Medi-Cal program. It projected an average monthly caseload of 14.5 million beneficiaries in fiscal year 2021-22 and assumed that statewide enrollment would peak at 14.8 million in January 2022. Major Medi-Cal program changes adopted in the budget include:

- Implementation of the California Advancing and Innovating Medi-Cal (CalAIM) Initiative;
- Carve-out of the Medi-Cal pharmacy benefit from managed care to fee-for-service effective January 1, 2022;
- Expansion of eligibility to undocumented adults aged 50 and older, effective no sooner than May 1, 2022;
- Extension of eligibility for postpartum individuals, effective April 1, 2022, for up to five years;
- Elimination of suspension of certain Medi-Cal adult optional benefits;
- Elimination of suspension of Proposition 56 supplemental payment increases; and
- Extension of telehealth flexibilities allowed during the federal public health emergency through December 2022 and coverage of remote patient monitoring.

The budget projected $175.3 billion in General Fund revenues and transfers in fiscal year 2021-22, a decrease of $13.4 billion or 7.1 percent compared to last fiscal year. The three largest General Fund taxes (i.e., personal income tax, sales and use tax, corporation tax) were projected to decrease by 1.9 percent. The State is projected to end fiscal year 2021-22 with $25.2 billion in total reserves.

DHCS annual audit – Due to the COVID-19 Public Health Emergency, the California Department of Health Care Services (DHCS) did not conduct its planned annual medical audit of CalOptima's Medi-Cal program in Quarter 1 2021, covering the lookback period of February 1, 2020, through January 31, 2021. DHCS intends to conduct an audit during Quarter 4 2021 with an expanded lookback period.

Economic Factors and the State's Fiscal Year 2021-22 Budget (continued)

CMS audit – The Centers for Medicare & Medicaid Services (CMS) engaged CalOptima for a virtual, full-scope program audit of OneCare and OneCare Connect in early June 2021. The audit began in mid-July 2021 and ended in early August 2021. CMS provided CalOptima with preliminary audit results, which will be formally communicated in the near future.

Requests for information – This financial report has been prepared in the spirit of full disclosure to provide the reader with an overview of CalOptima's operations. If the reader has questions or would like additional information about CalOptima, please direct the requests to CalOptima, 505 City Parkway West, Orange, CA 92868 or call 714.347.3237.

MOSSADAMS

Report of Independent Auditors

The Board of Directors
Orange County Health Authority, a Public Agency/
dba Orange Prevention and Treatment Integrated Medical Assistance/
dba CalOptima

Report on the Financial Statements

We have audited the accompanying statements of net position of Orange County Health Authority, a Public Agency/dba Orange Prevention and Treatment Integrated Medical Assistance/dba CalOptima (a discrete component unit of the County of Orange, California) (CalOptima), as of June 30, 2021 and 2020, and the related statements of revenues, expenses, and changes in net position and cash flows for the years ended June 30, 2021 and 2020, and the related notes to the financial statements, which collectively comprise CalOptima's basic financial statements.

Management's Responsibility for the Financial Statements

Management is responsible for the preparation and fair presentation of these financial statements in accordance with accounting principles generally accepted in the United States of America; this includes the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of financial statements that are free from material misstatement, whether due to fraud or error.

Auditor's Responsibility

Our responsibility is to express an opinion on these financial statements based on our audits. We conducted our audits in accordance with auditing standards generally accepted in the United States of America. Those standards require that we plan and perform the audits to obtain reasonable assurance about whether the financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the financial statements. The procedures selected depend on the auditor's judgment, including the assessment of the risks of material misstatement of the financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the entity's preparation and fair presentation of the financial statements in order to design audit procedures that are appropriate in the circumstances but not for the purpose of expressing an opinion on the effectiveness of the entity's internal control. Accordingly, we express no such opinion. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluating the overall presentation of the financial statements.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Opinion

In our opinion, the financial statements referred to above present fairly, in all material respects, the financial position of CalOptima as of June 30, 2021 and 2020, and the results of its operations and its cash flows for the years then ended in accordance with accounting principles generally accepted in the United States of America.

Other Matters

Required Supplementary Information

Accounting principles generally accepted in the United States of America require that the management's discussion and analysis, schedule of changes in net pension liability and related ratios, schedule of plan contributions, and schedule of changes in total OPEB liability and related ratios, as listed in the table of contents, be presented to supplement the basic financial statements. Such information, although not a part of the basic financial statements, is required by the Governmental Accounting Standards Board (GASB), which considers it to be an essential part of financial reporting for placing the basic financial statements in an appropriate operational, economic, or historical context. We have applied certain limited procedures to the required supplementary information in accordance with auditing standards generally accepted in the United States of America, which consisted of inquiries of management about the methods of preparing the information and comparing the information for consistency with management's responses to our inquiries, the basic financial statements, and other knowledge we obtained during our audit of the basic financial statements. We do not express an opinion or provide any assurance on the information because the limited procedures do not provide us with sufficient evidence to express an opinion or provide any assurance.

Irvine, California
September 24, 2021

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Orange County Health Authority, a Public Agency/ dba Orange Prevention and Treatment Integrated Medical Assistance/dba CalOptima
Statements of Net Position

	June 30, 2021	June 30, 2020
CURRENT ASSETS		
Cash and cash equivalents	$ 281,834,498	$ 378,797,374
Investments	1,065,409,806	724,186,314
Premiums due from the State of California and CMS	427,337,768	403,300,443
Prepaid expenses and other	59,536,860	49,768,791
Total current assets	1,834,118,932	1,556,052,922
BOARD-DESIGNATED ASSETS AND RESTRICTED CASH		
Cash and cash equivalents	60,144,705	59,979,769
Investments	585,534,360	582,103,037
Restricted deposit	300,000	300,000
	645,979,065	642,382,806
CAPITAL ASSETS, NET	45,727,881	46,654,576
Total assets	2,525,825,878	2,245,090,304
DEFERRED OUTFLOWS OF RESOURCES		
Net pension	10,542,297	10,388,070
Other postemployment benefit	4,450,000	1,273,000
Total deferred outflows of resources	14,992,297	11,661,070
Total assets and deferred outflows of resources	$ 2,540,818,175	$ 2,256,751,374

See accompanying notes to the financial statements.

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Orange County Health Authority, a Public Agency/ dba Orange Prevention and Treatment Integrated Medical Assistance/dba CalOptima
Statements of Net Position (Continued)

	June 30, 2021	June 30, 2020
CURRENT LIABILITIES		
Medical claims liability and capitation payable		
Medical claims liability	$ 288,919,790	$ 302,058,508
Provider capitation and withholds	144,779,788	142,981,028
Accrued reinsurance costs to providers	3,168,388	4,843,302
Due to the State of California and CMS	690,131,523	677,497,633
Unearned revenue	13,173,904	22,693,499
	1,140,173,393	1,150,073,970
Accounts payable and other	9,053,913	8,300,077
Accrued payroll and employee benefits and other	16,216,919	13,621,877
Total current liabilities	1,165,444,225	1,171,995,924
POSTEMPLOYMENT HEALTH CARE PLAN	31,610,000	25,824,000
NET PENSION LIABILITY	30,620,005	27,122,873
Total liabilities	1,227,674,230	1,224,942,797
DEFERRED INFLOWS OF RESOURCES		
Net pension	3,054,143	4,235,272
Other postemployment benefit	1,309,000	2,442,000
Total deferred inflows of resources	4,363,143	6,677,272
NET POSITION		
Net investment in capital assets	45,600,553	46,493,718
Restricted by legislative authority	101,509,138	100,573,922
Unrestricted	1,161,671,111	878,063,665
Total net position	1,308,780,802	1,025,131,305
Total liabilities, deferred inflows of resources, and net position	$ 2,540,818,175	$ 2,256,751,374

See accompanying notes to the financial statements.

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Orange County Health Authority, a Public Agency/ dba Orange Prevention and Treatment Integrated Medical Assistance/dba CalOptima

Statements of Revenues, Expenses, and Changes in Net Position

	Years Ended June 30,	
	2021	2020
REVENUES		
Premium revenues	$ 4,148,335,657	$ 3,833,145,186
Total operating revenues	4,148,335,657	3,833,145,186
OPERATING EXPENSES		
Medical expenses		
Claims expense to providers and facilities	1,273,147,198	1,354,894,408
Provider capitation	1,184,937,807	1,133,100,408
Prescription drugs	623,943,048	553,908,228
OneCare Connect	323,080,537	295,701,392
Other medical	266,737,045	261,321,998
PACE	33,312,760	29,648,249
OneCare	24,310,717	15,843,762
Total medical expenses	3,729,469,112	3,644,418,445
Administrative expenses		
Salaries, wages, and employee benefits	97,268,662	92,838,076
Supplies, occupancy, insurance, and other	23,040,905	26,463,554
Purchased services	12,344,872	12,950,542
Depreciation	6,185,440	6,208,308
Professional fees	2,326,477	3,681,376
Total administrative expenses	141,166,356	142,141,856
Total operating expenses	3,870,635,468	3,786,560,301
OPERATING INCOME	277,700,189	46,584,885
NON-OPERATING REVENUES		
Net investment income and other	5,949,308	43,003,548
Total non-operating revenues	5,949,308	43,003,548
Increase in net position	283,649,497	89,588,433
NET POSITION, beginning of year	1,025,131,305	935,542,872
NET POSITION, end of year	$ 1,308,780,802	$ 1,025,131,305

See accompanying notes to the financial statements.

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Orange County Health Authority, a Public Agency/ dba Orange Prevention and Treatment Integrated Medical Assistance/dba CalOptima
Statements of Cash Flows

	Years Ended June 30, 2021	Years Ended June 30, 2020
CASH FLOWS FROM OPERATING ACTIVITIES		
Capitation payments received and other	$ 4,127,412,627	$ 3,886,162,626
Payments to providers and facilities	(3,742,483,984)	(3,593,937,251)
Payments to vendors	(46,143,958)	(37,857,991)
Payments to employees	(91,035,844)	(86,945,852)
Net cash provided by operating activities	247,748,841	167,421,532
CASH FLOWS FROM CAPITAL AND RELATED FINANCING ACTIVITIES		
Purchases of capital assets	(5,841,274)	(6,838,076)
Net cash used in capital and related financing activities	(5,841,274)	(6,838,076)
CASH FLOWS FROM INVESTING ACTIVITIES		
Investment income received	9,894,229	47,645,156
Purchases of securities	(13,933,382,931)	(6,861,181,847)
Sales of securities	13,584,618,259	6,684,122,824
Net cash used in investing activities	(338,870,443)	(129,413,867)
Net change in cash and cash equivalents	(96,962,876)	31,169,589
CASH AND CASH EQUIVALENTS, beginning of year	378,797,374	347,627,785
CASH AND CASH EQUIVALENTS, end of year	$ 281,834,498	$ 378,797,374
RECONCILIATION OF OPERATING INCOME TO NET CASH PROVIDED BY OPERATING ACTIVITIES		
Operating income	$ 277,700,189	$ 46,584,885
ADJUSTMENT TO RECONCILE OPERATING INCOME TO NET CASH PROVIDED BY OPERATING ACTIVITIES		
Depreciation	6,767,969	6,808,392
Changes in assets and liabilities		
Premiums due from the State of California and CMS	(24,037,325)	(100,335,940)
Prepaid expenses and other	(9,768,069)	4,996,214
Medical claims liability	(13,138,718)	14,769,904
Provider capitation and withholds	1,798,760	34,077,889
Accrued reinsurance costs to providers	(1,674,914)	1,633,401
Due to the State of California and CMS	12,633,890	180,807,222
Unearned revenue	(9,519,595)	(27,453,842)
Accounts payable and other	753,836	(358,817)
Accrued payroll and employee benefits and other	2,595,042	2,552,599
Postemployment health care plan	1,476,000	341,000
Net pension liability	2,161,776	2,998,625
Net cash provided by operating activities	$ 247,748,841	$ 167,421,532
SUPPLEMENTAL SCHEDULE OF NON-CASH OPERATING AND INVESTING ACTIVITIES		
Change in unrealized appreciation on investments	$ 3,259,508	$ 14,075,788

See accompanying notes to the financial statements.

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Note 1 – Organization

Orange County Health Authority, a Public Agency/dba Orange Prevention and Treatment Integrated Medical Assistance/dba CalOptima ("CalOptima" or the "Organization"), is a County-Organized Health System (COHS) serving primarily Medi-Cal beneficiaries in Orange County, California. Pursuant to the California Welfare and Institutions Code, CalOptima was formed by the Orange County Board of Supervisors as a public/private partnership through the adoption of Ordinance No. 3896 in August 1992. The agency began operations in October 1995.

As a COHS, CalOptima maintains an exclusive contract with the State of California (the "State"), Department of Health Care Services (DHCS) to arrange for the provision of health care services to Orange County's Medi-Cal beneficiaries. Orange County had approximately 825,000 and 743,000 Medi-Cal beneficiaries for the years ended June 30, 2021 and 2020, respectively. CalOptima also offers OneCare, a Medicare Advantage Special Needs Plan, via a contract with the Centers for Medicare & Medicaid Services (CMS). OneCare served approximately 1,900 and 1,500 members eligible for both Medicare and Medi-Cal for the years ended June 30, 2021 and 2020, respectively. In January 2016, CalOptima began offering the OneCare Connect Cal MediConnect Plan, a Medicare-Medicaid Plan, via a contract with CMS and DHCS. OneCare Connect served approximately 15,000 and 14,000 members eligible for both Medicare and Medi-Cal for the years ended June 30, 2021 and 2020, respectively. In January 2016, CalOptima began transferring subscribers from OneCare to the OneCare Connect Cal MediConnect Plan. CalOptima also contracts with the California Department of Aging to provide case management of social and health care services to approximately 500 Medi-Cal eligible seniors under the State's Multipurpose Senior Services Program (MSSP). The Program of All-Inclusive Care for the Elderly (PACE) provides services to 55 years of age or older members who reside in the PACE service area and meet California nursing facility level of care requirements. The program receives Medicare and Medi-Cal funding.

CalOptima, in turn, subcontracts the delivery of health care services through health maintenance organizations and provider-sponsored organizations, known as Physician/Hospital Consortia, and Shared Risk Groups. Additionally, CalOptima has direct contracts with hospitals and providers for its fee-for-service network.

CalOptima is Knox-Keene licensed for purposes of its Medicare programs and is subject to certain provisions of the Knox-Keene Health Care Service Plan Act of 1975 (the "Act") to the extent incorporated by reference into CalOptima's contract with DHCS. As such, CalOptima is subject to the regulatory requirements of the Department of Managed Health Care (DMHC) under Section 1300, Title 28 of the California Administrative Code of Regulations, including minimum requirements of Tangible Net Equity (TNE), which CalOptima exceeded as of June 30, 2021 and 2020.

Note 2 – Summary of Significant Accounting Policies

Basis of presentation – CalOptima is a COHS plan governed by a 10-member Board of Directors appointed by the Orange County Board of Supervisors. The CalOptima Board of Directors served as the Board of Directors of the CalOptima Foundation (the "Foundation"). Effective for the fiscal year ended June 30, 2014, CalOptima began reporting as a discrete component unit of the County of Orange, California. The County made this determination based on the County Board of Supervisors' role in appointing all members of the Board of Directors.

Basis of accounting – CalOptima uses enterprise fund accounting. Revenues and expenses are recognized on the accrual basis using the economic resources measurement focus. The accompanying financial statements have been prepared in accordance with the standards of the Governmental Accounting Standards Board (GASB).

Use of estimates – The preparation of the financial statements in accordance with accounting principles generally accepted in the United States of America (U.S. GAAP) requires management to make estimates and assumptions that affect the amounts reported in the financial statements and accompanying notes. Actual results could differ from those estimates.

Cash and cash equivalents – The Organization considers all highly liquid investments with original maturities of three months or less to be cash and cash equivalents.

Investments – Investments are stated at fair value in accordance with GASB Codification Section 150. The fair value of investments is estimated based on quoted market prices, when available. For debt securities not actively traded, fair values are estimated using values obtained from external pricing services or are estimated by discounting the expected future cash flows using current market rates applicable to the coupon rate, credit, and maturity of the investments.

All investments with an original maturity of one year or less when purchased are recorded as current investments, unless designated or restricted.

Board-designated assets and restricted cash – Board-designated assets include amounts designated by the Board of Directors for the establishment of certain reserve funds for contingencies at a desired level between 1.4 and 2 months of premium revenues and amounts designated by the Board of Directors for CalOptima's homeless health initiative (see Note 3). Restricted cash represents a $300,000 restricted deposit required by CalOptima as part of the Act (see Note 9).

Capital assets – Capital assets are stated at cost at the date of acquisition. The costs of normal maintenance, repairs, and minor replacements are charged to expense when incurred.

Note 2 – Summary of Significant Accounting Policies (continued)

Depreciation is calculated using the straight-line method over the estimated useful lives of the assets. Long-lived assets are periodically reviewed for impairment. The following estimated useful lives are used:

	Years
Furniture	5 years
Vehicles	5 years
Computers and software	3 years
Leasehold improvements	15 years or life of lease, whichever is less
Building	40 years
Building components	10 to 30 years
Land improvements	8 to 25 years
Tenant improvements	7 years or life of lease, whichever is less

Fair value of financial instruments – The financial statements include financial instruments for which the fair market value may differ from amounts reflected on a historical basis. Financial instruments of the Organization consist of cash deposits, investments, premium receivable, accounts payable, and certain accrued liabilities. The Organization's other financial instruments except for investments, generally approximate fair market value based on the relatively short period of time between origination of the instruments and their expected realization.

Medical claims liability and expenses – CalOptima establishes a claims liability based on estimates of the ultimate cost of claims in process and a provision for incurred but not yet reported (IBNR) claims, which is actuarially determined based on historical claim payment experience and other statistics. Such estimates are continually monitored and analyzed with any adjustments made as necessary in the period the adjustment is determined. CalOptima retains an outside actuary to perform an annual review of the actuarial projections. Amounts for claims payment incurred related to prior years vary from previously estimated liabilities as the claims ultimately are settled.

Note 2 – Summary of Significant Accounting Policies (continued)

Provider capitation and withholds – CalOptima has provider services agreements with several health networks in Orange County, whereby the health networks provide care directly to covered members or through subcontracts with other health care providers. Payment for the services provided by the health networks is on a fully capitated basis. The capitation amount is based on contractually agreed-upon terms with each health network. CalOptima withholds amounts from providers at an agreed-upon percentage of capitation payments made to ensure the financial solvency of each contract. CalOptima also records a liability related to quality incentive payments and risk-share provisions. The quality incentive liability is estimated based on member months and rates agreed upon by the Board of Directors. For the risk-share provision liability, management allocates surpluses or deficits, multiplied by a contractual rate, with the shared-risk groups. Estimated amounts due to health networks pertaining to risk-share provisions were approximately $33,304,000 and $24,437,000 as of June 30, 2021 and 2020, respectively, and are included in provider capitation and withholds on the statements of net position. During the years ended June 30, 2021 and 2020, CalOptima incurred approximately $1,341,598,000 and $1,279,859,000, respectively, of capitation expense relating to health care services provided by health networks. Capitation expense is included in the provider capitation, OneCare Connect, and OneCare line items in the statements of revenues, expenses, and changes in net position. Estimated amounts due to health networks as of June 30, 2021 and 2020, related to the capitation withhold arrangements, quality incentive payments, and risk-share provisions were approximately $144,780,000 and $142,981,000, respectively.

Premium deficiency reserves – CalOptima performs periodic analyses of its expected future health care costs and maintenance costs to determine whether such costs will exceed anticipated future revenues under its contracts. Should expected costs exceed anticipated revenues, a premium deficiency reserve is accrued. Investment income is not included in the calculation to estimate premium deficiency reserves. CalOptima's management determined that no premium deficiency reserves were necessary as of June 30, 2021 and 2020.

Accrued compensated absences – CalOptima's policy permits employees who are regularly scheduled to work more than 20 hours per week to accrue 18 days of paid time off (PTO) (23 days for exempt employees) based on their years of continuous service, with an additional week of accrual after three years of service and another after 10 years of service. In the event that available PTO is not used by the end of the benefit year, employees may carry unused time off into subsequent years, up to the maximum accrual amount equal to two (2) times the employee's annual accrual. If an employee reaches his or her maximum PTO accrual amount, the employee will stop accruing PTO. Accumulated PTO will be paid to the employees upon separation from service with CalOptima. All compensated absences are accrued and recorded in accordance with GASB Codification Section C60 and are included in accrued payroll and employee benefits.

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Note 2 – Summary of Significant Accounting Policies (continued)

Net position – Net position is reported in three categories, defined as follows:

- *Net investment in capital assets* – This component of net position consists of capital assets, including restricted capital assets, net of accumulated depreciation, and is reduced by the outstanding balances of any bonds, notes, or other borrowings that are attributable (if any) to the acquisition, construction, or improvement of those assets.

- *Restricted by legislative authority* – This component of net position consists of external constraints placed on net asset use by creditors (such as through debt covenants), grantors, contributors, or the law or regulations of other governments. It also pertains to constraints imposed by law or constitutional provisions or enabling legislation (see Note 9).

- *Unrestricted* – This component of net position consists of net position that does not meet the definition of "restricted" or "net investment in capital assets."

Operating revenues and expenses – CalOptima's statements of revenues, expenses, and changes in net position distinguish between operating and nonoperating revenues and expenses. Operating revenues result from exchange transactions associated with arranging for the provision of health care services. Operating expenses are all expenses incurred to arrange for the provision of health care services, as well as the costs of administration. Unpaid claims adjustment expenses are an estimate of the cost to process the IBNR claims and are included in operating expenses. Non-exchange revenues and expenses are reported as nonoperating revenues and expenses.

Revenue recognition and due to or from the State and CMS – Premium revenue is recognized in the period the members are eligible to receive health care services. Premium revenue is generally received from the State each month following the month of coverage based on estimated enrollment and capitation rates as provided for in the State contract. As such, premium revenue includes an estimate for amounts receivable from or refundable to the State for these retrospective adjustments. These estimates are continually monitored and analyzed, with any adjustments recognized in the period when determined. OneCare premium revenue is generally received from CMS each month for the month of coverage. Premiums received in advance are recorded in unearned revenue on the statements of net position. Included in premium revenue are retroactive adjustments favorable to CalOptima in the amount of approximately $215,600,000 and $254,567,000 related to retroactive capitation rate adjustments and receipt of new information from DHCS during the years ended June 30, 2021 and 2020, respectively.

These estimates are continually reviewed, and adjustments to the estimates are reflected currently in the statements of revenues, expenses, and changes in net position. Eligibility of beneficiaries is determined by DHCS and validated by the State. The State provides CalOptima the validated monthly eligibility file of program beneficiaries who are continuing, newly added, or terminated from the program in support of premium revenue for the respective month.

Note 2 – Summary of Significant Accounting Policies (continued)

Effective with the enrollment of the Medi-Cal Expansion population per the Affordable Care Act (ACA), CalOptima is subject to DHCS requirements to meet the minimum 85 percent medical loss ratio (MLR) for this population. Specifically, CalOptima is required to expend at least 85 percent of the Medi-Cal premium revenue received for this population on allowable medical expenses as defined by DHCS. In the event CalOptima expends less than the 85 percent requirement, CalOptima will be required to return to DHCS the difference between the minimum threshold and the actual allowed medical expenses. CalOptima was notified in December 2020 that CalOptima is not required to remit any payment to DHCS, nor will DHCS make any additional payment for fiscal year 2018.

In April 2019, CalOptima was notified by DHCS that CMS will be working with DHCS to perform their own reconciliation of the MLR data. As of the date the financial statements were available to be issued, DHCS has not released the results of the reconciliation. As of June 30, 2021 and 2020, approximately $135,390,000 was accrued. This liability is presented in the Due to State of California and CMS line item in the accompanying statements of net position.

Premium revenue and related net receivables as a percent of the totals were as follows:

	Years Ended June 30,			
	2021		2020	
	Revenue	%	Revenue	%
Revenue				
Medi-Cal	$ 3,739,173,008	90.2%	$ 3,462,115,218	90.3%
OneCare	25,967,205	0.6%	15,950,202	0.4%
OneCare Connect	344,174,513	8.3%	317,641,605	8.3%
PACE	39,020,931	0.9%	37,438,161	1.0%
	$ 4,148,335,657	100.0%	$ 3,833,145,186	100.0%

	As of June 30,			
	2021		2020	
	Receivables	%	Receivables	%
Receivables				
Medi-Cal	$ 403,849,267	94.5%	$ 382,302,317	94.9%
OneCare	2,558,056	0.6%	2,930,861	0.7%
OneCare Connect	18,217,285	4.3%	14,654,822	3.6%
PACE	2,713,160	0.6%	3,412,443	0.8%
	$ 427,337,768	100.0%	$ 403,300,443	100.0%

Note 2 – Summary of Significant Accounting Policies (continued)

Intergovernmental transfer – CalOptima entered into an agreement with DHCS and Governmental Funding Entities to receive an Intergovernmental Transfer (IGT) through a capitation rate increase of approximately $140,446,000 and $128,932,000 during the years ended June 30, 2021 and 2020, respectively. Under the agreement, approximately $95,298,000 and $84,971,000 of the funds that were received from the IGT were passed through to Governmental Funding Entities and other contracted providers and organizations during the years ended June 30, 2021 and 2020, respectively. Under GASB, the amounts that will be passed through to Governmental Funding Entities are not reported in the statements of revenues, expenses, and changes in net position or the statements of net position. CalOptima accounts for the IGT for CalOptima purposes as an exchange transaction requiring funds to be expended prior to revenue recognition. CalOptima retains a portion of the IGT, which must be used to enhance provider reimbursement rates and strengthen the delivery system. Starting with rate year 2017-2018, funds expended must be tied to covered medical services provided to CalOptima's Medi-Cal beneficiaries. A retainer in the amount of approximately $12,721,000 and $22,267,000 as of June 30, 2021 and 2020, respectively, is included in unearned revenues in the statements of net position.

Directed Payments – DHCS implemented a new hospital Directed Payment program with CalOptima. The program implements enhanced reimbursement to eligible and participating network hospitals for contracted services. This hospital Directed Payment program is broken into three types: 1) Private Hospital Directed Payment Program (PHDP), 2) Public Hospital Enhanced Payment Program (EPP), and 3) Public Hospital Quality Incentive Program (QIP). Under the Directed Payment program, approximately $200,856,000 and $195,528,000 of the funds that were received from DHCS were passed through to hospitals as requested by DHCS during the years ended June 30, 2021 and 2020, respectively. The receipts from DHCS are included in premium revenues, and the payments made to the hospitals are included in other medical expenses in the statements of net position.

Medicare Part D – CalOptima covers prescription drug benefits in accordance with Medicare Part D under multiple contracts with CMS. The payments CalOptima receives monthly from CMS and members, which are determined from its annual bid, represent amounts for providing prescription drug insurance coverage. CalOptima recognizes premiums for providing this insurance coverage ratably over the term of its annual contract. CalOptima's CMS payment is subject to risk sharing through the Medicare Part D risk corridor provisions. In addition, receipts for reinsurance and low-income cost subsidies, as well as receipts for certain discounts on brand name prescription drugs in the coverage gap represent payments for prescription drug costs for which CalOptima is not at risk.

Note 2 – Summary of Significant Accounting Policies (continued)

The risk corridor provisions compare costs targeted in CalOptima's bids to actual prescription drug costs, limited to actual costs that would have been incurred under the standard coverage as defined by CMS. Variances exceeding certain thresholds may result in CMS making additional payments to CalOptima or require CalOptima to refund to CMS a portion of the premiums CalOptima received. CalOptima estimates and recognizes an adjustment to premiums revenue related to these risk corridor provisions based upon pharmacy claims experience to date, as if the annual contract were to terminate at the end of the reporting period. Accordingly, this estimate provides no consideration to future pharmacy claims experience. CalOptima records a receivable or payable at the contract level and classifies the amount as current or long-term in the accompanying statements of net position based on the timing of expected settlement. As of June 30, 2021 and 2020, the Part D payable balance was approximately $645,000 and $972,000, respectively, and is included in the Due to the State of California and CMS line item on the accompanying statements of net position. As of June 30, 2021 and 2020, the Part D receivable balance was approximately $36,868,000 and $31,628,000, respectively, and is included in the Prepaid expenses and other line item on the accompanying statements of net position.

Income taxes – CalOptima operates under the purview of the Internal Revenue Code (IRC), Section 501(a), and corresponding California Revenue and Taxation Code provisions. As such, CalOptima is not subject to federal or state taxes on related income. Accordingly, no provision for income tax has been recorded in the accompanying financial statements.

Premium taxes – Effective July 1, 2016, Senate Bill X2-2 (SB X2-2) *Managed Care Organization Tax* authorized DHCS to implement a Managed Care Organization (MCO) provider tax subject to approval by the federal CMS. This approved tax structure is based on enrollment (total member months) between specified tiers that are assessed different tax rates. During fiscal year 2020, the MCO tax was extended with an effective date of January 1, 2020. Using the approved structure, each MCO's total tax liability for years ended June 30, 2021 and 2020, were calculated. CalOptima recognized premium tax expense of approximately $149,694,000 and $74,845,000 as a reduction of premium revenues in the statements of revenue, expenses, and change in net position for the years ended June 30, 2021 and 2020, respectively. As of June 30, 2021 and 2020, CalOptima's MCO tax liability amounted to approximately $37,511,000 and $66,535,000, respectively, and is included in Due to the State of California and CMS line item on the accompanying statements of net position.

Note 2 – Summary of Significant Accounting Policies (continued)

Risk corridors – During the year ended June 30, 2020, CalOptima's contract with DHCS was subject to a risk corridor for the Managed Long-Term Services and Supports program for the period of July 1, 2015 through June 30, 2017. Additionally, the State's fiscal year 2020-21 enacted budget includes a Gross Medical Expense (GME) risk corridor for the period of July 1, 2020 to December 31, 2021. Both risk corridors are subject to certain thresholds of medical expenses compared to premium revenues. Variances exceeding the thresholds may require CalOptima to refund premium revenues back to DHCS. CalOptima estimates and recognizes an adjustment to premium revenues based on actual membership and capitation rates in effect. As of June 30, 2021 and 2020, CalOptima recognized a liability of approximately $163,293,000 and $124,212,000, respectively, related to the risk corridors, which is included in the Due to the State of California and CMS line item on the statements of net position. During the years ended June 30, 2021 and 2020, the reduction of premium revenue was approximately $39,080,000 and $124,212,000, respectively, related to the risk corridors, which is included in premium revenues on the statements of revenues, expenses, and changes in net position.

Pensions – For purposes of measuring the net pension liability and deferred outflows/inflows of resources related to pensions, and pension expense, information about the fiduciary net position of CalOptima's Miscellaneous Plan of the Orange County Health Authority (the "CalPERS Plan") and additions to/deductions from the Plan's fiduciary net position have been determined on the same basis as they are reported by California Public Employees Retirement Systems (CalPERS). For this purpose, benefit payments (including refunds of employee contributions) are recognized when due and payable in accordance with the benefit terms. Investments are reported at fair value.

Recent accounting pronouncements – In January 2017, the GASB issued Statement No. 84, *Fiduciary Activities*. The principal objective of this Statement is to enhance the consistency and comparability of fiduciary activity reporting by state and local governments. This Statement also is intended to improve the usefulness of fiduciary activity information primarily for assessing the accountability of governments in their roles as fiduciaries. This Statement was adopted by the Organization effective July 1, 2020, and did not have a significant impact on the financial statements.

In June 2017, the GASB issued Statement No. 87, *Leases*. The objective of this Statement is to better meet the information needs of financial statement users by improving accounting and financial reporting for leases by governments. This Statement requires recognition of certain lease assets and liabilities for leases that previously were classified as operating leases and recognized as inflows of resources or outflows of resources based on the payment provisions of the contract. It establishes a single model for lease accounting based on the foundational principle that leases are financings of the right to use an underlying asset. Under this Statement, a lessee is required to recognize a lease liability and an intangible right-to-use lease asset, and a lessor is required to recognize a lease receivable and a deferred inflow of resources, thereby enhancing the relevance and consistency of information about governments' leasing activities. This Statement is effective for the Organization for the year ending June 30, 2022, and management is evaluating the impact of this Statement on the financial statements.

Note 3 – Cash, Cash Equivalents, and Investments

Cash and investments are reported in the statements of net position as follows:

	June 30, 2021	June 30, 2020
Current assets		
Cash and cash equivalents	$ 281,834,498	$ 378,797,374
Investments	1,065,409,806	724,186,314
Board-designated assets and restricted cash		
Cash and cash equivalents	60,144,705	59,979,769
Investments	585,534,360	582,103,037
Restricted deposit	300,000	300,000
	$ 1,993,223,369	$ 1,745,366,494

Board-designated assets and restricted cash are available for the following purposes:

	June 30, 2021	June 30, 2020
Board-designated assets and restricted cash		
Contingency reserve fund	$ 588,880,152	$ 584,883,893
Homeless Health Initiative fund	56,798,913	57,198,913
Restricted deposit with DMHC	300,000	300,000
	$ 645,979,065	$ 642,382,806

Custodial credit risk deposits – Custodial credit risk is the risk that, in the event of a bank failure, the Organization may not be able to recover its deposits or collateral securities that are in the possession of an outside party. The California Government Code requires that a financial institution secure deposits made by public agencies by pledging securities in an undivided collateral pool held by a depository regulated under the state law. As of June 30, 2021 and 2020, no deposits were exposed to custodial credit risk, as the Organization has pledged collateral to cover the amounts.

Investments – CalOptima invests in obligations of the U.S. Treasury, other U.S. government agencies and instrumentalities, state obligations, corporate securities, money market funds, and mortgage or asset-backed securities.

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Note 3 – Cash, Cash Equivalents, and Investments (continued)

Interest rate risk – In accordance with its annual investment policy (investment policy), CalOptima manages its exposure to decline in fair value from increasing interest rates by matching maturity dates to the extent possible with CalOptima's expected cash flow draws. Its investment policy limits maturities to five years, while also staggering maturities. CalOptima maintains a low-duration strategy, targeting a portfolio duration of three years or less, with the intent of reducing interest rate risk. Portfolios with low duration are less volatile because they are less sensitive to interest rate changes. As of June 30, 2021 and 2020, CalOptima's investments, including cash equivalents, had the following modified duration:

	June 30, 2021			
		Investment Maturities (in Years)		
Investment Type	Fair Value	Less Than 1	1–5	More Than 5
U.S. Treasury notes	$ 384,597,567	$ 212,905,109	$ 171,692,458	$ -
U.S. Agency notes	145,970,235	46,408,728	99,561,507	-
Corporate bonds	433,093,746	62,753,919	370,339,827	-
Asset-backed securities	205,797,496	933,416	204,864,080	-
Mortgage-backed securities	59,941,816	977,812	58,964,004	-
Municipal bonds	197,208,250	50,269,488	146,938,762	-
Tax exempt municipal bonds	7,756,668	3,999,876	3,756,792	-
Supranational	79,450,167	20,445,676	59,004,491	-
Commercial paper	1,798,780	1,798,780	-	-
Certificates of deposit	131,384,520	129,385,206	1,999,314	-
Cash equivalents	281,460,545	281,460,545	-	-
Cash	5,852,311	5,852,311	-	-
	1,934,312,101	$ 817,190,866	$ 1,117,121,235	$ -
Accrued interest receivable	3,944,921			
	$ 1,938,257,022			

Note 3 – Cash, Cash Equivalents, and Investments (continued)

	June 30, 2020			
		Investment Maturities (in Years)		
Investment Type	Fair Value	Less Than 1	1–5	More Than 5
U.S. Treasury notes	$ 298,007,777	$ 112,195,755	$ 185,812,022	$ -
U.S. Agency notes	231,674,803	173,421,352	58,253,451	-
Corporate bonds	364,552,761	168,166,547	196,386,214	-
Asset-backed securities	111,283,270	8,968,371	102,314,899	-
Mortgage-backed securities	78,468,430	22,578,177	55,890,253	-
Municipal bonds	149,433,887	66,109,199	83,324,688	-
Tax exempt municipal bonds	2,078,441	2,078,441	-	-
Supranational	30,476,401	3,730,227	26,746,174	-
Commercial paper	17,490,611	17,490,611	-	-
Certificates of deposit	18,181,362	18,181,362	-	-
Cash equivalents	311,960,485	311,960,485	-	-
Cash	75,615,576	75,615,576	-	-
	1,689,223,804	$ 980,496,103	$ 708,727,701	$ -
Accrued interest receivable	4,641,608			
	$ 1,693,865,412			

Investment with fair values highly sensitive to interest rate fluctuations – When interest rates fall, debt is refinanced and paid off early. The reduced stream of future interest payments diminishes the fair value of the investment. The mortgage-backed and asset-backed securities in the CalOptima portfolio are of high credit quality, with relatively short average lives that represent limited prepayment and interest rate exposure risk. CalOptima's investments include the following investments that are highly sensitive to interest rate and prepayment fluctuations to a greater degree than already indicated in the information provided above:

	June 30,	
	2021	2020
Asset-backed securities	$ 205,797,496	$ 111,283,270
Mortgage-backed securities	59,941,816	78,468,430
	$ 265,739,312	$ 189,751,700

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Note 3 – Cash, Cash Equivalents, and Investments (continued)

Credit risk – CalOptima's investment policy conforms to the California Government Code as well as to customary standards of prudent investment management. Credit risk is mitigated by investing in only permitted investments. The investment policy sets minimum acceptable credit ratings for investments from the three nationally recognized rating services: Standard and Poor's Corporation (S&P), Moody's Investor Service (Moody's), and Fitch Ratings (Fitch). For an issuer of short-term debt, the rating must be no less than A-1 (S&P), P-1 (Moody's), or F-1 (Fitch), while an issuer of long-term debt shall be rated no less than an "A."

Note 3 – Cash, Cash Equivalents, and Investments (continued)

As of June 30, 2021, following are the credit ratings of investments and cash equivalents:

Investment Type	Fair Value	Minimum Legal Rating	Exempt from Disclosure	Rating as of Year-End					
				AAA	Aa & Aa+	Aa-	A+	A	A-
U.S. Treasury notes	$ 469,042,863	N/A	$ 469,042,863	$ -	$ -	$ -	$ -	$ -	$ -
U.S. Agency notes	191,616,279	N/A	191,616,279	-	-	-	-	-	-
Corporate bonds	349,716,328	A-	-	1,006,377	28,927,365	56,252,688	69,946,396	92,778,721	100,804,781
Floating-rate note securities	184,785,689	A-	-	91,501,339	26,293,614	6,288,960	20,563,093	15,289,876	24,848,807
Asset-backed securities	89,786,565	AAA	-	84,157,218	5,629,347	-	-	-	-
Mortgage-backed securities	158,920,715	AAA	-	158,920,715	-	-	-	-	-
Municipal bonds	228,782,972	A	-	62,716,750	95,592,804	56,751,316	10,727,242	2,994,860	-
Supranational	29,795,971	AAA	-	29,795,971	-	-	-	-	-
Repurchase agreement	53,007,361	N/A	53,007,361	-	-	-	-	-	-
Certificates of deposit	89,202,923	A1/P1	-	89,202,923	-	-	-	-	-
Commercial paper	87,747,047	A1/P1	-	66,748,544	20,998,503	-	-	-	-
Money market mutual funds	5,852,309	AAA	-	5,852,309	-	-	-	-	-
Total	$ 1,938,257,022		$ 713,666,503	$ 589,902,146	$ 177,441,633	$ 119,292,964	$ 101,236,731	$ 111,063,457	$ 125,653,588

As of June 30, 2020, following are the credit ratings of investments and cash equivalents:

Investment Type	Fair Value	Minimum Legal Rating	Exempt from Disclosure	Rating as of Year-End					
				AAA	Aa & Aa+	Aa-	A+	A	A-
U.S. Treasury notes	$ 490,315,250	N/A	$ 490,315,250	$ -	$ -	$ -	$ -	$ -	$ -
U.S. Agency notes	263,976,563	N/A	263,976,563	-	-	-	-	-	-
Corporate bonds	322,967,850	A-	-	1,020,286	24,279,656	32,941,534	70,325,043	135,117,495	59,283,836
Floating-rate note securities	78,472,158	A-	-	45,454,305	3,602,221	4,991,379	10,640,919	12,195,291	1,588,043
Asset-backed securities	93,579,787	AAA	-	92,986,592	593,195	-	-	-	-
Mortgage-backed securities	85,144,612	AAA	-	85,144,612	-	-	-	-	-
Municipal bonds	164,026,121	A	-	23,391,998	81,908,281	38,646,322	12,600,146	5,977,109	1,502,265
Supranational	10,109,748	AAA	-	10,109,748	-	-	-	-	-
Certificates of deposit	29,600,401	A1/P1	-	29,600,401	-	-	-	-	-
Commercial paper	70,079,433	A1/P1	-	70,079,433	-	-	-	-	-
Money market mutual funds	85,593,489	AAA	-	85,593,489	-	-	-	-	-
Total	$ 1,693,865,412		$ 754,291,813	$ 443,380,864	$ 110,383,353	$ 76,579,235	$ 93,566,108	$ 153,289,895	$ 62,374,144

Note 3 – Cash, Cash Equivalents, and Investments (continued)

Concentration of credit risk – Concentration of credit risk is the risk of loss attributed to the magnitude of CalOptima's investment in a single issuer. CalOptima's investment policy limits to no more than 5 percent of the total fair value of investments in the securities of any one issuer, except for obligations of the U.S. government, U.S. government agencies, or government-sponsored enterprises, and no more than 10 percent may be invested in one money market mutual fund unless approved by the governing board. The investment policy also places a limit of 35 percent of the amount of investment holdings with any one government-sponsored issuer and 5 percent of all other issuers. As of June 30, 2021 and 2020, all holdings complied with the foregoing limitations. The following holdings exceeded 5 percent of the portfolio as of June 30, 2021 and 2020:

		Percentage of Portfolio June 30,	
Investment Type	Issuer	2021	2020
U.S. Treasury notes	United States Treasury	24.30	29.93
U.S. Agency notes	Federal Home Loan Bank	4.25	11.24

The Organization categorizes its fair value investments within the fair value hierarchy established by U.S. GAAP. The hierarchy for fair value measurements is based upon the transparency of inputs to the valuation of an asset or liability as of the measurement date.

Level 1 – Quoted prices in active markets for identical assets or liabilities.

Level 2 – Inputs other than quoted prices included within Level 1 that are observable for an asset or liability, either directly or indirectly.

Level 3 – Significant unobservable inputs.

The following is a description of the valuation methodologies used for instruments at fair value on a recurring basis and recognized in the accompanying statements of net position, as well as the general classification of such instruments pursuant to the valuation hierarchy.

Marketable securities – Where quoted market prices are available in an active market, securities are classified within Level 1 of the valuation hierarchy. If quoted market prices are not available, then fair values are estimated by using pricing models, quoted prices of securities with similar characteristics, or discounted cash flows. These securities are classified within Level 2 of the valuation hierarchy. In certain cases, where Level 1 or Level 2 inputs are not available, securities are classified within Level 3 of the hierarchy.

Note 3 – Cash, Cash Equivalents, and Investments (continued)

The following table presents the fair value measurements of assets recognized in the accompanying statements of net position measured at fair value on a recurring basis and the level within the fair value hierarchy in which the fair value measurements fall:

	Investment Assets at Fair Value as of June 30, 2021			
	Level 1	Level 2	Level 3	Total
U.S. Treasury notes	$ 384,597,567	$ -	$ -	$ 384,597,567
U.S. Agency notes	-	145,970,235	-	145,970,235
Corporate bonds	-	433,093,746	-	433,093,746
Asset-backed securities	-	205,797,496	-	205,797,496
Mortgage-backed securities	-	59,941,816	-	59,941,816
Municipal bonds	-	197,208,250	-	197,208,250
Tax exempt Municipal bonds	-	7,756,668	-	7,756,668
Supranational	-	79,450,167	-	79,450,167
Commercial paper	-	1,798,780	-	1,798,780
Certificates of deposit	-	131,384,520	-	131,384,520
	$ 384,597,567	$ 1,262,401,678	$ -	$ 1,646,999,245

	Investment Assets at Fair Value as of June 30, 2020			
	Level 1	Level 2	Level 3	Total
U.S. Treasury notes	$ 298,007,777	$ -	$ -	$ 298,007,777
U.S. Agency notes	-	231,674,803	-	231,674,803
Corporate bonds	-	364,552,761	-	364,552,761
Asset-backed securities	-	111,283,270	-	111,283,270
Mortgage-backed securities	-	78,468,430	-	78,468,430
Municipal bonds	-	149,433,887	-	149,433,887
Tax exempt Municipal bonds	-	2,078,441	-	2,078,441
Supranational	-	30,476,401	-	30,476,401
Commercial paper	-	17,490,611	-	17,490,611
Certificates of deposit	-	18,181,362	-	18,181,362
	$ 298,007,777	$ 1,003,639,966	$ -	$ 1,301,647,743

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Note 4 – Capital Assets

Capital assets activity during the year ended June 30, 2021, consisted of the following:

	June 30, 2020	Additions	Retirements	Transfers	June 30, 2021
Capital assets not being depreciated					
Land	$ 5,876,002	$ -	$ -	$ -	$ 5,876,002
Construction in progress	3,378,335	5,841,274	-	(8,952,097)	267,512
	9,254,337	5,841,274	-	(8,952,097)	6,143,514
Capital assets being depreciated					
Furniture and equipment	7,398,013	-	(428,186)	1,104,507	8,074,334
Computers and software	32,488,778	-	(2,006,331)	7,690,593	38,173,040
Leasehold improvements	5,063,118	-	-	-	5,063,118
Building	45,744,223	-	-	156,997	45,901,220
	90,694,132	-	(2,434,517)	8,952,097	97,211,712
Less: accumulated depreciation for					
Furniture and equipment	6,154,830	646,320	(428,186)	-	6,372,964
Computers and software	28,153,140	3,472,046	(2,006,331)	-	29,618,855
Leasehold improvements	4,363,841	586,190	-	-	4,950,031
Building	14,622,082	2,063,413	-	-	16,685,495
	53,293,893	6,767,969	(2,434,517)	-	57,627,345
Total depreciable assets, net	37,400,239	(6,767,969)	-	8,952,097	39,584,367
Capital assets, net	$ 46,654,576	$ (926,695)	$ -	$ -	$ 45,727,881

Note 4 – Capital Assets (continued)

Capital asset activity during the year ended June 30, 2020, consisted of the following:

	June 30, 2019	Additions	Retirements	Transfers	June 30, 2020
Capital assets not being depreciated					
Land	$ 5,876,002	$ -	$ -	$ -	$ 5,876,002
Construction in progress	499,632	6,838,076	-	(3,959,373)	3,378,335
	6,375,634	6,838,076	-	(3,959,373)	9,254,337
Capital assets being depreciated					
Furniture and equipment	6,601,345	-	-	796,668	7,398,013
Computers and software	30,481,310	-	-	2,007,468	32,488,778
Leasehold improvements	5,063,118	-	-	-	5,063,118
Building	44,588,986	-	-	1,155,237	45,744,223
	86,734,759	-	-	3,959,373	90,694,132
Less accumulated depreciation for					
Furniture and equipment	5,669,418	485,412	-	-	6,154,830
Computers and software	24,434,229	3,718,911	-	-	28,153,140
Leasehold improvements	3,776,978	586,863	-	-	4,363,841
Building	12,604,876	2,017,206	-	-	14,622,082
	46,485,501	6,808,392	-	-	53,293,893
Total depreciable assets, net	40,249,258	(6,808,392)	-	3,959,373	37,400,239
Capital assets, net	$ 46,624,892	$ 29,684	$ -	$ -	$ 46,654,576

The Organization recognized depreciation expense of approximately $6,768,000 and $6,808,000 during the years ended June 30, 2021 and 2020, respectively. During the years ended June 30, 2021 and 2020, depreciation expense of approximately $583,000 and $600,000, respectively, was included within PACE medical expenses on the accompanying statements of revenues, expenses, and changes in net position.

Note 5 – Medical Claims Liability

Medical claims liability consisted of the following:

	June 30, 2021	June 30, 2020
Claims payable or pending approval	$ 19,551,355	$ 20,849,394
Provisions for IBNR claims	269,368,435	281,209,114
	$ 288,919,790	$ 302,058,508

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Note 5 – Medical Claims Liability (continued)

The cost of health care services is recognized in the period in which care is provided and includes an estimate of the cost of services that has been IBNR. CalOptima estimates accrued claims payable based on historical claims payments and other relevant information. Unpaid claims adjustment expenses are an estimate of the cost to process the IBNR claims and are included in medical claims liability. Estimates are continually monitored and analyzed and, as settlements are made or estimates adjusted, differences are reflected in current operations.

Such estimates are subject to the impact of changes in the regulatory environment and economic conditions. Given the inherent variability of such estimates, the actual liability could differ significantly from the amounts provided.

The following is a reconciliation of the medical claims liability:

	For the Years Ended June 30,	
	2021	2020
Beginning balance	$ 302,058,508	$ 287,288,604
Incurred		
Current	2,334,701,565	2,172,813,310
Prior	(96,907,575)	(76,706,716)
	2,237,793,990	2,096,106,594
Paid		
Current	2,045,781,775	1,870,754,802
Prior	205,150,933	210,581,888
	2,250,932,708	2,081,336,690
Ending balance	$ 288,919,790	$ 302,058,508

Amounts incurred related to prior years vary from previously estimated liabilities as the claims are ultimately adjudicated and paid. Liabilities at any year end are continually reviewed and re-estimated as information regarding actual claim payments becomes known. This information is compared to the originally established prior reporting period liability. Negative amounts reported for incurred, related to prior years, result from claims being adjudicated and paid for amounts less than originally estimated. The results included a decrease of prior year incurred of approximately $96,908,000 and $76,707,000 for the fiscal years ended June 30, 2021 and 2020, respectively. Original estimates are increased or decreased as additional information becomes known regarding individual claims.

Note 5 – Medical Claims Liability (continued)

The amounts accrued in the Due to the State of California and CMS line item represent excess payments from DHCS that are primarily due to capitation payments received that do not reflect the current Medi-Cal rates issued by DHCS. DHCS continues to process the recoupments and the remaining overpayments not yet recouped are included within the Due to the State of California and CMS line item on the statements of net position. On January 15, 2020, DHCS recouped $10,174,350 relating to the California Medicaid Managed Care Organizations Received Capitation Payments After Beneficiaries' Deaths audit.

Note 6 – Defined Benefit Pension Plan

Plan description – CalOptima's defined benefit pension plan, the CalPERS Plan, provides retirement and disability benefits, annual cost of living adjustments, and death benefits to plan members and beneficiaries. The CalPERS Plan is part of the public agency portion of CalPERS, an agent multiple-employer plan administered by CalPERS, which acts as a common investment and administrative agent for participating public employers within the State. A menu of benefit provisions as well as other requirements is established by state statutes within the Public Employees' Retirement Law (PERL). CalOptima selects optional benefit provisions from the benefit menu by contract with CalPERS and adopts those benefits through the Board of Directors' approval. CalPERS issues a publicly available financial report that includes financial statements and required supplementary information for CalPERS. Copies of the report can be obtained from CalPERS Executive Office, 400 P Street, Sacramento, CA 95814.

Benefits provided – CalPERS provides service retirement and disability benefits, annual cost of living adjustments, and death benefits to plan members, who must be public employees and beneficiaries. Benefits are based on years of credited service, equal to one full year of full-time employment. Members with five years of total service are eligible to retire at age 50 with statutorily reduced benefits. All members are eligible for non-duty disability benefits after 10 years of service. The death benefit is one of the following: The Basic Death Benefit, the 1957 Survivor Benefit, or the Optional Settlement 2W Death Benefit. The cost of living adjustments for the Plan are applied as specified by the PERL.

Note 6 – Defined Benefit Pension Plan (continued)

The CalPERS Plan's provisions and benefits in effect as of June 30, 2021, are summarized as follows:

Hire date	Prior to January 1, 2013	On or after January 1, 2013
Benefit formula	2% at 60	2% at 62
Benefit vesting schedule	5 years of service	5 years of service
Benefit payments	monthly for life	monthly for life
Retirement age	50 plus	52 plus
Monthly benefits as a % of eligible compensation	2.0% to 2.7%	1.0% to 2.5%
Required employee contribution rates	7.0%	7.3%
Required employer contribution rates	8.5%	8.5%

The following is a summary of Plan participants:

	June 30, 2021	June 30, 2020
Active employees	1,369	1,361
Retirees and beneficiaries		
Receiving benefits	71	72
Deferred retirement benefits		
Terminated employees	173	202
Surviving spouses	3	3
Beneficiaries	3	3

Contributions – Section 20814(c) of the California Public Employees' Retirement Law requires that the employer contribution rates for all public employers are determined on an annual basis by the actuary and shall be effective on the July 1 following notice of a change in the rate. The total Plan contributions are determined through CalPERS' annual actuarial valuation process. The actuarially determined rate is the estimated amount necessary to finance the costs of benefits earned by employees during the year, with an additional amount to finance any unfunded accrued liability. The employer is required to contribute the difference between the actuarially determined rate and the contribution rate of employees. The average active employee contribution rate is 7.75 percent of annual pay for the years ended June 30, 2021 and 2020. The employer's contribution rate is 8.5 percent and 8.6 percent of annual payroll for the years ended June 30, 2021 and 2020, respectively.

Note 6 – Defined Benefit Pension Plan (continued)

CalOptima's net pension liability for the CalPERS Plan is measured as the total pension liability, less the pension plan's fiduciary net position. For the measurement period ended June 30, 2020 (the measurement date), the total pension liability was determined by rolling forward the June 30, 2019 total pension liability. Total pension liabilities were based on the following actuarial methods and assumptions as of June 30, 2020 and June 30, 2019, respectively:

Valuation date	June 30, 2019
Measurement date	June 30, 2020
Actuarial cost method	Entry age normal
Actuarial assumptions	
Discount rate	7.15%
Inflation	2.63%
Salary increases	Varies by entry age and service
Investment rate of return	7.25% net of pension plan investment and administrative expenses; includes inflation
Mortality rate table	Derived using CalPERS' membership data for all funds
Post-retirement benefit increase	Contract COLA up to 2.5% until Purchasing Power Protection Allowance Floor on Purchasing Power applies, 2.50% thereafter

The mortality table used was developed based on CalPERS-specific data. The table includes 15 years of mortality improvements using Society of Actuarials Scale MP 2016. For more details on this table, please refer to the December 2017 experience study report based on CalPERS demographic data from 1997 to 2015 that can be found on the CalPERS website.

Note 6 – Defined Benefit Pension Plan (continued)

Changes in the net pension liability are as follows:

	Increase (Decreases)		
	Total Pension Liability	Plan Fiduciary Net Position	Net Pension Liability (Asset)
Balance at June 30, 2020	$ 187,171,344	$ 160,048,471	$ 27,122,873
Changes during the year			
Service cost	15,223,385	-	15,223,385
Interest on the total pension liability	13,770,107	-	13,770,107
Differences between expected and actual experience	(405,662)	-	(405,662)
Contributions from the employer	-	9,608,656	(9,608,656)
Contributions from employees	-	7,518,241	(7,518,241)
Net investment income	-	8,189,430	(8,189,430)
Benefit payments, including refunds of employee contributions	(3,576,922)	(3,576,922)	-
Administrative expenses	-	(225,629)	225,629
Net changes during the year	25,010,908	21,513,776	3,497,132
Balance at June 30, 2021	$ 212,182,252	$ 181,562,247	$ 30,620,005

Note 6 – Defined Benefit Pension Plan (continued)

	Increase (Decreases)		
	Total Pension Liability	Plan Fiduciary Net Position	Net Pension Liability (Asset)
Balance at June 30, 2019	$ 161,697,511	$ 138,095,447	$ 23,602,064
Changes during the year			
Service cost	14,303,164	-	14,303,164
Interest on the total pension liability	12,107,314	-	12,107,314
Differences between expected and actual experience	1,904,567	-	1,904,567
Contributions from the employer	-	8,661,466	(8,661,466)
Contributions from employees	-	6,853,391	(6,853,391)
Net investment income	-	9,377,613	(9,377,613)
Benefit payments, including refunds of employee contributions	(2,841,212)	(2,841,212)	-
Administrative expenses	-	(98,234)	98,234
Net changes during the year	25,473,833	21,953,024	3,520,809
Balance at June 30, 2020	$ 187,171,344	$ 160,048,471	$ 27,122,873

Discount rate and long-term rate of return – The discount rate used to measure the total pension liability was 7.15 percent. The projection of cash flows used to determine the discount rate assumed that contributions from Plan members will be made at the current member contribution rates and that contributions from employers will be made at statutorily required rates, actuarially determined. Based on those assumptions, the Plan's fiduciary net position was projected to be available to make all projected future benefit payments of current Plan members. Therefore, the long-term expected rate of return on Plan investments was applied to all periods of projected benefit payments to determine the total pension liability.

The long-term expected rate of return on pension plan investments was determined using a building-block method in which expected future real rates of return (expected returns, net of pension plan investment expense and inflation) are developed for each major asset class.

Note 6 – Defined Benefit Pension Plan (continued)

In determining the long-term expected rate of return, CalPERS took into account both short-term and long-term market return expectations as well as the expected pension fund cash flows. Using historical returns of all of the funds' asset classes, expected compound (geometric) returns were calculated over the short-term (first 10 years) and the long-term (11+ years) using a building-block approach. Using the expected nominal returns for both short-term and long-term, the present value of benefits was calculated for each fund. The expected rate of return was set by calculating the rounded single equivalent expected return that arrived at the same present value of benefits for cash flows as the one calculated using both short-term and long-term returns. The expected rate of return was then set equal to the single equivalent rate calculated above and adjusted to account for assumed administrative expenses.

The table below reflects long-term expected real rate of return by asset class.

New Strategic Asset Class	Real Return Allocation	Real Return Years 1–10 (a)	Years 11+ (b)
Global equity	50.0%	4.80%	5.98%
Global fixed income	28.0%	1.00%	2.62%
Inflation sensitive	0.0%	0.77%	1.81%
Private equity	8.0%	6.30%	7.23%
Real estate	13.0%	3.75%	4.93%
Liquidity	1.0%	0.00%	-0.92%

(a) An expected inflation of 2.00% was used for this period
(b) An expected inflation of 2.92% was used for this period

Note 6 – Defined Benefit Pension Plan (continued)

The following presents the net pension liability of the CalPERS Plan calculated using the discount rate, as well as what the net pension liability would be if it were calculated using a discount rate that is 1 percentage point lower or 1 percentage point higher than the current rate:

	June 30, 2021		
	Discount Rate -1% 6.15%	Current Discount Rate 7.15%	Discount Rate +1% 8.15%
Net pension liability	$ 66,024,233	$ 30,620,005	$ 2,041,896

	June 30, 2020		
	Discount Rate -1% 6.15%	Current Discount Rate 7.15%	Discount Rate +1% 8.15%
Net pension liability	$ 58,702,340	$ 27,122,873	$ 1,654,408

Note 6 – Defined Benefit Pension Plan (continued)

Pension expense and deferred outflows/inflows of resources related to pensions – CalOptima recognized pension expense of approximately $13,022,000 and $13,356,000, presented within salaries, wages, and employee benefits in the statements of revenues, expenses, and changes in net position for the years ended June 30, 2021 and 2020, respectively. As of June 30, 2021 and 2020, CalOptima recognized deferred outflows of resources and deferred inflows of resources related to pensions from the following sources:

	June 30, 2021	
	Deferred Outflows of Resources	Deferred Inflows of Resources
Contributions from employers subsequent to the measurement date	$ 1,508,025	$ -
Net differences between projected and actual earnings on plan investments	2,104,780	-
Changes in assumptions	3,692,771	2,709,945
Differences between expected and actual experiences	3,236,721	344,198
	$ 10,542,297	$ 3,054,143

	June 30, 2020	
	Deferred Outflows of Resources	Deferred Inflows of Resources
Contributions from employers subsequent to the measurement date	$ 1,047,297	$ -
Changes in assumptions	5,060,465	3,728,725
Differences between expected and actual experiences	4,280,308	506,547
	$ 10,388,070	$ 4,235,272

Note 6 – Defined Benefit Pension Plan (continued)

The deferred outflows of resources related to employer contributions subsequent to the measurement date will be recognized as a reduction of the net pension liability during the year ended June 30, 2021. The net differences reported as deferred outflows of resources related to pensions will be recognized as pension expense as follows:

Years Ending June 30,	Deferred Outflows (Inflows) of Resources
2021	$ 1,176,983
2022	2,044,465
2023	1,891,514
2024	766,526
2025	137,519
Thereafter	(36,878)
	$ 5,980,129

Note 7 – Employee Benefit Plans

Deferred compensation plan – CalOptima sponsors a deferred compensation plan created in accordance with Internal Revenue Code Section 457 (the "457 Plan") under which employees are permitted to defer a portion of their annual salary until future years. CalOptima may make discretionary contributions to the 457 Plan as determined by the Board of Directors. For the years ended June 30, 2021 and 2020, no discretionary employer contributions were made.

Defined contribution plan – Effective January 1, 1999, CalOptima established a supplemental retirement plan for its employees called the CalOptima Public Agency Retirement System Defined Contribution Supplemental Retirement Plan ("PARS Plan"). All regular and limited-term employees are eligible to participate in the PARS Plan. The current PARS Plan design does not require employee contributions. CalOptima makes discretionary employer contributions to the PARS Plan as authorized by the Board of Directors. Vesting occurs over 16 quarters of service. For the years ended June 30, 2021 and 2020, CalOptima contributed approximately $4,420,000 and $3,533,000, respectively.

Note 8 – Postemployment Health Care Plan

Plan description – CalOptima sponsors and administers a single-employer, defined benefit postemployment health care plan to provide medical and dental insurance benefits to eligible retired employees and their beneficiaries. Benefit provisions are established and may be amended by the Board of Directors.

Note 8 – Postemployment Health Care Plan (continued)

Effective January 1, 2004, CalOptima terminated postemployment health care benefits for employees hired on or after January 1, 2004. For employees hired prior to January 1, 2004, the employee's eligibility for retiree health benefits remains similar to the eligibility requirements for the defined benefit pension plan.

During the year ended June 30, 2006, CalOptima modified the benefit offered to eligible participants, requiring participants to enroll in Medicare and specifying that CalOptima would be responsible only for the cost of Medicare supplemental coverage, subject to a cost sharing between the participant and CalOptima.

For purposes of measuring the total postemployment retirement liability, deferred outflows of resources and deferred inflows of resources related to OPEB, and OPEB expense, information about the fiduciary net position of the CalOptima's plan and additions to/deductions from the OPEB plan's fiduciary net position have been determined on the same basis. For this purpose, benefit payments are recognized when currently due and payable in accordance with the benefit terms.

U.S. GAAP requires that the reported results must pertain to liability and asset information within certain defined timeframes. For this report, the following timeframes are used:

Measurement date	June 30, 2020
Measurement period	July 1, 2019 – June 30, 2020
Valuation date	January 1, 2020

Covered employees – The following numbers of participants were covered by the benefit terms:

	June 30, 2021	June 30, 2020
Inactives currently receiving benefits	73	72
Inactives entitled to but not yet receiving benefits	-	-
Active employees	71	76
Total	144	148

Contributions – The contribution requirements of plan members and CalOptima are established and may be amended by the Board of Directors. CalOptima's contribution is based on projected pay-as-you-go financing requirements, with no additional amount to prefund benefits. CalOptima contributed $544,000, including $485,000 in premium payments for retirees and $59,000 for implied subsidies, for the year ended June 30, 2021. CalOptima contributed $570,000, including $532,000 in premium payments for retirees and $38,000 for implied subsidies, for the year ended June 30, 2020. The most recent actuarial report for the postemployment health care plan was June 30, 2020. As of that point, the actuarial accrued liability and unfunded actuarial accrued liability for benefits were approximately $31,610,000.

Note 8 – Postemployment Health Care Plan (continued)

Actuarial assumptions – CalOptima's total postemployment retirement liability was measured as of June 30, 2020, and the total postemployment retirement liability used to calculate the total postemployment retirement liability was determined by an actuarial valuation dated January 1, 2020, that was rolled forward to determine the June 30, 2020 total postemployment retirement liability, based on the following actuarial methods and assumptions:

Salary increases	3% per annum, in aggregate
Medical trend	Non-Medicare – 7.25% for 2021, decreasing to an ultimate rate of 4.0% in 2076 Medicare – 6.5% for 2021, decreasing to an ultimate rate of 4.0% in 2076
Discount rate	2.21% at June 30 2020, Bond Buyer 20 Index 3.50% at June 30 2019, Bond Buyer 20 Index
Mortality, retirement, disability, termination	CalPERS 1997-2015 Experience Study Post-retirement mortality projection Scale MP-2019
General inflation	2.75% per annum

Discount rate and long-term rate of return – The discount rate used to measure the total OPEB liability was 2.21 percent for June 30, 2020. There were no plan investments; as such, the expected long-term rate of return on investment is not applicable.

Changes in the net OPEB liability – Changes in the net OPEB liability were as follows:

Balance at June 30, 2020	$ 25,824,000
Changes for the year	
Service cost	811,000
Interest	922,000
Assumption changes	4,623,000
Benefit payments	(570,000)
Net changes	5,786,000
Balance at June 30, 2021	$ 31,610,000

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Note 8 – Postemployment Health Care Plan (continued)

Balance at June 30, 2019	$ 24,705,000
Changes for the year	
Service cost	832,000
Interest	977,000
Actual vs. expected experience	(1,072,000)
Assumption changes	938,000
Benefit payments	(556,000)
Net changes	1,119,000
Balance at June 30, 2020	$ 25,824,000

Sensitivity of the net OPEB liability to changes in the discount rate – The following presents the net OPEB liability, as well as what the net OPEB liability would be if it were calculated using a discount rate that is 1 percentage point lower (1.21 percent) or 1 percentage point higher (3.21 percent) than the current discount rate:

	1% Decrease (1.21%)	Current Rate (2.21%)	1% Increase (3.21%)
Total OPEB liability	$ 37,153,000	$ 31,610,000	$ 27,188,000

Sensitivity of the net OPEB liability to changes in health care cost trend rates – The following presents the net OPEB liability, as well as what the net OPEB liability would be if it were calculated using health care cost trend rates that are 1 percentage point lower or 1 percentage point higher than the current health care cost trend rates:

	1% Decrease	Current Rate	1% Increase
Total OPEB liability	$ 26,497,000	$ 31,610,000	$ 38,150,000

Note 8 – Postemployment Health Care Plan (continued)

For the years ended June 30, 2021 and 2020, CalOptima recognized OPEB expense of approximately $2,020,000 and $911,000, respectively. As of June 30, 2021 and 2020, the reported deferred outflows of resources and deferred inflows of resources related to OPEB from the following sources:

	June 30, 2021	
	Deferred Outflows of Resources	Deferred Inflows of Resources
Differences between expected and actual experience	$ -	$ 536,000
Changes in assumptions	3,906,000	773,000
Employer contributions made subsequent to measurement date	544,000	-
Total	$ 4,450,000	$ 1,309,000

	June 30, 2020	
	Deferred Outflows of Resources	Deferred Inflows of Resources
Differences between expected and actual experience	$ -	$ 804,000
Changes in assumptions	703,000	1,638,000
Employer contributions made subsequent to measurement date	570,000	-
Total	$ 1,273,000	$ 2,442,000

Amounts reported as deferred outflows of resources will be recognized in OPEB expense as follows:

	Deferred Outflows of Resources
Years Ending June 30,	
2022	$ 474,000
2023	1,055,000
2024	1,068,000
	$ 2,597,000

The required schedule of changes in total OPEB liability immediately following the notes to the financial statements presents multiyear trend information about the actuarial accrued liability for benefits.

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Note 9 – Restricted Net Position

On June 28, 2000, CalOptima became a fully licensed health care service plan under the Act, as required by statutes governing the Healthy Families program. Under the Act, CalOptima is required to maintain and meet a minimum level of TNE as of June 30, 2021 and 2020, of $101,509,138 and $100,573,921, respectively. As of June 30, 2021 and 2020, the Organization is in compliance with its TNE requirement.

The Act further required that CalOptima maintain a restricted deposit in the amount of $300,000. CalOptima met this requirement as of June 30, 2021 and 2020.

Note 10 – Lease Commitments

CalOptima leases office space and equipment under noncancelable, long-term operating leases, with minimum annual payments as follows:

	Minimum Lease Payments
Year Ending June 30, 2022	$ 231,434
	$ 231,434

Rental expense under operating leases was approximately $471,000 for the years ended June 30, 2021 and 2020.

Note 11 – Contingencies

Litigation – CalOptima is party to various legal actions and is subject to various claims arising in the ordinary course of business. Management believes that the disposition of these matters will not have a material adverse effect on CalOptima's financial position or results of operations.

Regulatory matters – The health care industry is subject to numerous laws and regulations of federal, state, and local governments. Violations of these laws and regulations could result in expulsion from government health care programs together with the imposition of significant fines and penalties. Management believes that CalOptima is in compliance with fraud and abuse, as well as other applicable government laws and regulations. Compliance with such laws and regulations can be subject to future government review and interpretation, as well as regulatory actions unknown or unasserted at this time.

Note 11 – Contingencies (continued)

COVID-19 pandemic – In March 2020, the World Health Organization declared the novel coronavirus (COVID-19) a global pandemic. This contagious disease outbreak, which has continued to spread, and any related adverse public health developments have adversely affected workforces, customers, economies, and financial markets globally, potentially leading to an economic downturn. It has also disrupted the normal operations of many businesses, including that of the Organization's operations. The Organization's management has been closely monitoring the impact of COVID-19 on the Organization's operations. At this time, the Organization cannot reasonably estimate the duration and severity of this pandemic, which could have a material adverse impact on the Organization's operations.

Supplementary Information

Orange County Health Authority, a Public Agency/ dba Orange Prevention and Treatment Integrated Medical Assistance/dba CalOptima

Schedule of Changes in Net Pension Liability and Related Ratios

	June 30,						
	2021	2020	2019	2018	2017	2016	2015
Total pension liability							
Service cost	$ 15,223,385	$ 14,303,164	$ 13,491,596	$ 13,118,795	$ 10,272,406	$ 8,363,183	$ 6,464,105
Interest	13,770,107	12,107,314	10,431,464	9,136,725	7,702,198	6,620,025	5,661,111
Differences between expected and actual experience	(405,662)	1,904,567	2,812,748	632,642	102,384	1,444,808	-
Changes in assumptions	-	-	(4,737,905)	9,163,547	-	(1,963,270)	-
Benefit payments, including refunds of employee contributions	(3,576,922)	(2,841,212)	(2,748,699)	(2,068,356)	(2,111,578)	(1,676,666)	(1,326,364)
Net change in total pension liability	25,010,908	25,473,833	19,249,204	29,983,353	15,965,410	12,788,080	10,798,852
Total pension liability – beginning	187,171,344	161,697,511	142,448,307	112,464,954	96,499,544	83,711,464	72,912,613
Total pension liability – ending	212,182,252	187,171,344	161,697,511	142,448,307	112,464,954	96,499,544	83,711,465
Plan fiduciary net position							
Contributions – employer	9,608,656	8,661,466	7,588,200	5,234,580	3,787,544	3,033,171	3,119,804
Contributions – employee	7,518,241	6,853,391	6,213,420	5,793,911	4,951,820	4,142,126	3,385,296
Net investment income	8,189,430	9,377,613	10,225,467	11,496,425	498,498	1,913,380	12,062,654
Benefit payments, including refunds of employee contributions	(3,576,922)	(2,841,212)	(2,748,699)	(2,068,356)	(2,111,578)	(1,676,666)	(1,326,364)
Other changes in fiduciary net position	(225,629)	(98,234)	(530,428)	(143,264)	(54,828)	(101,246)	-
Net change in fiduciary net position	21,513,776	21,953,024	20,747,960	20,313,296	7,071,456	7,310,765	17,241,390
Plan fiduciary net position – beginning	160,048,471	138,095,447	117,347,487	97,034,191	89,962,735	82,651,970	65,410,580
Plan fiduciary net position – ending	181,562,247	160,048,471	138,095,447	117,347,487	97,034,191	89,962,735	82,651,970
Plan net pension liability – ending	$ 30,620,005	$ 27,122,873	$ 23,602,064	$ 25,100,820	$ 15,430,763	$ 6,536,809	$ 1,059,495
Plan fiduciary net position as percentage of the total liability	85.57%	85.51%	85.40%	82.38%	86.28%	93.23%	98.73%
Covered-employee payroll	$ 98,088,822	$ 91,587,145	$ 85,764,390	$ 80,217,654	$ 68,583,296	$ 55,676,606	$ 40,940,556
Plan net pension liability as a percentage of covered-employee payroll	31.22%	29.61%	27.52%	31.29%	22.50%	11.74%	2.59%

See accompanying report of independent auditors.

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Orange County Health Authority, a Public Agency/ dba Orange Prevention and Treatment Integrated Medical Assistance/dba CalOptima
Schedule of Plan Contributions

	Years Ended June 30,						
	2021	2020	2019	2018	2017	2016	2015
Actuarially determined contributions	$ 9,608,656	$ 8,661,466	$ 7,588,200	$ 5,234,580	$ 3,787,544	$ 3,033,171	$ 3,119,804
Contributions in relation to the actuarially determined contribution	(9,608,656)	(8,661,466)	(7,588,200)	(5,234,580)	(3,787,544)	(3,033,171)	(3,119,804)
Contribution deficiency (excess)	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Covered-employee payroll	$ 98,088,822	$ 91,587,145	$ 85,764,390	$ 80,217,654	$ 68,583,296	$ 55,676,606	$ 40,940,556
Contributions as a percentage of covered-employee payroll	9.80%	9.46%	8.85%	6.53%	5.52%	5.45%	7.62%

See accompanying report of independent auditors.

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Orange County Health Authority, a Public Agency/ dba Orange Prevention and Treatment Integrated Medical Assistance/dba CalOptima

Schedule of Changes in Total OPEB Liability and Related Ratios

	2020-2021 (Measurement Period 2019–2020)	2019–2020 (Measurement Period 2018–2019)	2018–2019 (Measurement Period 2017–2018)	2017–2018 (Measurement Period 2016–2017)
Changes in total OPEB liability				
Service cost	$ 811,000	$ 832,000	$ 867,000	$ 1,012,000
Interest	922,000	977,000	900,000	770,000
Actual vs. expected experience	-	(1,072,000)	-	-
Assumption changes	4,623,000	938,000	(1,067,000)	(2,923,000)
Benefit payments	(570,000)	(556,000)	(560,000)	(572,000)
Net changes	5,786,000	1,119,000	140,000	(1,713,000)
Total OPEB liability (beginning of year)	25,824,000	24,705,000	24,565,000	26,278,000
Total OPEB liability (end of year)	$ 31,610,000	$ 25,824,000	$ 24,705,000	$ 24,565,000
Total OPEB liability	$ 31,610,000	$ 25,824,000	$ 24,705,000	$ 24,565,000
Covered employee payroll	8,513,000	8,353,000	8,150,000	9,135,000
Total OPEB liability as a percentage of covered employee payroll	371.3%	309.2%	303.1%	268.9%

See accompanying report of independent auditors.

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Audit Results - CalOptima

Prepared by the Moss Adams Health Care Group

September 16, 2021

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Finance and Audit Committee (FAC)

CalOptima

Dear Finance and Audit Committee (FAC) Members:

Thank you for your continued engagement of Moss Adams LLP. We are pleased to have the opportunity to meet with you to discuss the results of our audit of the financial statements of CalOptima ("the Organization") for the year ended June 30, 2021.

The accompanying report, which is intended solely for the use of the FAC and management, presents important information regarding the financial statements of the Organization and our audit that we believe will be of interest to you. It is not intended for, and should not be used by, anyone other than these specified parties.

We received the full support and assistance of the Organization personnel. We are pleased to serve and be associated with the Organization as its independent public accountants and look forward to our continued relationship.

We look forward to discussing our report or any other matters of interest with you during this meeting.

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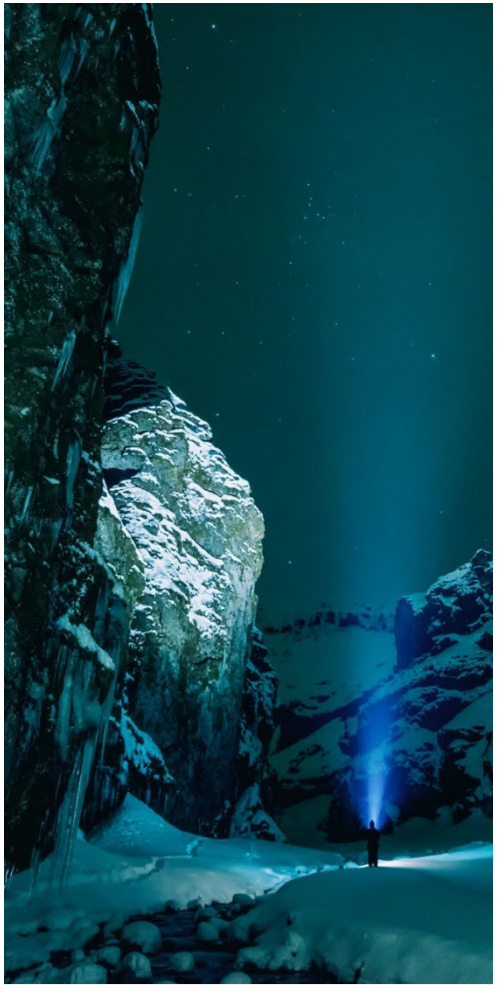

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1. Auditor Opinions & Reports
2. Communications with the FAC

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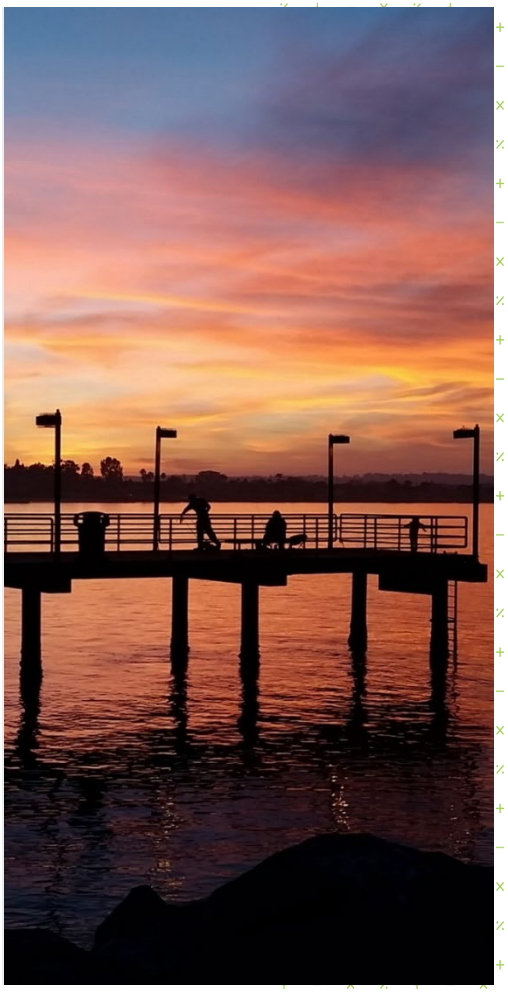
Auditor Opinions & Reports



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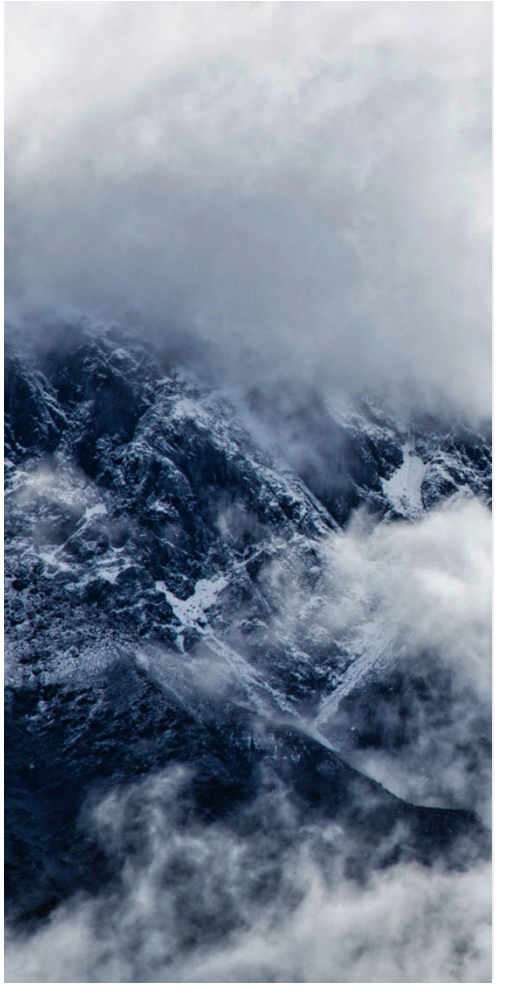
Scope of Services



We have performed the following services for CalOptima.

- Annual financial statement audit as of and for the year ended June 30, 2021

We have also performed the following nonattest services:

- Assisted in the drafting the financial statements of CalOptima, excluding Management's Discussion and Analysis
- Assisted in the completion of the Auditee portion of the Data Collection Form

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Auditor Report on the Financial Statements

Unmodified Opinion

- Financial statements are presented fairly and in accordance with U.S. Generally Accepted Accounting Principles (GAAP).

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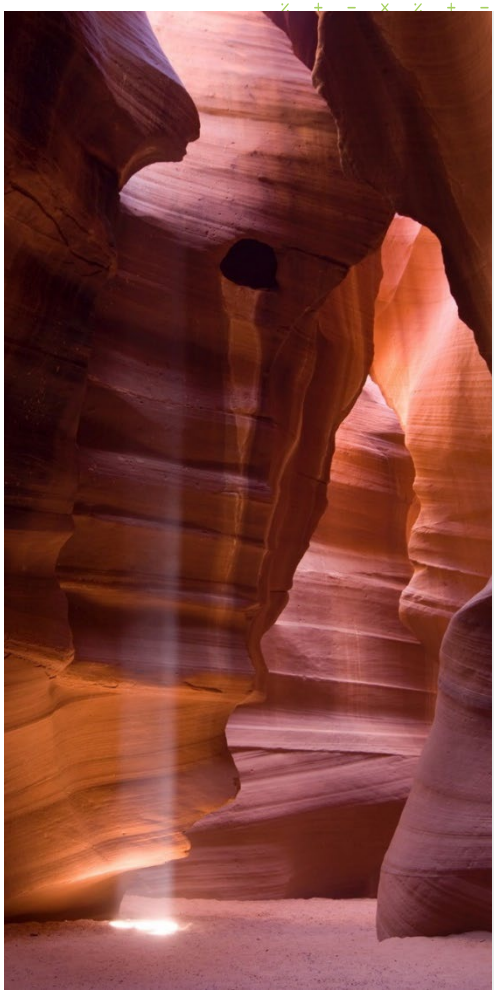
Communications with the FAC



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Our Responsibility

			
To express our opinion on whether the financial statements prepared by management with your oversight are fairly presented, in all material respects, and in accordance with U.S. GAAP. However, our audit does not relieve you or management of your responsibilities.	To perform an audit in accordance with generally accepted auditing standards issued by the American Institute of Certified Public Accountants (AICPA), and Government Auditing Standards issued by the Comptroller General of the United States, and design the audit to obtain reasonable, rather than absolute, assurance about whether the financial statements are free of material misstatement.	To consider internal control over financial reporting and compliance as a basis for designing audit procedures but not for the purpose of expressing an opinion on its effectiveness or to provide assurance concerning such internal control.	To communicate findings that, in our judgment, are relevant to your responsibilities in overseeing the financial reporting process. However, we are not required to design procedures for the purpose of identifying other matters to communicate to you.

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Planned Scope & Timing of the Audit

It is the auditor's responsibility to determine the overall audit strategy and the audit plan, including the nature, timing, and extent of procedures necessary to obtain sufficient appropriate audit evidence and to communicate with the FAC an overview of the planned scope and timing of the audit.

Our Comments

The planned scope and timing of the audit was communicated to the FAC at the audit entrance meeting on May 20, 2021.

Significant Accounting Policies & Unusual Transactions

The auditor should determine that the FAC is informed about the initial selection of and changes in significant accounting policies or their application. The auditor should also determine that the FAC is informed about the methods used to account for significant unusual transactions and the effect of significant accounting policies in controversial or emerging areas for which there is a lack of authoritative guidance or consensus.

Our Comments

Management has the responsibility for selection and use of appropriate accounting policies. The significant accounting policies used by the Organization are described in the footnotes to the financial statements. Throughout the course of an audit, we review changes, if any, to significant accounting policies or their application, and the initial selection and implementation of new policies. There were no changes to significant accounting policies for the year ended June 30, 2021.

We believe management has selected and applied significant accounting policies appropriately and consistent with those of the prior year.

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Management Judgments & Accounting Estimates

The FAC should be informed about the process used by management in formulating particularly sensitive accounting estimates and about the basis for the auditor's conclusions regarding the reasonableness of those estimates.

Our Comments

Management's judgments and accounting estimates are based on knowledge and experience about past and current events and assumptions about future events. We apply audit procedures to management's estimates to ascertain whether the estimates are reasonable under the circumstances and do not materially misstate the financial statements.

Significant management estimates impacted the financial statements including the following: **fair value of investments; capital asset lives; actuarially determined accruals for incurred but not reported (IBNR), medical claims liabilities, other non-IBNR medical liabilities, pension, and other postemployment liabilities.**

We deem them to be reasonable.

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Areas of Audit Emphasis

	Medical Claims Liability and Claims Expense
	Capitation Revenue and Receivables
	Amounts due to the State of California or DHCS
	Pension and Other Postemployment Benefits (OPEB) liabilities
	Impact of COVID-19

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Significant Accounting Policies, Accounting Estimates, and Financial Statement Disclosures

Our views about the quantitative aspects of the Organization's significant accounting policies, accounting estimates, and financial statement disclosures.

Our Comments

The disclosures in the financial statements are clear and consistent. Certain financial statement disclosures are particularly sensitive because of their significance to financial statements users. We call your attention to the following notes:

- Note 3 – Cash and Investments
- Note 5 – Medical Claims Liability
- Note 6 – Defined Benefit Pension Plan
- Note 8 – Postemployment Health Care Plan

Significant Audit Adjustments & Unadjusted Differences Considered by Management to Be Immaterial

The FAC should be informed of all significant audit adjustments arising from the audit. Consideration should be given to whether an adjustment is indicative of a significant deficiency or a material weakness in the Organization's internal control over financial reporting, or in its process for reporting interim financial information, that could cause future financial statements to be materially misstated.

The FAC should also be informed of uncorrected misstatements aggregated by the auditors during the current engagement and pertaining to the latest period presented that were determined by management to be immaterial, both individually and in the aggregate, to the financial statements as a whole.

Our Comments

CORRECTED ADJUSTMENTS:

- None noted

UNCORRECTED ADJUSTMENTS:

- There were no uncorrected audit adjustments

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Deficiencies in Internal Control and in Internal Control over Compliance

Any material weaknesses and significant deficiencies in the design or operation in internal control or in internal control over compliance that came to the auditor's attention during the audit must be reported to the FAC.

Our Comments

MATERIAL WEAKNESS

- None noted

SIGNIFICANT DEFICIENCIES

- Nothing to communicate

NONCOMPLIANCE

- Nothing to communicate

Potential Effect on the Financial Statements of Any Significant Risks, Exposures & Uncertainties

The FAC should be adequately informed of the potential effect on financial statements of significant risks, exposures, and uncertainties that are disclosed in the financial statements.

Our Comments

The Organization is subject to potential legal proceedings and claims that arise in the ordinary course of business, which are disclosed in the notes to the financial statements.

Difficulties Encountered in Performing the Audit

The FAC should be informed of any significant difficulties encountered in dealing with management related to the performance of the audit, including disagreements with management, whether or not satisfactorily resolved, about matters that individually or in the aggregate could be significant to the Organization's financial statements or the auditor's report.

Our Comments

No significant difficulties were encountered during the audit.

We are pleased to report that there were no disagreements with management.

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Material Uncertainties Related to Events & Conditions/ Fraud & Noncompliance with Laws & Regulations

Any doubt regarding the Organization's ability to continue, as a going concern, should be communicated to the FAC.

Fraud involving senior management and fraud (whether caused by senior management or other employees) that causes a material misstatement of the financial statements should be communicated. We are also required to communicate any noncompliance with laws and regulations involving senior management that come to our attention, unless clearly inconsequential.

Our Comments

No such matters came to our attention during the audit.

We have not become aware of any instances of fraud or noncompliance with laws and regulations.

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Other Material Written Communications

Report to the FAC significant written communications between the auditor and management.

Our Comments

We have requested certain representations from management that will be included in the representation letter, which we will receive prior to issuance.

Other than the engagement letter, management representation letter, and communications to the FAC, there have been no other significant communications.

Management's Consultation with Other Accountants

In some cases, management may decide to consult about auditing and accounting matters. If management has consulted with other accountants about an auditing and accounting matter that involves application of an accounting principle to the Organization's financial statements or a determination of the type of auditor's opinion that may be expressed on those statements, our professional standards require the consulting accountant to check with us to determine that the consultant has all the relevant facts.

Our Comments

We are not aware of any significant accounting or auditing matters for which management consulted other accountants.

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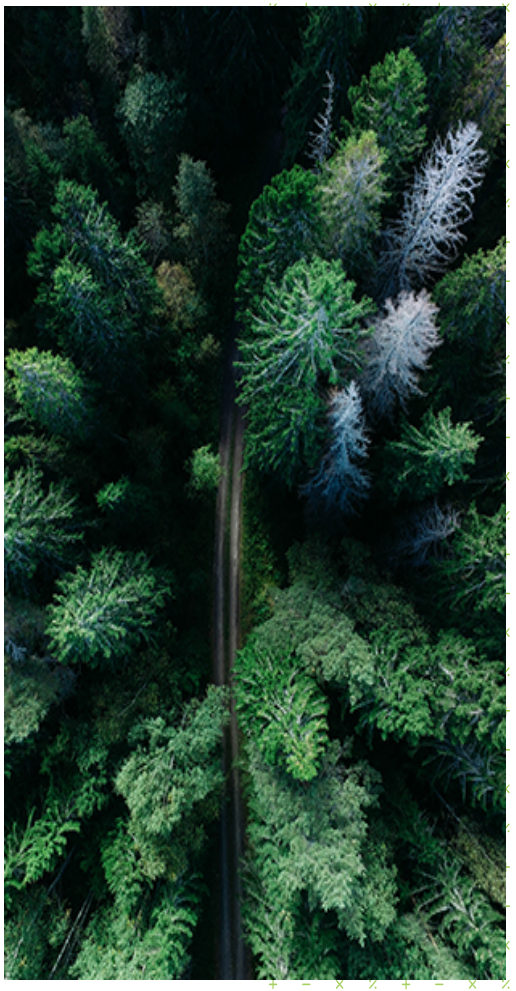
About Moss Adams



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Our Response to COVID-19

The COVID-19 pandemic has touched all aspects of our lives. We're here to guide you to the information and resources you need now and provide strategies for the changes to come. We'll support you as you rebuild and help you take advantage of rising opportunities.

NAVIGATE

- Stay up to date with guidance and support to help combat uncertainty
- Reach out to your Moss Adams professional with any questions on the most current updates and advisements

ARTICLE

- Weather COVID-19 Market Volatility: Investments, Finances, and Tax Planning

REBUILD

- Strategize needs and be aware of what's to come
  - We'll connect you with the right resource, either within the greater Moss Adams team or through our various industry contacts
- Review Moss Adams announcements that provide tax and regulatory relief

ALERTS

- CARES Act Overview: Implications for Business Taxpayers
- CARES Act: Implications for Individual Taxpayers

THRIVE

- Take steps to bolster your workforce and organization
- Evaluate additional service needs, such as the following:
  - Capital sourcing
  - Cloud tools
  - Cost segregation
  - Enterprise resource planning
  - Estate and succession planning
  - Financial planning
  - Forecasting
  - IT security and cybersecurity
  - Process improvement
  - Outsourced finance accounting
  - R&D tax credits
  - Risk assessment
  - State and local tax
  - Transactions services

HELPING YOU ADAPT TO UNCERTAIN TIMES

Find more information and resources here: https://mossadams.com/covid-19-implications

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Stacy Stelzriede, Partner
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(949) 474-2684

Aparna Venkateswaran, Senior Manager
Aparna.Venkateswaran@mossadams.com
(949) 517-9473

THANK YOU

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken October 7, 2021
Regular Meeting of the CalOptima Board of Directors

Consent Calendar

6. Consider Adopting Resolution No. 21-1007-01, Authorizing the Execution of Contract MS-21-22-41 with the California Department of Aging in order to Continue Operation of the Multipurpose Senior Services Program

Contacts

Emily Fonda, M.D., Chief Medical Officer, (714) 246-8887
Nancy Huang, Chief Financial Officer, (714) 246-8400

Recommended Action

Adopt Board Resolution No. 21-1007-01, authorizing the Chairman of the CalOptima Board of Directors to execute Contract MS-21-22-41 with the California Department of Aging in order to continue operations of the CalOptima Multipurpose Senior Services Program (MSSP) for Fiscal Year 2021-22.

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 services as a cost-effective alternative to institutionalization of the frail elderly.

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 MSSP in various areas of the State.

As the operator of the MSSP site for Orange County, CalOptima improves the quality of care for our aging population by linking frail, elderly members 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 has successfully implemented the MSSP program over the past 20 years for up to a maximum of 455 members at any given point in time. Currently, CalOptima serves 455 members.

Discussion

CalOptima received CDA Contract MS-21-22-41 for execution by the Chairman of the CalOptima Board, which, upon the adoption of a Board resolution and execution of the contract will extend the MSSP through June 30, 2022, with the maximum amount of the contract set at $2,437,071.

The scope of work and other obligations are consistent with previous contract obligations. In addition to primarily wording and technical revisions, there are some proposed clarifications regarding the content of future audits and the responsibility of CalOptima MSSP in these audits. These responsibilities include cooperating with authorized representatives of federal or State government, and inserting contract language into contracts with independent audit firms to ensure audit documents are made

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available to state and federal regulators if requested. There is also a language revision to indicate expenditures should be reconciled to the total budget allocation.

Staff does not anticipate that any of these changes will have a significant operational or financial impact as they are largely already in operation.

With the advent of the Coordinated Care Initiative (CCI) on July 1, 2015, the MSSP program now operates within CalOptima's Long-Term Services and Supports (LTSS) department, which will continue through 12/31/2021. The payment structure from DHCS for the MSSP program transitioned from fee-for-service with advance payments to a CCI payment model following CCI integration. Some of the attached contract language referring to non-CCI models may therefore not apply through 12/31/2021. Under the CCI payment model, DHCS provides CalOptima with Medi-Cal revenue for the MSSP program by accounting for MSSP members in the established capitation rate setting process. The payment structure from DHCS for the MSSP program will transition back to fee-for-service effective 1/1/2022 with the return of the MSSP to the 1915(c) Medicaid Waiver.

Fiscal Impact
The recommended action to adopt Board Resolution No. 21-1007-01, authorizing execution of Contract MS-21-22-41 for the MSSP program is a budgeted item and included in the CalOptima Fiscal Year 2021-22 Operating Budget approved by the Board on June 3, 2021.

Rationale for Recommendation
Adoption of Board Resolution No. 21-1007-01, authorizing the execution of the FY 2021-22 contract with the CDA for the MSSP program will allow CalOptima to continue to address the long-term community care needs of some of the frailest older adult CalOptima members by helping them to remain in their homes.

Concurrence
Gary Crockett, Chief Counsel

Attachment
1. Board Resolution No. 21-1007-01, Execute Contract No. MS-21-22-41 with the State of California Department of Aging for the Multipurpose Senior Services Program
2. CDA MSSP Contract FY 2021-22

/s/ Richard Sanchez *09/29/2021*
Authorized Signature **Date**

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RESOLUTION NO. 21-1007-01

RESOLUTION OF THE BOARD OF DIRECTORS
ORANGE COUNTY HEALTH AUTHORITY
Orange Prevention and Treatment Integrated Medical Assistance
d.b.a. CalOptima

EXECUTE CONTRACT NO. MS-21-22-41
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 ("CalOptima") continues to provide services as a Multipurpose Senior Service Program Site under contract with the California Department of Aging; and,

WHEREAS, the California Department of Aging notified CalOptima of its intent to contract for the assignment of 455 MSSP participant slots to CalOptima; and,

WHEREAS, the California Department of Aging has requested the execution of Contract MS-21-22-41, which covers the period of July 1, 2021, through June 30, 2022; and,

WHEREAS, the Board of Directors has determined that it is in the best interest of the ongoing development of CalOptima home and community-based services to the Medi-Cal beneficiaries residing in Orange County to approve CalOptima executing the Contract.

NOW, THEREFORE, BE IT RESOLVED:

I. That CalOptima is hereby authorized to enter into contract MS-21-22-41 with the State of California Department of Aging on the terms and conditions set forth in the form provided to this Board of Directors; and,

II. That the Chair of this Board of Directors is hereby authorized and directed to execute and deliver the Contract by and on behalf of CalOptima on the terms and conditions set forth in the form provided to this Board of Directors.

APPROVED AND ADOPTED by the Board of Directors of the Orange County Health Authority, d.b.a. CalOptima, this 7th day of October 2021.

AYES:

NOES:

ABSENT:

ABSTAIN:

/s/_____
Title: Chair, Board of Directors
Printed Name and Title: Andrew Do, M.D., Chair, Board of Directors

Attest:
/s/_____
Sharon Dwiers, Clerk of the Board

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STATE OF CALIFORNIA
CALIFORNIA DEPARTMENT OF AGING
MSSP CONTRACT CHECKLIST
CDA 9007B (NEW 02/2020)

All documents listed in Sections A and B 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
  1300 National Drive, Suite 200
  Sacramento, CA 95834

☒ **Four (4) 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.

☒ **Agreement authorization document** – Submit a 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 Non-profits, 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]

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☒ **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 coverages requires an additional insured statement naming the California Department of Aging and/or the State of California as an additional insured. 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: 4170-MS212241

AGREEMENT NUMBER	PURCHASING AUTHORITY NUMBER (If Applicable)
MS-2122-41	

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
7/1/2021

THROUGH END DATE
6/30/2022

3. The maximum amount of this Agreement is:
$ 2,437,071 Two million four hundred thirty-seven thousand seventy-one 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	22 pages
Exhibit A, Attachment 1	General Information	1 page
Exhibit B	Budget Detail and Payment Provisions	8 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	8 pages
Exhibit F	HIPPA Business Associates Addendum	8 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
Andrew Do, M.D.	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
1300 National Drive, Suite 200	Sacramento	CA	95834

PRINTED NAME OF PERSON SIGNING	TITLE
Nate Gillen	Chief, Business Management Branch

CONTRACTING AGENCY AUTHORIZED SIGNATURE	DATE SIGNED

CALIFORNIA DEPARTMENT OF GENERAL SERVICES APPROVAL	EXEMPTION (If Applicable)
	SCM, VOLUME 1, 4.04, A., (4)

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken October 7, 2021
Regular Meeting of the CalOptima Board of Directors

Consent Calendar

6. Consider Adopting Resolution No. 21-1007-01, Authorizing the Execution of Contract MS-21-22-41 with the California Department of Aging in order to Continue Operation of the Multipurpose Senior Services Program

Contact

Emily Fonda, M.D., Chief Medical Officer, (714) 246-8887
Nancy Huang, Chief Financial Officer, (714) 246-8400

Recommended Action

Adopt Board Resolution No. 21-1007-01, authorizing the Chairman of the CalOptima Board of Directors to execute Contract MS-21-22-41 with the California Department of Aging in order to continue operations of the CalOptima Multipurpose Senior Services Program (MSSP) for Fiscal Year 2021-22.

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 services as a cost-effective alternative to institutionalization of the frail elderly.

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 MSSP in various areas of the State.

As the operator of the MSSP site for Orange County, CalOptima improves the quality of care for our aging population by linking frail, elderly members 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 has successfully implemented the MSSP program over the past 20 years for up to a maximum of 455 members at any given point in time. Currently, CalOptima serves 455 members.

Discussion

CalOptima received CDA Contract MS-21-22-41 for execution by the Chairman of the CalOptima Board, which, upon the adoption of a Board resolution and execution of the contract will extend the MSSP through June 30, 2022, with the maximum amount of the contract set at $2,437,071.

The scope of work and other obligations are consistent with previous contract obligations. In addition to primarily wording and technical revisions, there are some proposed clarifications regarding the content of future audits and the responsibility of CalOptima MSSP in these audits. These responsibilities include cooperating with authorized representatives of federal or State government, and inserting contract language into contracts with independent audit firms to ensure audit documents are made

available to state and federal regulators if requested. There is also a language revision to indicate expenditures should be reconciled to the total budget allocation.

Staff does not anticipate that any of these changes will have a significant operational or financial impact as they are largely already in operation.

With the advent of the Coordinated Care Initiative (CCI) on July 1, 2015, the MSSP program now operates within CalOptima's Long-Term Services and Supports (LTSS) department, which will continue through 12/31/2021. The payment structure from DHCS for the MSSP program transitioned from fee-for-service with advance payments to a CCI payment model following CCI integration. Some of the attached contract language referring to non-CCI models may therefore not apply through 12/31/2021. Under the CCI payment model, DHCS provides CalOptima with Medi-Cal revenue for the MSSP program by accounting for MSSP members in the established capitation rate setting process. The payment structure from DHCS for the MSSP program will transition back to fee-for-service effective 1/1/2022 with the return of the MSSP to the 1915(c) Medicaid Waiver.

Fiscal Impact
The recommended action to adopt Board Resolution No. 21-1007-01, authorizing execution of Contract MS-21-22-41 for the MSSP program is a budgeted item and included in the CalOptima Fiscal Year 2021-22 Operating Budget approved by the Board on June 3, 2021.

Rationale for Recommendation
Adoption of Board Resolution No. 21-1007-01, authorizing the execution of the FY 2021-22 contract with the CDA for the MSSP program will allow CalOptima to continue to address the long-term community care needs of some of the frailest older adult CalOptima members by helping them to remain in their homes.

Concurrence
Gary Crockett, Chief Counsel

Attachment
1. Board Resolution No. 21-1007-01, Execute Contract No. MS-21-22-41 with the State of California Department of Aging for the Multipurpose Senior Services Program
2. CDA MSSP Contract FY 2021-22

_____ _____
Authorized Signature **Date**

RESOLUTION NO. 21-1007-01

RESOLUTION OF THE BOARD OF DIRECTORS
ORANGE COUNTY HEALTH AUTHORITY
Orange Prevention and Treatment Integrated Medical Assistance
d.b.a. CalOptima

EXECUTE CONTRACT NO. MS-21-22-41
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 ("CalOptima") continues to provide services as a Multipurpose Senior Service Program Site under contract with the California Department of Aging; and,

WHEREAS, the California Department of Aging notified CalOptima of its intent to contract for the assignment of 455 MSSP participant slots to CalOptima; and,

WHEREAS, the California Department of Aging has requested the execution of Contract MS-21-22-41, which covers the period of July 1, 2021, through June 30, 2022; and,

WHEREAS, the Board of Directors has determined that it is in the best interest of the ongoing development of CalOptima home and community-based services to the Medi-Cal beneficiaries residing in Orange County to approve CalOptima executing the Contract.

NOW, THEREFORE, BE IT RESOLVED:

I. That CalOptima is hereby authorized to enter into contract MS-21-22-41 with the State of California Department of Aging on the terms and conditions set forth in the form provided to this Board of Directors; and,

II. That the Chair of this Board of Directors is hereby authorized and directed to execute and deliver the Contract by and on behalf of CalOptima on the terms and conditions set forth in the form provided to this Board of Directors.

APPROVED AND ADOPTED by the Board of Directors of the Orange County Health Authority, d.b.a. CalOptima, this 7th day of October 2021.

AYES:

NOES:

ABSENT:

ABSTAIN:

/s/_____
Title: Chair, Board of Directors
Printed Name and Title: Andrew Do, M.D., Chair, Board of Directors

Attest:
/s/_____
Sharon Dwiers, Clerk of the Board

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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 / Andrew Do, M.D., Chair, Board of Directors
Contractor/Vendor Printed Name and Title

Contractor/Vendor Signature | Date

CDA Program/Project | MS-2022-41 Contract Number

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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 County Health Agency, DBA CalOptima	330599891

By (Authorized Signature)

Printed Name and Title of Person Signing

Andrew Do, M.D., 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
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):	Federal ID Number:
Orange Cty. Health Authority, DBA CalOptima	33059989 1
By (Authorized Signature):	
Printed Name and Title of Person Signing: Andrew Do, M.D.	
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)

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CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY): 3/26/2021

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 Woodruff-Sawyer & Co. 50 California Street, Floor 12 San Francisco CA 94111	CONTACT NAME: PHONE (A/C, No, Ext): 415-391-2141 FAX (A/C, No): 415-989-9923 E-MAIL ADDRESS:
INSURED CALOPTI-01 CalOptima 505 City Parkway West Orange CA 92868	INSURER(S) AFFORDING COVERAGE / NAIC # INSURER A : Indian Harbor Insurance Company 36940 INSURER B : Continental Insurance Company 35289 INSURER C : Valley Forge Insurance Company 20508 INSURER D : National Fire Insurance Company of Hartford 20478 INSURER E : INSURER F :

COVERAGES **CERTIFICATE NUMBER:** 1122880055 **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		6080046159	4/7/2021	4/7/2022	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 X OWNED AUTOS ONLY [ ] SCHEDULED AUTOS X HIRED AUTOS ONLY [ ] NON-OWNED AUTOS ONLY	Y		6080046131	4/7/2021	4/7/2022	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 $			6080046145	4/7/2021	4/7/2022	EACH OCCURRENCE AGGREGATE $	$ 25,000,000 $ 25,000,000 $
C D	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY Y / N ANYPROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? [ ] N / A (Mandatory in NH) If yes, describe under DESCRIPTION OF OPERATIONS below	N / A		6080046114 6080046128	4/7/2021 4/7/2021	4/7/2022 4/7/2022	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
A	E&O/Cyber Liability			MTP903849702	4/7/2021	4/7/2022	Per Claim/Aggregate: Retention:	$10,000,000 $500,000

DESCRIPTION OF OPERATIONS / LOCATIONS / VEHICLES (ACORD 101, Additional Remarks Schedule, may be attached if more space is required)

RE: MS -2122-41

CA Department of Aging, MSSP. is included as Additional Insured with respect to the General Liability and Auto Liability policies per services or operattions per MSSP contract with California Department of Aging per 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

Sue Eich

DESIGNATED INSURED FOR COVERED AUTOS LIABILITY COVERAGE

THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

This endorsement modifies insurance provided under the following:

AUTO DEALERS COVERAGE FORM

BUSINESS AUTO COVERAGE FORM

MOTOR CARRIER COVERAGE FORM

With respect to coverage provided by this endorsement, the provisions of the Coverage Form apply unless modified by this endorsement.

This endorsement identifies person(s) or organization(s) who are "**insureds**" for Covered Autos Liability Coverage under the Who Is An Insured provision of the Coverage Form. This endorsement does not alter coverage provided in the Coverage Form.

This endorsement changes the policy effective on the inception date of the policy unless another date is indicated below.

Named Insured: CALOPTIMA

Endorsement Effective Date: 04/07/2021

SCHEDULE
Name Of Person(s) Or Organization(s):
CA DEPARTMENT OF AGING 1300 NATIONAL DRIVE, SUITE 200 SACRAMENTO, CA 95834
Information required to complete this Schedule, if not shown above, will be shown in the Declarations.

Each person or organization shown in the Schedule is an "**insured**" for Covered Autos Liability Coverage, but only to the extent that person or organization qualifies as an "**insured**" under the Who Is An Insured provision contained in Paragraph **A.1.** of Section **II** - Covered Autos Liability Coverage in the Business Auto and Motor Carrier Coverage Forms and Paragraph **D.2.** of Section **I** - Covered Autos Coverages of the Auto Dealers Coverage Form.

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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Multipurpose Senior Services Program (MSSP)
Summary of CDA Standard Agreement Changes
Fiscal Year 2021-22

This document contains a summary of CDA Standard Agreement changes for Fiscal Year (FY) 2021-22. The FY 2021-22 MSSP CDA Standard Agreement contains the following Exhibits:

- Scope of Work – Exhibit A
- Budget Detail and Payment Provisions – Exhibit B
- Special Terms and Conditions – Exhibit D
- Additional Provisions - Exhibit E
- HIPAA Business Associate Addendum – Exhibit F
- Catchment Area Zip Codes – Exhibit G

Below is a quick reference to the Articles contained within each Exhibit for FY 2021-22 followed by a detailed summary of CDA Standard Agreement changes:

Exhibit A:

- Article I – STD 213
- Article II – Multipurpose Senior Services Program Overview
- Article III – MSSP Program Operations
- Article IV – Additional Provisions Specific to Contractors Operating Under the Coordinated Care Initiative (CCI) Payment Model
- Article V – Medi-Cal Aid Definition & Codes
- Article VI – Definitions of Services Provided Under the Waiver

Exhibit B:

- Article I – Invoicing and Payment
- Article II – Funds
- Article III – Budget and Budget Revision
- Article IV – Default Provisions
- Article V – Additional Provisions Specific to Contractors Operating Under the CCI Payment Model
- Attachment 1 – Site Specific Final Approved Budget

Exhibit D:

- Article I – Definitions and Resolutions of Language Conflicts
- Article II – Assurances

- Article III – Agreement
- Article IV – Commencement of Work
- Article V – Subcontracts
- Article VI – Records
- Article VII – Property
- Article VIII – Access
- Article IX – Monitoring and Evaluation
- Article X – Audit Requirements
- Article XI – Insurance
- Article XII – Termination
- Article XIII – Remedies
- Article XIV – Dissolution of Entity
- Article XV – Amendments, Revisions or Modifications
- Article XVI – Notices
- Article XVII – Department Contact
- Article XVIII – Information Integrity, and Security
- Article XIX – Copyrights and Rights in Data
- Article XX – Bilingual and Linguistic Program Services

Exhibit E:

- Article I – Subcontracting Provisions Specific to This MSSP Agreement
- Article II – Records Provisions Specific to This MSSP Agreement
- Article III – Property Provisions Specific to This MSSP Agreement
- Article IV – Audit Requirements Specific to This MSSP Agreement
- Article V – Termination Obligations Specific to This MSSP Agreement
- Article VI – Information Integrity and Security Provisions Specific to This MSSP Agreement
- Article VII – Transition Plans Specific to This MSSP Agreement
- Article VIII – Reporting Requirements Specific to This MSSP Agreement

Exhibit F:

- Section I – Recitals
- Section II – Definitions
- Section III – Terms of Agreement
- Section IV – Obligations of This Agreement
- Section V – Audits, Inspection and Enforcement
- Section VI – Termination
- Section VII – Miscellaneous Provisions

Exhibit G:

- Contains Zip Codes served by each individual MSSP Site

The following Articles and Sections in Exhibits have been relocated, revised, removed and/or updated with new language as outlined below:

Updated hyperlinks and minor spacing throughout all Exhibits.

CALIFORNIA DEPARTMENT OF AGING
Multipurpose Senior Services Program
1300 National Drive, Suite 200
Sacramento, CA 95834
www.aging.ca.gov
TEL 916-419-7552
FAX 916-928-2508
TTY1-800-735-2929

March 4, 2021

Ms. Evelyn Rounds, Site Director
Multipurpose Senior Services Program -41
CalOptima
505 City Parkway West
Orange, California 92868

Dear Ms. Rounds,

The California Department of Aging, Multipurpose Senior Services Program (MSSP) Branch has completed a review of your MSSP site budget for Fiscal Year (FY) 2021-2022. 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,

Katie Schmidt, Operations Manager
Multipurpose Senior Services Program Branch
California Department of Aging

Enclosure

cc: Susan Rodrigues, Chief
Multipurpose Senior Services Program Branch
California Department of Aging

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	455	Date Submitted to CDA-MSSP	26-Feb-21
	Fiscal Year 2021-22						
Line #	**A. Care Management**						
	Position Title	Last Name		Base Salary	Salary Adjustment	FTE	Adjusted Salary
1	MSW	Rivera		$71,860	0.000%	1.000	$71,860
2	MSW	Pratt		$72,842	0.000%	1.000	$72,842
3	BASW	Osorio		$71,477	0.000%	1.000	$71,477
4	RN	Nguyen V.		$113,644	0.000%	1.000	$113,644
5	BSW	Nguyen Se.		$62,806	0.000%	1.000	$62,806
6	RN	Nguyen Sa.		$95,482	0.000%	1.000	$95,482
7	MSW	Nguyen F.		$61,083	0.000%	1.000	$61,083
8	BSW	Hoang R.		$69,141	0.000%	1.000	$69,141
9	RN	Flinn		$115,836	0.000%	1.000	$115,836
10	MSW	Fierro		$75,156	0.000%	1.000	$75,156
11	MSW	Dinh		$71,926	0.000%	1.000	$71,926
12	RN	Baylis		$117,341	0.000%	1.000	$117,341
13				$0	0.000%	0.000	$0
14				$0	0.000%	0.000	$0
15				$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	$998,595
27	Total Care Management (CM) FTE		12.00			Care Management Benefits	$284,599
28	Ratio		37.9				
29	**Total Care Management**				% Budget	53%	$1,283,194
	B. Care Management Support/Administration						
Line #	*Salaries*						
	Position Title	Last Name		Base Salary	Salary Adjustment	FTE	Adjusted Salary
30	Clerk Supp	Castaneda		$49,489	0.000%	1.000	$49,489
31	Clerk Supp	Diaz De Leon		$47,520	0.000%	1.000	$47,520
32	Clerk Supp	Esparza		$50,048	0.000%	1.000	$50,048
33	Fiscal Officer	Hoang A.		$72,141	0.000%	0.750	$54,106
34	Supervisor-MSW	Rakowski		$84,218	0.000%	1.000	$84,218
35	Site Director	Rounds		$136,585	0.000%	1.000	$136,585
36	Supervisor-LCSW	Young (Bitterman)		$88,725	0.000%	1.000	$88,725
37				$0	0.000%	0.000	$0
38				$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	$510,690
49						CMS/Administration Benefits	$145,547
50	Total CMS/Administration FTE		6.75				
51						Total CMS/Administration Salaries	$656,237
	Operating Costs						
52	Consultation, Professional Services						$58,600
53	Facility, Rent & Operations						$0
54	Equipment Cost equal to or greater than $5,000 per Unit						$0
55	Equipment, Maintenance & Rental Costs; Supplies						$34,000
56	Travel (In & Out of State)						$9,421
57	Training without Associated Travel Costs						$2,000
58	Subscriptions, Membership Dues						$4,800
59	Insurance						$0
60	Communications, Postage, Internet						$20,000
61	Other Expenses, Purchased Services						$1,500
62							$0
63	Indirect Costs (Indirect Costs/Base) - 15% maximum					3%	$50,500
64	Base = Salaries & Benefits					$1,939,431	
65							$0
66							$0
67						Total CMS/Administration Operating Costs	$180,821
68	**Total CMS/Admin**				% Budget	34%	$837,058
	C. Waived Services						
69	**Total Waived Services**				% Budget	13%	$316,819
	D. Total Budget Amounts						
70	**Fiscal Year Total Allocation**						$2,437,071

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	MSSP Site Director	8/20/21	
Evelyn Rounds, LCSW	Site Director	February 25, 2021	☑

For CDA Use Only.	Approved by:	
	Jeffery Mercer	3/3/2021
	Analyst Signature	Date

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MSSP Employees FY 2021 - 2022
07/01/2021 - 06/30/2022

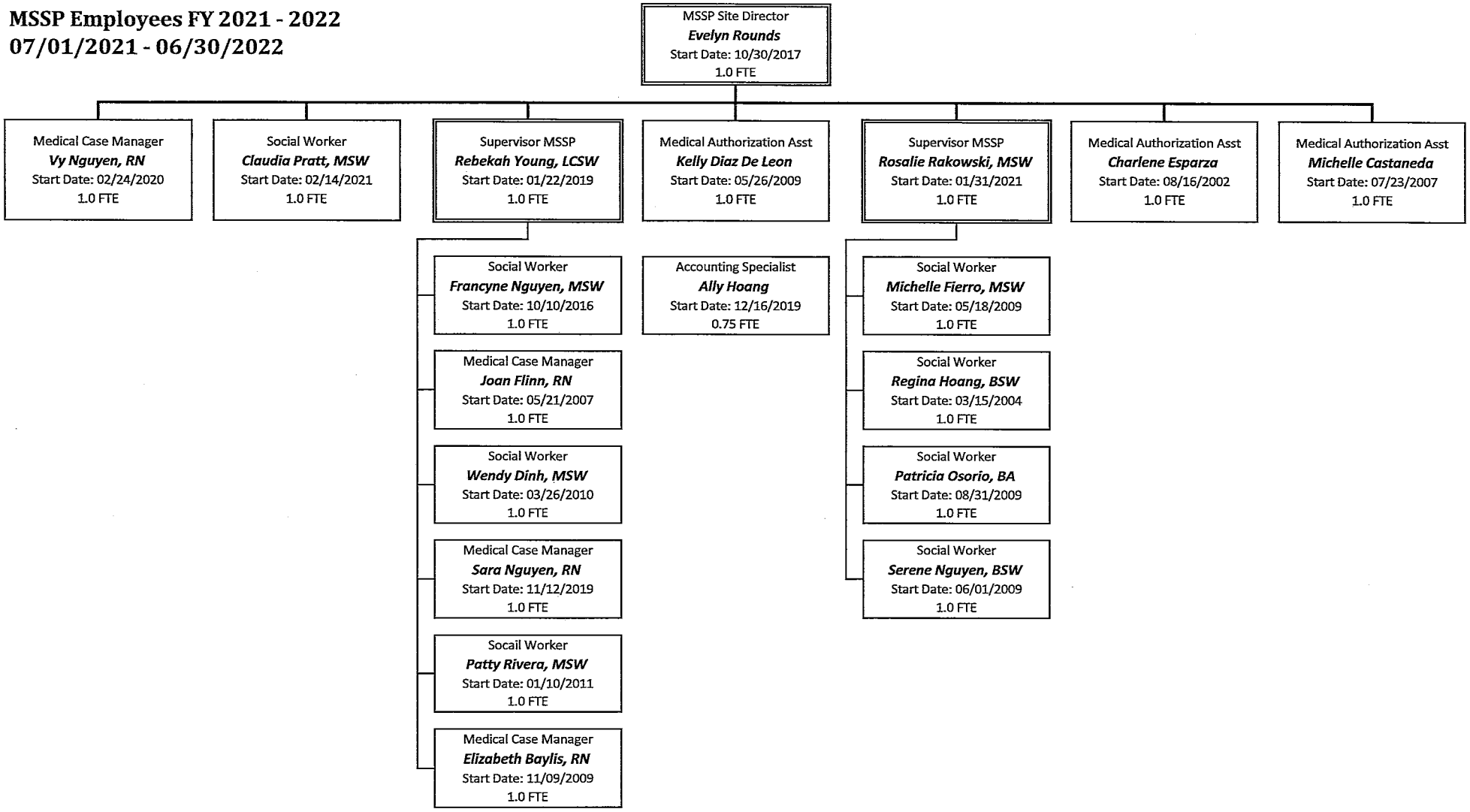

EXHIBIT A, Attachment 1
General Information

SCOPE OF WORK – GENERAL INFORMATION

1. The Contractor agrees to provide to the California Department of Aging (CDA) the services described herein Agreement number MS-2122-41. The number of client months under this Agreement is 5,460.

2. The services shall be performed in the catchment area zip codes listed in Exhibit G.

3. The services shall be provided as needed.

4. 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, Site Director
Phone:	(916) 419-7561	Phone:	(714) 246-8773
Fax:	(916) 928-2508	Fax:	(714) 481-6536
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:	Business Services and Contracts	Phone:	(714) 246-8773Multipurpose Senior Services Program
Attention:	Grace Parker	Attention:	Evelyn Rounds
Address:	1300 National Drive, Ste 200 Sacramento, CA 95834	Address:	505 City Parkway West Orange, CA 92868
Phone:	(916) 931-1929	Phone:	(714) 246-8773
Fax:	(916) 928-2500	Fax:	(714) 481-6536
Email:	BMBContractAnalyst@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.

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ARTICLE II. MULTIPURPOSE SENIOR SERVICES PROGRAM (MSSP) OVERVIEW

The MSSP is a Medi-Cal Home and Community Based Services Waiver, Control Number CA.0141.R06.00 authorized pursuant to Section 1915(c) of Title XIX of the Social Security Act (HCBS Waiver). 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-five (65) or older; meet the eligibility criteria as a Medi-Cal recipient with an eligible Medi-Cal Aid Code for MSSP as described in the MSSP Medi-Cal Aid Codes, Article V of this Exhibit; 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 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 and a PLAN(S) (see definition in Article VI of this Exhibit).

ARTICLE III. MSSP PROGRAM OPERATIONS

The Contractor shall be responsible for all care management obligations including processing Waiver Participant applications, determining 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 III. MSSP PROGRAM OPERATIONS (Continued)

the Waiver. The care management team shall determine Waiver Participant eligibility based on the criteria specified in the MSSP Site Manual. 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, PLAN(S), and others to develop a care plan covering the full range of required psycho-social 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 or the PLAN(S).

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 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 III. 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, 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. Client Enrollment/Termination Information

4. Level of Care Certification "Level of Care" (LOC) means a clinical certification by the Contractor that a MSSP Applicant or MSSP Waiver Participant meets the requirement(s) for a nursing facility placement.

5. MSSP Initial Health Assessment, MSSP Initial Psychosocial Assessment, and MSSP Reassessments

ARTICLE III. 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, level of care, 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 end-of-month Waiver Participant count for the preceding month. The end-of-month Waiver Participant count consists of the number of Waiver 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.

ARTICLE III. MSSP PROGRAM OPERATIONS (Continued)

6. 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).

7. 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 or more than 105 percent of the specified number of client months included in the Scope of Work, Exhibit A, Section 1. 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 Waiver 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.

"Active Waiver Participant count" is the total number of Waiver Participants served during each month. This will be the number of Waiver Participants enrolled in the MSSP as of the first of the month, plus the number enrolled during the month.

"Waiver 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.

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.

ARTICLE III. MSSP PROGRAM OPERATIONS (Continued)

4. The Contractor shall develop an emergency preparedness training plan to be provided to all staff at least annually or 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 his/her appeal rights.

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.

5. The Contractor shall abide by the MSSP Site Manual, training manuals, and other guidance issued by the CDA MSSP Branch. The Contractor

ARTICLE III. MSSP PROGRAM OPERATIONS (Continued)

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 IV. ADDITIONAL PROVISIONS SPECIFIC TO CONTRACTORS OPERATING UNDER THE COORDINATED CARE INITIATIVE (CCI) PAYMENT MODEL

A. Definitions specific to the CCI model:

1. "Coordinated Care Initiative" (CCI) means Coordinated Care Initiative enacted in California in July 2012 through SB 1036 and SB 1008.

2. "Member" means any person who is enrolled with the PLAN(S) and receives benefits from the PLAN(S).

3. "PLAN(S)" is an independent organization contracted directly with the DHCS to implement the CCI. PLAN(S) contract with MSSP providers to provide Medi-Cal covered benefits to Medi-Cal beneficiaries who are enrolled with the PLAN(S).

4. "Encounter" means any authorized service consistent with any of the three (3) MSSP service categories (Care Management, Care Management Support, or Purchased Waiver Services) provided to or purchased by the Contractor for an enrolled PLAN(S) Member during a given month. Each MSSP Waiver Participant incurs one encounter per month for Care Management and Care Management Support. However, each MSSP Waiver Participant may incur more than one purchased Waiver Service encounter because each unit of purchased Waiver Service is counted as a separate encounter.

5. "MSSP Applicant" means a Member who has submitted an application to the Contractor to receive MSSP Waiver Services.

6. "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 determine 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. The wait list report is due on the 5th working day of each month, unless otherwise specified by CDA.

ARTICLE IV. ADDITIONAL PROVISIONS SPECIFIC TO CONTRACTORS OPERATING UNDER THE COORDINATED CARE INITIATIVE (CCI) PAYMENT MODEL (Continued)

7. "Eligibility Determination" means a process by which the Contractor determines whether a MSSP Applicant or MSSP Waiver Participant meets eligibility criteria to participate in the MSSP and receive MSSP Waiver Services.

B. Management Information Systems (MIS)

The Contractor shall maintain and operate an MIS at its site for submission of encounter data to PLAN(S), consistent with Exhibit A, Article IV., Section I, Encounter Data Submission.

C. Notice Requirements

The Contractor shall be responsible for providing written notice to PLAN(S) as follows:

1. Within five (5) business days after the following occurrences:

   a) Disenrollment of a MSSP Waiver Participant from MSSP due to death, relocation, or voluntary disenrollment.
   b) Enrollment in the MSSP Waiver of a PLAN Member who was not referred by PLAN(S).
   c) Referral of a PLAN(S) Member to MSSP by non-PLAN(S) sources.
   d) Determination by the Contractor that an MSSP Applicant referred by the PLAN(S) is ineligible for enrollment in MSSP.
   e) Placing PLAN(S) Member on a wait list.
   f) Enrollment of a PLAN(S) Member MSSP Applicant from the wait list to MSSP.
   g) Change of the Contractor ownership or legal name.
   h) Transition of MSSP Waiver Participants to another Contractor and location.
   i) Denial or discontinuation of services.

2. Within thirty-five (35) days of relocation of a MSSP site.

3. Within one hundred and eighty (180) days prior written notice to PLAN(S) of termination of the Contractor's agreement with PLAN(S).

4. Within thirty (30) days written notice to State of California prior to termination of the Contractor's Agreement with PLAN(S).

ARTICLE IV. ADDITIONAL PROVISIONS SPECIFIC TO CONTRACTORS OPERATING UNDER THE COORDINATED CARE INITIATIVE (CCI) PAYMENT MODEL (Continued)

D. Transition Plan

In the event of termination of this Agreement, the Contractor shall work collaboratively with PLAN(S) to develop a plan to ensure safe transition of Waiver Participants out of MSSP.

E. Enrollment Verification

The Contractor shall verify monthly whether the MSSP Waiver Participant remains eligible for Medi-Cal and in which managed care PLAN(S) the MSSP Waiver Participant is enrolled. The Contractor shall verify PLAN(S) enrollment using the Medi-Cal Eligibility Determination System (MEDS) and/or directly with PLAN(S). This verification should occur prior to submitting monthly claims to PLAN(S) as outlined in Exhibit B, Article V., Section A.

1. Unencrypted Member electronic Protected Health Information (ePHI) sent to entities outside of the contracted PLAN(S) using internet-based services must be secured using virtual private networks (VPN), secure socket layer (SSL), transmission layer security (TLS), secure file transport protocol (SFTP), or other method that can encrypt communications over the public internet; and

2. Removable storage devices used to store ePHI must be encrypted before being sent to entities outside of PLAN(S).

F. Orientation

The Contractor shall provide orientation of MSSP to designated staff of PLAN(S).

G. Referrals

The Contractor shall establish a mechanism to receive referral of Members who are enrolled in the Medi-Cal PLAN(S) for Managed Long-Term Services and Support and are potentially eligible for the MSSP Program.

H. Care Coordination

The Contractor shall coordinate and work collaboratively with PLAN(S) on care coordination activities surrounding the MSSP Waiver Participant including, but not limited to, coordination of benefits between PLAN(S) and the Contractor to avoid duplication of services and coordinate Care Management activities particularly at the point of discharge from the MSSP.

ARTICLE IV. ADDITIONAL PROVISIONS SPECIFIC TO CONTRACTORS OPERATING UNDER THE COORDINATED CARE INITIATIVE (CCI) PAYMENT MODEL (Continued)

I. Encounter Data Submission

1. The Contractor shall submit monthly to CA-MMIS and PLAN(S) zero-cost electronic encounter data for all MSSP Waiver Services rendered to MSSP Waiver Participants.

2. The Contractor shall submit all encounter data within three (3) months from the end of the month that service was provided.

ARTICLE V. MEDI-CAL AID DEFINITION & CODES

Contractors are to use the following codes to verify Waiver Participant eligibility. Multipurpose Senior Services Program Waiver Participants qualify under the following Medi-Cal Aid codes:

1. CASH GRANT

AID CODE		PROGRAM DEFINITION
10	AGED	SSI/SSP Aid to the Aged – Cash assistance program administered by the Social Security Administration, pays a cash grant to needy persons age sixty-five (65) or older.
20	BLIND	SSI/SSP Aid to the Blind – Cash assistance program administered by the Social Security Administration, pays a cash grant to needy blind persons of any age.
60	DISABLED	SSI/SSP Aid to the Disabled – Cash assistance program administered by the Social Security Administration, pays a cash grant to needy persons who meet the federal definition of disability.

2. PICKLE ELIGIBLES/20 PERCENT SOCIAL SECURITY DISREGARDS

AID CODE		PROGRAM DEFINITION
**16	AGED	Aid to the Aged-Pickle Eligibles – Persons age sixty- five (65) or older who were eligible for and receiving SSI/SSP and Title II Benefits concurrently in any month since April 1977 and were subsequently discontinued from SSI/SSP but would be eligible to receive SSI/SSP if their Title II cost-of-living increases were disregarded. These persons are eligible for Medi-Cal benefits as public assistance recipients in accordance with the provisions of the Lynch v. Rank lawsuit.

ARTICLE V. MEDI-CAL AID DEFINITION & CODES (Continued)

**26	BLIND	Aid to the Blind-Pickle Eligibles – Persons who meet the federal criteria for blindness and are covered by the provision of the Lynch v. Rank lawsuit. See Aid Code 16 for definition of Pickle Eligibles.
**66	DISABLED	Aid to the Disabled-Pickle Eligibles – Persons who meet the federal definition of disability and are covered by the provision of the Lynch v. Rank lawsuit. See Aid Code 16 for definition of Pickle Eligibles.

**NOTE: This also includes persons who were discontinued from cash grant status due to the twenty percent (20%) Social Security increase under Public Law 32-336. These persons are eligible for Medi-Cal benefits as public assistance recipients in accordance with 22 CCR 50247.

3. MEDICALLY NEEDY/NO SHARE OF COST

AID CODE		PROGRAM DEFINITION
14	AGED-MN	Aid to the Aged-Medically Needy – Persons age sixty-five (65) or older who do not wish or are not eligible for a cash grant but are eligible for Medi-Cal only. No share of cost required of the beneficiaries.
24	BLIND-MN	Aid to the Blind-Medically Needy – Persons who meet the federal definition of disability and do not wish or are not eligible for a cash grant, but are eligible for Medi-Cal only. No share of cost required of the beneficiaries.
64	DISABLED MN	Aid to the Disabled-Medically Needy – Persons who meet the federal definition of disability and do not wish or are not eligible for a cash grant, but are eligible for Medi-Cal only. No Share of cost required of the beneficiaries.

4. MEDICALLY NEEDY/SHARE OF COST

AID CODE		PROGRAM DEFINITION
***17	AGED-MN SOC	Aid to the Aged-Medically Needy, Share of Cost – See Aid Code 14 for definition of AGED-MN. Share of cost is required of the beneficiaries.
***27	BLIND-MN	Aid to the Blind-Medically Needy, Share of Cost – SOC See Aid Code 24 for definition of BLIND-MN. Share of cost is required of the beneficiaries.
***67	DISABLED MN-SOC	Aid to the Disabled-Medically Needy, Share of Cost – See Aid Code 64 for definition of Disabled-MN. Share of cost is required of the beneficiaries.

ARTICLE V. MEDI-CAL AID DEFINITION & CODES (Continued)

***NOTE: As a result of the implementation of the In-Home Supportive Services (IHSS) Plus Waiver, the special program codes of 1F, 2F, and 6F that were paired with the 17, 27, and 67 aid codes are no longer valid Medi- Cal aid codes as of November 1, 2005. MSSP sites are only required to serve Waiver Participants with the aid codes of 17, 27, or 67 who were active as of November 1, 2005 or were subsequently re-determined into aid codes 17, 27, or 67.

5. AGED AND DISABLED FEDERAL POVERTY LEVEL PROGRAM

AID CODE		PROGRAM DEFINITION
1H	AGED	Aged persons who, due to their income levels, would normally be included in the Medi-Cal Share of Cost population (Aid Code 17). Under this new program, those recipients with a Share of Cost of $1 to $326 will be given full scope, no Share of Cost Medi-Cal.
6H	DISABLED	Disabled persons who, due to their income levels, would normally be included in the Medi-Cal Share of Cost population (Aid Code 17). Under this program, those recipients with a Share of Cost of $1 to $326 will be given full scope, no Share of Cost Medi-Cal.

6. INSTITUTIONAL DEEMING

AID CODE		PROGRAM DEFINITION
1X	NO SOC	MSSP Medi-Cal Qualified. Eligible due to application of spousal impoverishment rules.
1Y	SOC	MSSP Medi-Cal Qualified. Eligible due to application of spousal impoverishment rules. Share of cost is required of the beneficiaries. These recipients are identified apart from the regular Medi-Cal SOC population by the Special Program Aid Code of 1F.

7. CONTINUED ELIGIBILITY – REDETERMINATION

AID CODE		PROGRAM DEFINITION
1E	AGED	Continued eligibility for the Aged - Former SSI beneficiaries who are aged until the county redetermines their eligibility.
2E	BLIND	Continued eligibility for the Blind - Former SSI beneficiaries who are blind until the county redetermines their eligibility.
6E	DISABLED	Continued eligibility for the Disabled - Discontinued SSI beneficiaries who are disabled until the county redetermines their eligibility.

ARTICLE VI. 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 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. 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.

2. **Minor Home Repairs and Maintenance** (2.2): Minor Home Repairs do not involve major structural changes or 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. **Non-medical Home Equipment** (2.3): Includes those 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; 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

ARTICLE VI. DEFINITIONS OF SERVICES PROVIDED UNDER THE WAIVER (Continued)

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)

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- Moving Services** (2.4): This service involves facilitating a smooth transition from a facility/institution or care provider-owned residence. Eligible Waiver Participants are those who reside in a facility/institution or care provider-owned residence and require assistance with relocation from a facility/institution to their own home or apartment in the community, or to/from a care provider owned residence. Services may be provided by moving companies or other individuals who can guarantee the safe transfer of the Waiver Participant's possessions. Activities may include materials and labor necessary for such moves.

Community Transition Services- Housing & Utility Set-up (2.5): Allows for one-time set-up expenses for eligible Waiver Participants who make the transition from an institution to their own home or apartment in the community. Community Transitions Services are non-recurring set-up expenses for Waiver Participants who are transitioning from an institutional or another provider-operated living arrangement to a living arrangement in a private residence 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) activities to assess need, arrange for and procure need resources. 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

ARTICLE VI. DEFINITIONS OF SERVICES PROVIDED UNDER THE WAIVER (Continued)

technology device. 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; (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. (E) the costs associated with delivery and repairs of the items allowable under this service are also included.

6. **Supplemental Homemaker Services** (3.1): Is 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.

   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.

   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.

7. **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 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; 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 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.

ARTICLE VI. DEFINITIONS OF SERVICES PROVIDED UNDER THE WAIVER (Continued)

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.

8. **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 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. The unit of service can be an hour, day, or visit.

9. **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 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.

10. **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. Additionally, care managers initiate and oversee the process of assessment and reassessment of Waiver Participant level of care and the monthly review of plans of care.

    a) **Site-Provided 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 VI. DEFINITIONS OF SERVICES PROVIDED UNDER THE WAIVER (Continued)

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 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

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 the decision is made to cease MSSP activity. Federal Financial Participation (FFP) is not claimed for DCM services where the participant does not transition into the Waiver, but is billed to Medi-Cal as an administrative cost. No care management services available under the State Plan will be duplicated under the MSSP Waiver.

11. **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).
- 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 consultation
- Legal and paralegal professionals' consultation
- Dietitian/Nutrition consultation
- Pharmacy consultation

ARTICLE VI. DEFINITIONS OF SERVICES PROVIDED UNDER THE WAIVER (Continued)

- Vital sign monitoring

12. **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) 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.

13. **Transportation** (6.3 [escort, hour] and 6.4 [one-way trip]): 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 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 the elderly and handicapped (e.g., in California, some counties provide reduced fare vouchers for trips made via private taxicabs for the elderly and handicapped).

    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

ARTICLE VI. DEFINITIONS OF SERVICES PROVIDED UNDER THE WAIVER (Continued)

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.

14. **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).

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.

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 (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.
- 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.

ARTICLE VI. DEFINITIONS OF SERVICES PROVIDED UNDER THE WAIVER (Continued)

15. **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.

    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. 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.

    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.

ARTICLE VI. DEFINITIONS OF SERVICES PROVIDED UNDER THE WAIVER (Continued)

16. 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:

        (i) 24-hour answering/paging
        (ii) Medic-alert type bracelets/pendants
        (iii) Intercoms
        (iv) Emergency Response System
        (v) Room monitors
        (vi) Light fixture adaptations (blinking lights, etc.)
        (vii) 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

ARTICLE VI. DEFINITIONS OF SERVICES PROVIDED UNDER THE WAIVER (Continued)

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 I. INVOICING AND PAYMENT

A. To receive payment under the fee-for-service payment model, the Contractor shall prepare and submit electronic claims through the State's Fiscal Intermediary 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 Fiscal Intermediary, 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 waiver slot budget for the year.

E. Rate Adjustment

Any rate adjustments must be approved by CDA.

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 fee-for-service 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.

2. No advance payments shall be authorized for a contractor that has entered into the CCI payment model with a PLAN(S).

ARTICLE I. INVOICING AND PAYMENT (Continued)

3. 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.

4. 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.

5. 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.

6. Repayment of advances will be recovered from claims submitted to the State's Fiscal Intermediary 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.

7. Repayment of any remaining advances funds not collected through the process described in subsection 6 above, will be recovered through the Closeout 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.

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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.

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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.

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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 deleted 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 XIII., A

   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 category expenses only as itemized in the most recent approved or revised Budget.

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.

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.

3. Consultation, Professional Services-Contractual Costs, subcontract and consultant cost detail.

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ARTICLE III. BUDGET AND BUDGET REVISION (CONTINUED)

4. Facility, Rent & Operations – specify square footage and rate.

5. Equipment - detailed descriptions and unit costs.

6. Travel (Include: In State and Out of State) – mileage reimbursement rate, lodging, per diem and other costs.

7. 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 must 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 percent (5%) of the approved or revised total budget or $10,000, whichever is less. The Contractor must obtain prior written approval from CDA to transfer any funds into or out of the Purchased Waiver Service category.

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:

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ARTICLE IV. DEFAULT PROVISIONS (CONTINUED)

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 V. ADDITIONAL PROVISIONS SPECIFIC TO CONTRACTORS OPERATING UNDER THE CCI PAYMENT MODEL

A. Submission of Claim to PLAN(S)

The Contractor shall submit a monthly claim to the PLAN(S) as specified in the MSSP site contract with the Managed Care Plan. The monthly claim shall be for each PLAN Member enrolled in the MSSP as of the first day of the month for which the claim is submitted. The claim shall include at a minimum the following data elements: Member name, Client Identification Number (CIN), and Contractor number.

B. Payment of Claims

1. The Contractor will receive a fixed monthly amount for each PLAN(S) Member receiving MSSP Waiver Services. Such MSSP amount shall be equal to $ 446.35 per MSSP Waiver slot allotment in the MSSP Waiver.

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ARTICLE V. ADDITIONAL PROVISIONS SPECIFIC TO CONTRACTORS OPERATING UNDER THE CCI PAYMENT MODEL (continued)

2. The Contractor shall accept PLAN(S) monthly payment as payment in full and final satisfaction of PLAN(S) monthly payment obligation for MSSP Waiver Services for each MSSP Waiver Participant enrolled in PLAN(S).

3. The Contractor shall not submit separate claims to different PLAN(S) for the same MSSP Waiver Participant within the same invoice period.

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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.

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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 200.4)

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 200.31)

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 state and federal share of the questioned cost.

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

The terms and conditions of this Agreement have the following order of precedence, if there is any conflict in what they require:

1. Section 1915(c) of Title XIX of the Social Security Act, 42 USC 1396n, and other applicable federal statutes and their implementing regulations.

2. The Interagency Agreement Terms and Conditions.

ARTICLE I. DEFINITIONS AND RESOLUTIONS OF LANGUAGE CONFLICTS (Continued)

3. As applicable, Welfare and Institutions Code Sections 9560 to 9568 and other California State codes and regulations governing the MSSP.

4. Standard Agreement (Std. 213), all Exhibits and any amendments thereto.

5. Any other documents incorporated herein by reference including, but not limited to, the MSSP Site Manual.

6. 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

This section applies only to Title III funds and not to other funds allocated to other Titles under the OAA. Title III funds may be used for 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 Subcontractor/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, 1300 National Drive, Suite 200, Sacramento, California 95834.

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 at risk as a mere volunteer 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 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 Subcontractor's 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 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, and a summary worksheet identifying the results of performing an audit resolution of its subcontractors in accordance with Article X of this Exhibit. 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

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ARTICLE VI. RECORDS (Continued)

hereunder in a form satisfactory to CDA. All records pertaining to this Agreement must be made available for inspection and audit by 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 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. 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.

1. Property includes land, buildings, improvements, machinery, vehicles, furniture, tools, and intangibles, etc.

ARTICLE VII. PROPERTY (Continued)

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 or other tag identifying it as State of California property.
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 federal or State representatives to any books, documents, papers, and records of the Contractor or subcontractor which are directly pertinent to this specific

ARTICLE VIII. ACCESS (Continued)

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 allocable, including, but not limited to books, documents, papers, and records. Contractor shall agree to make such information available to the federal government, the State, or any of their duly authorized

ARTICLE X. AUDIT REQUIREMENTS (Continued)

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 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 200.16)

   b. Internal controls (2 CFR 200.303)

   c. Allocation of expenditures (2 CFR 200.4)

   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

   a. Contractors that expend $750,000 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

ARTICLE X. AUDIT REQUIREMENTS (Continued)

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 Branch
1300 National Drive, Suite 200
Sacramento, California 95834

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

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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 the Subcontractor. Further, the Subcontractor 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 $750,000 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]

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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 adequate insurance coverage for general liability, Worker's Compensation liabilities, and if appropriate, auto liability including non-owned auto and professional liability, and 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 for the terminated portion of the Agreement, the remainder of 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. In case of threat of life, health, or safety of the public, termination of the Agreement shall be effective immediately.

2. A violation of the law or failure to comply with any condition of this Agreement.

3. Inadequate performance or failure to make progress so as to endanger performance of this Agreement.

4. Failure to comply with reporting requirements.

5. 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.

6. Delinquency in payment of taxes or payment of costs for performance of this Agreement in the ordinary course of business.

ARTICLE XII. TERMINATION (Continued)

7. 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.

8. Service of any writ of attachment, levy of execution, or commencement of garnishment proceedings against the Contractor's assets or income.

9. The commission of an act of bankruptcy.

10. Finding of debarment or suspension. [Article II J]

11. The Contractor's organizational structure has materially changed.

12. 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.

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).

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 and Termination without Cause is ninety (90) days subsequent to written notice to the Contractor. The notice shall describe the action being taken by CDA, the reason

ARTICLE XII. TERMINATION (Continued)

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 terminate 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 effected 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 Branch 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 Branch 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 Branch, 1300 National Drive, Suite 200, Sacramento, California, 95834. 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.

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 Branch (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

ARTICLE XVII. DEPARTMENT CONTACT (Continued)

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 storage media (including but not limited to, discs, thumb/flash drives, portable hard drives, and backup media).

ARTICLE XVIII. INFORMATION INTEGRITY, AND SECURITY (Continued)

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 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.

ARTICLE XVIII. INFORMATION INTEGRITY, AND SECURITY (Continued)

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 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

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.

ARTICLE XVIII. INFORMATION INTEGRITY, AND SECURITY (Continued)

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 Participant information authorized by the participant or summary program information which is not Waiver Participant specific.

ARTICLE XIX. COPYRIGHTS AND RIGHTS IN DATA (Continued)

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.

2. The Contractor shall prepare and make available a report of the findings of the group-needs assessment that summarizes:

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ARTICLE XX. BILINGUAL AND LINGUISTIC PROGRAM SERVICES (Continued)

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]

ARTICLE XX. BILINGUAL AND LINGUISTIC PROGRAM SERVICES (Continued)

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]

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ARTICLE I. SUBCONTRACTING PROVISIONS SPECIFIC TO THIS MSSP AGREEMENT

A. The Contractor shall ensure that all subcontractors of Waiver Services complete a CDA-approved Vendor Application.

B. The 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, in subcontractors operations.

E. The Contractor shall require all subcontracts 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. 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 principle 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.

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ARTICLE IV. AUDIT REQUIREMENT PROVISIONS SPECIFIC TO THIS MSSP AGREEMENT (Continued)

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 Audit 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 the California Department of Aging's (CDA) 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.

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ARTICLE V. TERMINATION OBLIGATIONS SPECIFIC TO THIS MSSP AGREEMENT (Continued)

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, the HITECH Act, the HIPAA regulations, and the Final Omnibus Rule, including the requirement to implement reasonable and appropriate administrative, physical, and technical safeguards to protect PHI and PI.

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ARTICLE VI. INFORMATION INTEGRITY AND SECURITY PROVISIONS SPECIFIC TO THIS MSSP AGREEMENT (Continued)

B. Contractor, and its Subcontractors/Vendors, agrees that any security incidents or breaches of unsecured PHI or PI will be immediately reported 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.

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.

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ARTICLE VII. TRANSITION PLANS SPECIFIC TO THIS MSSP AGREEMENT (Continued)

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 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 written reports, on a format prescribed by the State, to 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

- 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

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ARTICLE VIII. REPORTING REQUIREMENTS SPECIFIC TO THIS MSSP AGREEMENT (Continued)

- 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
- 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
d. Availability of care
e. Waiver Participant satisfaction
f. MIS operations
g. Administrative procedures
h. Database
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

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ARTICLE VIII. REPORTING REQUIREMENTS SPECIFIC TO THIS MSSP AGREEMENT (Continued)

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.

C. Additional Reporting Provisions Specific to Contractors Operating Under the Coordinated Care Initiative (CCI) Model

1. The Contractor shall submit written reports, on a format prescribed by the State, to the State, as follows:

   a. Payment Detail from PLAN(S) as requested.

   b. Upon request, Contractor agrees to furnish PLAN(S) with the following:

      i. Monthly Active Waiver Participant Count
      ii. MSSP Encounter Data
      iii. MSSP Quarterly Report

2. Contractor shall submit monthly zero-cost electronic Encounter Data to CA-MMIS and PLAN(s).

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Exhibit F
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 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. 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, and the person notifies the Business Associate of any instances of which it is aware that the confidentiality of the information has been breached.

8. Compliance with Other Applicable Law

8.1 To the extent that other state and/or federal laws provide additional, stricter and/or more protective (collectively, more protective) privacy and/or security protections to PHI or other confidential information covered under this Agreement beyond those provided through HIPAA, Business Associate agrees:

8.1.1 To comply with the more protective of the privacy and security standards set forth in applicable state or federal laws to the extent such standards provide a greater degree of protection and security than HIPAA or are otherwise more favorable to the individuals whose information is concerned; and

8.1.2 To treat any violation of such additional and/or more protective standards as a breach or security incident, as appropriate, pursuant to Section 18. of this Agreement.

8.2 Examples of laws that provide additional and/or stricter privacy protections to certain types of PHI and/or confidential information, as defined in Section 4. of this Agreement, include, but are not limited to the Information Practices Act, California Civil Code sections 1798-1798.78, Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2, 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 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.

9.2 Safeguards and Security.

9.2.1 Business Associate shall use safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of PHI and other confidential data and comply, where applicable, with subpart C of 45 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.

9.2.2 Business Associate shall, at a minimum, utilize an industry-recognized security framework when selecting and implementing its security controls, and shall maintain continuous compliance with its selected framework as it may be updated from time to

time. Examples of industry-recognized security frameworks include but are not limited to

9.2.2.1 NIST SP 800-53 – National Institute of Standards and Technology Special Publication 800-53

9.2.2.2 FedRAMP – Federal Risk and Authorization Management Program

9.2.2.3 PCI – PCI Security Standards Council

9.2.2.4 ISO/ESC 27002 – International Organization for Standardization / International Electrotechnical Commission standard 27002

9.2.2.5 IRS PUB 1075 – Internal Revenue Service Publication 1075

9.2.2.6 HITRUST CSF – HITRUST Common Security Framework

9.2.3 Business Associate shall employ FIPS 140-2 compliant encryption of PHI at rest and in motion unless Business Associate determines it is not reasonable and appropriate to do so based upon a risk assessment, and equivalent alternative measures are in place and documented as such. In addition, Business Associate shall maintain, at a minimum, the most current industry standards for transmission and storage of PHI and other confidential information.

9.2.4 Business Associate shall apply security patches and upgrades, and keep virus software up-to-date, on all systems on which PHI and other confidential information may be used.

9.2.5 Business Associate shall ensure that all members of its workforce with access to PHI and/or other confidential information sign a confidentiality statement prior to access to such data. The statement must be renewed annually.

9.2.6 Business Associate shall identify the security official who is responsible for the development and implementation of the policies and procedures required by 45 CFR Part 164, Subpart C.

9.3 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. **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 shall 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 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.

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 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.

18. **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:

    18.1 Notice to DHCS.

    18.1.1 Business Associate shall 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 shall provide notice by telephone to DHCS.

    18.1.2 Business Associate shall notify DHCS **within 24 hours by email** (or by telephone if Business Associate is unable to email DHCS) of the discovery of:

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 data affecting this Agreement.

18.1.3 Notice shall 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 shall 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 shall include all information known at the time the incident is reported. The form is available online at http://www.dhcs.ca.gov/formsandpubs/laws/priv/Pages/DHCSBusinessAssociatesOnly.aspx.

Upon discovery of a breach or suspected security incident, intrusion or unauthorized access, use or disclosure of PHI, Business Associate shall 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 shall immediately investigate such security incident or confidential 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" must include any applicable additional information not included in the Initial Form. The Final PIR Form 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 information in addition to that requested through the PIR form, Business Associate shall 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 shall 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, 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.

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 subcontractors, 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 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: Office of HIPAA Compliance Department of Health Care Services P.O. Box 997413, MS 4722 Sacramento, CA 95899-7413 Email: incidents@dhcs.ca.gov Telephone: (916) 445-4646	Information Security Office DHCS Information Security Office P.O. Box 997413, MS 6400 Sacramento, CA 95899-7413 Email: incidents@dhcs.ca.gov

19. Responsibility of DHCS. DHCS agrees to not request the Business Associate to use or disclose PHI in any manner that would not be permissible under HIPAA and/or other applicable federal and/or state law.

20. Audits, Inspection and Enforcement

20.1 From time to time, DHCS may inspect the facilities, systems, books and records of Business Associate to monitor compliance with this Agreement. Business Associate 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.

20.2 If Business Associate is the subject of an audit, compliance review, investigation or any proceeding that is related to the performance of its obligations pursuant to this Agreement, or is the subject of any judicial or administrative proceeding alleging a violation of HIPAA, Business Associate shall promptly notify 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 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.

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.

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

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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 BOARD ACTION AGENDA REFERRAL

Action To Be Taken October 7, 2021
Regular Meeting of the CalOptima Board of Directors

Consent Calendar
7. Consider Approval of Modifications to CalOptima PACE Policy PA.1002 Mandatory Medical Equipment and Supply Requirements

Contacts
Emily Fonda, M.D., MMM, CHCQM, Chief Medical Officer, (714) 246-8887
Monica Macias, Director, PACE (714) 468-1100

Recommended Actions
Approve recommended modifications to CalOptima PACE Policy PA.1002 Mandatory Medical Equipment and Supply Requirements in accordance with CalOptima PACE's regular review process and consistent with regulatory requirements.

Background/Discussion
CalOptima PACE regularly reviews its Policies and Procedures to ensure they are up to date and aligned with Federal and State health care program requirements, contractual obligations, and laws, as well as CalOptima PACE operations. As part of the current annual policy review cycle, the staff proposed to attach tracking logs already in use to add clarity to the policy.

CalOptima PACE PA.1002 Mandatory Medical Equipment and Supply Requirements outlines and defines the standards that the CalOptima PACE Center is required to meet in order to comply with quality control standards related to medical equipment and supplies located at the CalOptima PACE Center.

Below is a list of substantive changes to the policy, which are reflected in the attached reline. This list does not include non-substantive changes that may also be reflected in the redline (e.g., formatting, spelling, punctuation, capitalization, minor clarifying language and/or grammatical changes).

Modifications Made to Policy PA.2001: Mandatory Medical Equipment and Supply Requirements

Policy Pages, Section, and Line	Proposed Changes	Rationale	Impact of Change
Page 1, Section III.A,1, line 19	Removed "suction equipment" and replaced with "Airways"	The language is changed to better clarify content.	There is no impact to CalOptima PACE as minor language changes were made to improve clarity of the content.
Page 2, Section III.B.15, lines 12-13	Removed "Glucometers" and replaced with "Test supplies necessary to	The language is changed to clarify that glucometers are not a sole source for measuring urine, sugar, and acetone testing.	There is no impact to CalOptima PACE as this

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	perform urine, sugar, and acetone testing"		was updated to improve clarity of content.
Page 2, Section III.B.1.a, line 30	Removed "on" and replaced with "using" and removed "Inventory logs" and replaced with "logs".	Minor language changes to better clarify and increase clarity	There is no impact to CalOptima PACE as this was updated to improve clarity of content.
Page 2, Section III.B.1.c, line 35	Removed "quarterly" and replaced with "periodic".	This change was made to include a reference to all equipment checks as periodic and not simply quarterly, as all checks have varying inspection intervals which are more frequent than just quarterly intervals.	There is no impact to CalOptima as an additional language was added to improve clarity of the content.
Page 2, Section IV., Attachments, Lines 43-54	A. Automatic External Defibrillator (AED) Log—Line 43 B. Emergency Kit Lock and Oxygen Supply Log—Line 44 C. Emergency Eye Wash Station Log—Line 45 D. Emergency Kit Log—Line 46 E. Glucometer Daily Quality Control Record—Line 47 F. Portable Suction Log—Line 48 G. Scale Balance Check—Line 49 H. Stock Medication Supply List—Line 50	Samples of all logs were added as attachments to increase clarity and provide more transparency	There is no impact to CalOptima PACE as the attachments were added as a way to provide greater clarity and transparency.

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	I. Stock Medication Supply Record of Use Log—Line 51 J. Strep A Quality Control Log—Line 52 K. Temperature Log for Clinic Medication Room Freezer-Fahrenheit—Line 53 L. Temperature Log for Clinic Refrigerator-Lab Freezer—Line 54		
Page 3, Section IV., Attachments, Line 1	M. PACE Clinic Urine Dipstick Quality Control Log	Samples of all logs were added as attachments to increase clarity and provide more transparency	There is no impact to CalOptima as minor language changes were made to improve clarity of the content.

Fiscal Impact
The recommended action to revise CalOptima PACE Policy PA.1002 is operational in nature and has no additional fiscal impact beyond what was incorporated in the CalOptima Fiscal Year 2021-22 Operating Budget approved by the Board on June 3, 2021.

Rationale for Recommendation
CalOptima PACE staff has updated CalOptima PACE PA.1002 as part of its annual policy review

Concurrence
Gary Crockett, Chief Counsel

Attachments
1. 50. PA. 1002_PRC20210716-19_RLS20210621_v.TBD_sub20211007BOD_Final BOD Packet.pdf

/s/ Richard Sanchez *09/29/2021*
Authorized Signature **Date**

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Policy:	PA.1002
Title:	**Mandatory Medical Equipment and Supply Requirements**
Department:	CalOptima PACE
Section:	Not Applicable
CEO Approval:	*/s/*
Effective Date:	10/01/2013
Revised Date:	TBD
Applicable to:	☐ Medi-Cal ☐ OneCare ☐ OneCare Connect ☒ PACE ☐ Administrative

I. PURPOSE

This policy outlines and defines the minimum standards that the CalOptima Program of All-Inclusive Care for the Elderly (PACE) Center is required to maintain for mandatory medical equipment and supplies located at the CalOptima PACE Center.

II. POLICY

A. CalOptima PACE Centers shall meet the quality, quantity, and maintenance regulations of the California Department of Health Care Services (DHCS~~)*~~) for all medical equipment and supplies required for the care of Participants.

III. PROCEDURE

A. Each CalOptima PACE Center shall maintain medical equipment and supplies in the quality and quantity necessary for the care of Participants as ordered or indicated by DHCS. These shall be provided and properly maintained at all times and shall include at least the following:

1. ~~Suction equipment~~Airways;
2. Emergency oxygen supply and equipment for administration;
3. Examination light;
4. First aid and emergency equipment available as needed, as determined by the registered nurse and staff, or attending physician;
5. Flashlights;
6. Medicine glasses, cups, or other small containers, which are accurately calibrated;
7. Refrigerator thermometer;
8. Scales for weighing Participants;
9. Commode chairs, wheelchairs, walkers, canes, and crutches;

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10. Soap for bathing;

11. Sphygmomanometer;

12. Sterile dressings;

13. Stethoscopes;

14. Syringes and needles;

~~15. Glucometers;~~
15. Test supplies necessary to perform urine, sugar, and acetone testing;

16. Thermometers;

17. Tongue depressors; and

18. Current drug reference that lists, for each drug administered in the CalOptima PACE Center, indications for use, dosage, and side effects.

B. Monitoring of medical equipment and supplies

1. A CalOptima PACE Registered Nurse (RN), Licensed Vocational Nurse (LVN), or Medical Assistant shall:

a. Be assigned and be responsible for the monitoring of all medical equipment and supplies on a daily, weekly, or monthly basis (depending on equipment specifications) to ensure quality and quantity of the PACE Center's medical equipment and supplies and will keep records ~~on~~using the Medical Equipment ~~Inventory log~~logs;

b. Order medical equipment, as necessary, and appropriately discard any outdated medical equipment and supplies;

c. Be responsible for ~~quarterly~~periodic inspections of both the quality and quantity of all necessary medical equipment and supplies; and

d. Report any issues to be addressed regarding medical equipment and supplies to the CalOptima PACE Medical Director for follow-up action.

IV. ATTACHMENT(S)

A. Automatic External Defibrillator (AED) Log
B. Emergency Kit Lock and Oxygen Supply Log
C. Emergency Eye Wash Station Log
D. Emergency Kit Log
E. Glucometer Daily Quality Control Record
F. Portable Suction Log
G. ~~Stock Medication Log~~Scale Balance Check
H. Stock Medication ~~Log~~Supply List
I. Stock Medication Supply Record of Use Log
J. Strep A Quality Control Log
K. Temperature Log for Clinic Medication Room Freezer-Fahrenheit
L. Temperature Log for Clinic Refrigerator-Lab Freezer

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M. PACE Clinic Urine Dipstick Quality Control Log

V. REFERENCE(S)

A. CalOptima PACE Contract with the Department of Health Care Services for the PACE Program
~~A.~~B. CalOptima PACE Program Agreement
~~B.~~C. Title 22, California Code of Regulations (C.C.R.), §78439

~~V.~~VI. REGULATORY AGENCY APPROVAL(S)

None to Date

~~VI.~~VII. BOARD ACTION(S)

Date	Meeting
TBD	Regular Meeting of CalOptima Board of Directors

~~VII.~~VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	10/01/2013	PA.1002	Mandatory Medical Equipment Requirements	PACE
Revised	10/01/2014	PA.1002	Mandatory Medical Equipment Requirements	PACE
Revised	01/01/2015	PA.1002	Mandatory Medical Equipment Requirements	PACE
Revised	05/01/2016	PA.1002	Mandatory Medical Equipment Requirements	PACE
Revised	04/01/2017	PA.1002	Mandatory Medical Equipment Requirements	PACE
Revised	07/01/2018	PA.1002	Mandatory Medical Equipment Requirements	PACE
Revised	05/01/2019	PA.1002	Mandatory Medical Equipment Requirements	PACE
Revised	TBD	PA.1002	Mandatory Medical Equipment and Supply Requirements	PACE

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~~IX.~~X. GLOSSARY

Term	Definition
Department of Health Care Services (DHCS)	The single State Department responsible for administration of the federal Medicaid (referred to as Medi-Cal ~~program,~~in California ~~Children Services (CCS), Genetically Handicapped Persons)~~ Program ~~(GHPP), Child Health and Disabilities Prevention (CHDP), and other health related programs~~.
PACE Center	The location designated by CalOptima PACE at which Members shall receive PCP services.
Participant	~~For the purposes of this policy, an~~An individual enrolled in the CalOptima PACE program.

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Policy:	PA.1002
Title:	**Mandatory Medical Equipment and Supply Requirements**
Department:	CalOptima PACE
Section:	Not Applicable
CEO Approval:	*/s/*
Effective Date:	10/01/2013
Revised Date:	TBD

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

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This policy outlines and defines the minimum standards that the CalOptima Program of All-Inclusive Care for the Elderly (PACE) Center is required to maintain for mandatory medical equipment and supplies located at the CalOptima PACE Center.

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1. Airways;
2. Emergency oxygen supply and equipment for administration;
3. Examination light;
4. First aid and emergency equipment available as needed, as determined by the registered nurse and staff, or attending physician;
5. Flashlights;
6. Medicine glasses, cups, or other small containers, which are accurately calibrated;
7. Refrigerator thermometer;
8. Scales for weighing Participants;
9. Commode chairs, wheelchairs, walkers, canes, and crutches;

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10. Soap for bathing;

11. Sphygmomanometer;

12. Sterile dressings;

13. Stethoscopes;

14. Syringes and needles;

15. Test supplies necessary to perform urine, sugar, and acetone testing;

16. Thermometers;

17. Tongue depressors; and

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b. Order medical equipment, as necessary, and appropriately discard any outdated medical equipment and supplies;

c. Be responsible for periodic inspections of both the quality and quantity of all necessary medical equipment and supplies; and

d. Report any issues to be addressed regarding medical equipment and supplies to the CalOptima PACE Medical Director for follow-up action.

IV. ATTACHMENT(S)

A. Automatic External Defibrillator (AED) Log
B. Emergency Kit Lock and Oxygen Supply Log
C. Emergency Eye Wash Station Log
D. Emergency Kit Log
E. Glucometer Daily Quality Control Record
F. Portable Suction Log
G. Scale Balance Check
H. Stock Medication Supply List
I. Stock Medication Supply Record of Use Log
J. Strep A Quality Control Log
K. Temperature Log for Clinic Medication Room Freezer-Fahrenheit
L. Temperature Log for Clinic Refrigerator-Lab Freezer
M. PACE Clinic Urine Dipstick Quality Control Log

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V. REFERENCE(S)

A. CalOptima PACE Contract with the Department of Health Care Services for the PACE Program
B. CalOptima PACE Program Agreement
C. Title 22, California Code of Regulations (C.C.R.), §78439

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

Date	Meeting
TBD	Regular Meeting of CalOptima Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	10/01/2013	PA.1002	Mandatory Medical Equipment Requirements	PACE
Revised	10/01/2014	PA.1002	Mandatory Medical Equipment Requirements	PACE
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Revised	05/01/2016	PA.1002	Mandatory Medical Equipment Requirements	PACE
Revised	04/01/2017	PA.1002	Mandatory Medical Equipment Requirements	PACE
Revised	07/01/2018	PA.1002	Mandatory Medical Equipment Requirements	PACE
Revised	05/01/2019	PA.1002	Mandatory Medical Equipment Requirements	PACE
Revised	TBD	PA.1002	Mandatory Medical Equipment and Supply Requirements	PACE

IX.

X. GLOSSARY

Term	Definition
Department of Health Care Services (DHCS)	The single State Department responsible for administration of the federal Medicaid (referred to as Medi-Cal in California) Program.
PACE Center	The location designated by CalOptima PACE at which Members shall receive PCP services.
Participant	An individual enrolled in the CalOptima PACE program.

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Automatic External Defibrillator (AED) Log

INSTRUCTIONS:

- Check the AED in the clinic and activity area to ensure the green light is displayed, indicating proper functioning.
- Initial the month/date you performed the check. Your initials indicate the green LIGHT was visible.
- Sign the initial key below (once per year)
- If the green light is not visible, contact the Nursing Supervisor or Clinic Manager immediately.

YEAR: 2021 Area: Day Floor Area **Last battery replacement: July 2019**

Day of Month	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEPT	OCT	NOV	DEC
1												
2												
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31												
Mgr √												

CORRECTION REQUIRED	ACTION TAKEN

Initial Signature Initial Signature

Initial Signature Initial Signature

G:\PACE\PACE Clinical\PACE Clinic Logs\AED log
Revised 1/2020

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Emergency Kit Lock and Oxygen Supply Log

(Crash Cart) INSTRUCTIONS:

At the beginning of each shift, the designated staff member will check the Emergency Kit lock and O2 tanks, then make a signed entry

Replace O2 tanks if register reads less than 500 PSI.

Make an entry in the Findings column for situations described in the Emergency Kit Policy and Procedure.

YEAR: 2021 **MONTH:**

Date	Lock Intact	Crash Cart Lock #	Amount O2 In Tank #1	Amount O2 In Tank #2	Amount O2 In Tank #3	Amount O2 In Tank #4	Amount O2 In Tank #5	Amount O2 In Tank #6	Checked By (Initial)
1	Y N								
2	Y N								
3	Y N								
4	Y N								
5	Y N								
6	Y N								
7	Y N								
8	Y N								
9	Y N								
10	Y N								
11	Y N								
12	Y N								
13	Y N								
14	Y N								
15	Y N								
16	Y N								
17	Y N								
18	Y N								
19	N								
20	Y N								

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Date	Lock Intact	Lock #	Amount O2 In Tank #1	Amount O2 In Tank #2	Amount O2 In Tank #3	Amount O2 In Tank #4	Amount O2 In Tank #5	Amount O2 In Tank #6	Checked By (Initial)
21	Y N								
22	Y N								
23	Y N								
24	Y N								
25	Y N								
26	Y N								
27	Y N								
28	Y N								
29	Y N								
30	Y N								
31	Y N								

Monthly Audit Reviewer: _____

Initial Signature Initial Signature Title: Date: __

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on this log, indicating if lock is intact, lock # and document amount of O2 in each tank.

Findings / Corrective Action (indicate which tank # if action needed)

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Findings / Corrective Action (indicate which tank # if action needed)

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Emergency Eye Wash Station Log

INSTRUCTIONS:

- Activate the emergency eye wash station *weekly* and allow water to run feely for 3 minutes. When turned on, tepid water (between 60-100 degrees Fahrenheit) will flow from the valve.
- Check water for clarity. Water should be clear.
- Initial the month/date you performed the check. Your initials indicate the station functioned as described above.
- Sign the initial key below (once per year)
- If the station is not functioning properly, contact the Nursing Supervisor or Clinic Manager immediately.

YEAR: 2021

Day of Month	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEPT	OCT	NOV	DEC
1												
2												
3												
4												
5												
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30												
31												

Initial _____ Signature _____ Initial _____ Signature _____

Initial _____ Signature _____ Initial _____ Signature of Monthly Reviewer _____

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Emergency Kit Log

INSTRUCTIONS:

- Monthly, the designated clinic staff member will check the contents of the Emergency Kit, replacing any expired medications or supplies.
- Actions taken will be documented in this log.

YEAR: 2021 **MONTH:** **January**

SUPPLY	LOT #	EXP DATE	QUANTITY	COMPLIANCE Y/N	COMMENTS / FINDINGS
MEDICATION					
Aspirin 325mg tablet	P114103	02/2021	1 bottle – 100 tabs	☐Y ☐N	
Diphenhydramine (Benadryl) 12.5mg/5ml Liquid	68351	08/2021	1 bottle – 4 oz.	☐Y ☐N	
Diphenhydramine (Benadryl) 25mg capsule	191353	02/2022	100 capsules	☐Y ☐N	
Diphenhydramine (Benadryl) 50mg/ml Injectable (single-dose x25)	DBTU0012	11/2022	25 vials	☐Y ☐N	
Epinephrine 1:1,000 1mg/1ml	20112	09/2021	10 Ampules	☐Y ☐N	
EpiPen 0.3 mg injection auto-injector adult	G191206x	05/2021	1 kit	☐Y ☐N	
Glucagon (Glucagon) 1mg/ml	D177685A (1) D140631A (1)	11/2021 08/2021	2 Kit(s)	☐Y ☐N	
Nitroglycerin SL 0.4mg tablet	AN8859	10/2021	1 bottle – 25 tabs	☐Y ☐N	
Naloxone Hydrochloride Injection, USP 0.4mg/ml	146600	03/2021	3 vials	☐Y ☐N	
0.9% sodium chloride injection 10ml	02-334-DK	02/01/2021	2 vials	☐Y ☐N	
0.9% sodium chloride 250ml bag	J0J071	07/2022	1 bag	☐Y ☐N	
50 % Dextrose (0.5g/ml) 4 Syringes 50% Dextrose (0.5g/ml) 1 vial	BD016D0 14-424-DK	03/2022 02/01/2022	3 syringes 1 Vial	☐Y ☐N	
Normal Saline 0.9% 500ml Bottle	2004102	04/2023	1 bottle	☐Y ☐N	

MEDICAL SUPPLY					
Alcohol Pads	CYE12-14	06/2021	10	☐Y ☐N	
Betadine	81363-17	10/2021	1 Bottle	☐Y ☐N	
Sterile Gauze Pads 4in x 4 in	2384-20121225	NA	22	☐Y ☐N	
BD Filter Needle 19G 1 ½	0061542408	12/31/2021	4	☐Y ☐N	
Blunt Filter Needles 18g 1 ½"	6055915	04/2021	2	☐Y ☐N	
Needles- 25 Gauge needle 1" & 1½"	00170624B 190909A	05/01/2022 08/31/2024	3 of each	☐Y ☐N	
IV Catheters 20g, x1" 22g, x1" 24gx3/4"	170112SD 91556559 1702215B	12/2021 05/2025 01/31/2022	2 of each	☐Y ☐N	
Non-Rebreathing Mask (Adult) Nasal Cannula Adult Face Mask	MWM 041717N27 102317n12 032717n30	N/A	1 of each	☐Y ☐N	
Oral Airways as applicable (Adult) 80 mm (Adult Sm) 90 mm (Adult L g) 100mm	NA	NA	9,11,10	☐Y ☐N	
Paper Tape	N/A	NA	1	☐Y ☐N	
Pocket Mask	190606	NA	2	☐Y ☐N	
Sphygmomanometer: Adult Small Adult Adult Large	NA	NA	1 of each	☐Y ☐N	
Stethoscope	NA	NA	1	☐Y ☐N	
Tuberculin 27 Gauge 1/2" needle	170204A	01/21/22	2	☐Y ☐N	
Syringes 3cc, 5cc, 10cc	4E05048 CKDF1202 CKDF12-02	11/2021 11/2021	3 of each	☐Y ☐N	

Tourniquet	NA	NA	2	☐Y ☐N	
EKG Electrodes	919724	10/03/2021	1	☐Y ☐N	
IV Starter kit	257612	01/31/2022	2	☐Y ☐N	
EZ-Personal Protection Kit	NA	NA	1	☐Y ☐N	
21 G x1" Needle	1261027B	09/30/2021	2	☐Y ☐N	
Suction Machine and Components (Suction Yankauer)	NA	NA	1	☐Y ☐N	
Suction Catheter 12 Fr	1729683264	NA	2	☐Y ☐N	
Laryngoscope Blade	1204122	NA	1	☐Y ☐N	
Laryngoscope Handle	02J1202461	NA	1	☐Y ☐N	
Digital Thermometer	CE0197	NA	1	☐Y ☐N	
Mini Maglite Flash Light	NA	NA	1	☐Y ☐N	
Face Mask	NA	NA	2	☐Y ☐N	
Safety Goggles	NA	NA	5	☐Y ☐N	
AMBU Spur II Adult Resuscitator	1650702	NA	2 (1 outside of cart, one inside)	☐Y ☐N	
Gloves – Small Medium Large	MMG08-02 MMG09-02 MNG01-05-L2F	N/A N/A N/A	1 BOX OF EACH	☐Y ☐N	
Neck brace	110817	N/A	1	☐Y ☐N	
Narcan Nasal spray 4mg	192759	12/2021	(1 bottle) but 2 sprays	☐Y ☐N	
Surgifoam (For bleeding)	2577644	07/05/2023	12 pack	☐Y ☐N	
Flumazenil 1 mg per 10mL	1805238.1	11/2021	10	☐Y ☐N	

(used to wake pt. up if overdose on Benzo's)					
Recothrom 5000 (For excessive bleeding)	ZAC1901A	11/2021	2	☐Y ☐N	
0.9% Sodium Chloride Injection 10ml Syringe	3137279	11/2021	2	☐Y ☐N	
Extension Set 6 in	0061673088	03/31/2021	2	☐Y ☐N	
IV Administration Set	0061576400	07/31/2022	1	☐Y ☐N	
IV Administration Set with Flow Regulator	19022C824	09/07/2022	1	☐Y ☐N	

O_2 Tank w/ key (secured to wall) and Mask tubing connected Ambu bag), Cardiac Board and Adult (Connected to O_2 Tank)

Date	*Corrective Action:*

Reviewed by _____ Date: _____ Title: _____

Reviewed by _____ Date: _____ Title: _____

Glucometer Daily Quality Control Record

PACE CalOptima A Public Agency Better. Together.

YEAR: 2021 **MONTH: February** Meter # _____

METER SERIAL NUMBER: _____ Immediately report any out of range to your supervisor

DAY	TIME	TEST STRIPS			GLUCOSE CONTROL LEVEL 1					GLUCOSE CONTROL LEVEL 3					INITIALS
		LOT	Date Opened	Date Exp	LOT	Date Opened	Date Exp	Acceptable Range	RESULT	LOT	Date Opened	Date Exp	Acceptable Range	RESULT	
1															
2															
3															
4															
5															
6															
7															
8															
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31															

Name: _____ Initials: _____

Name: _____ Initials: _____

Action taken for results out of range:

Monthly Audit Review By: _____

Portable Suction Log

INSTRUCTIONS:

- Suction Machine will be checked daily for Supplies and proper functioning by turning on Machine and listen for compressor to be running. Then check suction by turning regulator handle to the right to visualize needle gauge moving upwards.
- Check “yes” or “no” whether the portable suction machine is working properly. If no, note the corrective action taken.
- Initial for each day the portable suction machine is checked.
- Sign the initial key below (once per month)
- If the portable suction machine is not functioning properly, contact the Nursing Supervisor or Clinic Manager immediately.

YEAR: 2021 MONTH: February

Day of Month	Working Properly YES	Working Properly NO	Action	Supplies: Yankuer, Tubing, sterile water, gloves and gauze (√)	Initials
1					
2					
3					
4					
5					
6					
7					
8					
9					
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30					
31					

_____ _____ _____ _____

Initial Signature Initial Signature

_____ _____ _____ _____

Initial Signature Initial Signature of Monthly Audit Reviewer

Scale Balance Check

YEAR: 2021 **MONTH**: February

PACE CalOptima A Public Agency Better. Together.

DAY	SCALE: STANDING	SCALE: WHEELCHAIR	SCALE_____	SCALE_____	SCALE_____	SCALE_____	SCALE_____	INITIALS
1	☐Y ☐N	☐Y ☐N	☐Y ☐N	☐Y ☐N	☐Y ☐N	☐Y ☐N	☐Y ☐N	
2	☐Y ☐N	☐Y ☐N	☐Y ☐N	☐Y ☐N	☐Y ☐N	☐Y ☐N	☐Y ☐N	
3	☐Y ☐N	☐Y ☐N	☐Y ☐N	☐Y ☐N	☐Y ☐N	☐Y ☐N	☐Y ☐N	
4	☐Y ☐N	☐Y ☐N	☐Y ☐N	☐Y ☐N	☐Y ☐N	☐Y ☐N	☐Y ☐N	
5	☐Y ☐N	☐Y ☐N	☐Y ☐N	☐Y ☐N	☐Y ☐N	☐Y ☐N	☐Y ☐N	
6	☐Y ☐N	☐Y ☐N	☐Y ☐N	☐Y ☐N	☐Y ☐N	☐Y ☐N	☐Y ☐N	
7	☐Y ☐N	☐Y ☐N	☐Y ☐N	☐Y ☐N	☐Y ☐N	☐Y ☐N	☐Y ☐N	
8	☐Y ☐N	☐Y ☐N	☐Y ☐N	☐Y ☐N	☐Y ☐N	☐Y ☐N	☐Y ☐N	
9	☐Y ☐N	☐Y ☐N	☐Y ☐N	☐Y ☐N	☐Y ☐N	☐Y ☐N	☐Y ☐N	
10	☐Y ☐N	☐Y ☐N	☐Y ☐N	☐Y ☐N	☐Y ☐N	☐Y ☐N	☐Y ☐N	
11	☐Y ☐N	☐Y ☐N	☐Y ☐N	☐Y ☐N	☐Y ☐N	☐Y ☐N	☐Y ☐N	
12	☐Y ☐N	☐Y ☐N	☐Y ☐N	☐Y ☐N	☐Y ☐N	☐Y ☐N	☐Y ☐N	
13	☐Y ☐N	☐Y ☐N	☐Y ☐N	☐Y ☐N	☐Y ☐N	☐Y ☐N	☐Y ☐N	
14	☐Y ☐N	☐Y ☐N	☐Y ☐N	☐Y ☐N	☐Y ☐N	☐Y ☐N	☐Y ☐N	
15	☐Y ☐N	☐Y ☐N	☐Y ☐N	☐Y ☐N	☐Y ☐N	☐Y ☐N	☐Y ☐N	
16	☐Y ☐N	☐Y ☐N	☐Y ☐N	☐Y ☐N	☐Y ☐N	☐Y ☐N	☐Y ☐N	
17	☐Y ☐N	☐Y ☐N	☐Y ☐N	☐Y ☐N	☐Y ☐N	☐Y ☐N	☐Y ☐N	
18	☐Y ☐N	☐Y ☐N	☐Y ☐N	☐Y ☐N	☐Y ☐N	☐Y ☐N	☐Y ☐N	
19	☐Y ☐N	☐Y ☐N	☐Y ☐N	☐Y ☐N	☐Y ☐N	☐Y ☐N	☐Y ☐N	
20	☐Y ☐N	☐Y ☐N	☐Y ☐N	☐Y ☐N	☐Y ☐N	☐Y ☐N	☐Y ☐N	
21	☐Y ☐N	☐Y ☐N	☐Y ☐N	☐Y ☐N	☐Y ☐N	☐Y ☐N	☐Y ☐N	
22	☐Y ☐N	☐Y ☐N	☐Y ☐N	☐Y ☐N	☐Y ☐N	☐Y ☐N	☐Y ☐N	
23	☐Y ☐N	☐Y ☐N	☐Y ☐N	☐Y ☐N	☐Y ☐N	☐Y ☐N	☐Y ☐N	
24	☐Y ☐N	☐Y ☐N	☐Y ☐N	☐Y ☐N	☐Y ☐N	☐Y ☐N	☐Y ☐N	
25	☐Y ☐N	☐Y ☐N	☐Y ☐N	☐Y ☐N	☐Y ☐N	☐Y ☐N	☐Y ☐N	
26	☐Y ☐N	☐Y ☐N	☐Y ☐N	☐Y ☐N	☐Y ☐N	☐Y ☐N	☐Y ☐N	
27	☐Y ☐N	☐Y ☐N	☐Y ☐N	☐Y ☐N	☐Y ☐N	☐Y ☐N	☐Y ☐N	
28	☐Y ☐N	☐Y ☐N	☐Y ☐N	☐Y ☐N	☐Y ☐N	☐Y ☐N	☐Y ☐N	
29	☐Y ☐N	☐Y ☐N	☐Y ☐N	☐Y ☐N	☐Y ☐N	☐Y ☐N	☐Y ☐N	
30	☐Y ☐N	☐Y ☐N	☐Y ☐N	☐Y ☐N	☐Y ☐N	☐Y ☐N	☐Y ☐N	
31	☐Y ☐N	☐Y ☐N	☐Y ☐N	☐Y ☐N	☐Y ☐N	☐Y ☐N	☐Y ☐N	

Date	Corrective Action Required:	Action Taken:

_____ _____
Initial Signature

_____ _____
Initial Signature

G:\PACE\PACE Clinical\PACE Clinic Logs\scale balance check log updated 1/2020

Monthly Audit Reviewed by: _____ **Title:** _____ **Date:** ____

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STOCK MEDICATION SUPPLY LIST

Instructions:

- Nursing will check the expiration date of all stock medications on a monthly basis.
- Nursing will monitor quantities of all stock medications and will re-order as necessary to Replenish the supply.

Month: **Year:** 0

Medication Name	Exp. Date	RN/LVN init.	Comments/Actions
5% Dextrose + 0.45% Sodium Chloride IV Solution = 1 Liter Bag			
50% Dextrose injection USP x 3			
Acetaminophen 325 mg tablets			
Acetaminophen 500mg tabs			
Acetaminophen 650mg			
Acephen Suppositories 650mg			
Afrin Pump Mist			
Albuterol sulfate Inhalation Solution 0.083% 2.5mg/3ml			
Amlodipine 5mg # 30			
Ammonia			
Articial tears (Refresh)			
Aspirin Chewable 81mg			
Aspirin 81mg			
Aspirin 325 mg (Enteric Coated tabs)			
Aspirin 325mg tabs			
Bacitracin Ointment			
Bisacodyl 10mg suppositories			
Bupivacaine 0.5 % 10ml injections			
Cefepime for injection 1gram USP 5 vials			
Ceftriaxone 500mg vial			
Ceftriaxone 1 gm vials			
Ceftriaxone injection USP 2 GM (2)			
Clonidine 0.3 mg/day patch			
clonidine 0.2 md/ Day patch			
Clonidine 0.1mg tabs # 60			
Clotrimazole Cream 1%			
Cyanocobalamin 1,000mcg/ml			
Desitin cream (2 tubes)			
Diclofenac sodium topical gel 1%			
Diphenhydramine 50mg tabs			
Diphenhydramine 50mg/ml injectable			
Diphenhydramine Oral Solution 12.5mg/5cc			
Ear drops (carbamide peroxide 6.5%)			
Enema Saline Laxative 4.5 fl oz			
Furosemide injection 10mg/mL			
Furosemide injection 20mg/2ml			
Furosemide 20mg			
Furosemide 40mg tabs			

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Gentamicin 80mg/2ml vial			
Glucagon 1mg vials			
Glucose chewable tabs			
Glucose 15 - Oral Glucose Gel			
Hydralazine 25mg # 30			
Hep B vaccine Recombinant 1mL vial (6 vials)			
Hydrocholorthiazide 25mg # 30			
Hydrocortisone Cream Usp, 2%			
Hydroxyzine HCL 25mg tablets			
Ibuprofen 200mg			
Influenza vaccine 5mL			
Iodosorb Cadexomer Iodine Gel			
Ipratr Bro/Albu Sulf Inhal Sol 0.5mg/3mg/3ml			
Ipratropium Bromide Inhalation 0.02% 0.5mg/vial			
Kenalog - 40 (40 mg/1 ml)			
Ketorolac injection 30 mg			
Levalbuterol 0.25% (1025mg/0.5ml)			
Lactulose solution 10g/15ml			
levaquin 500mg # 7			
Lidocaine HCL 10mg/ml/Lidocaine 1% injection			
Lidocaine Hydrocloride Gel			
Lidocaine HCL 20mg/ml/Lidocaine 2%			
Lidocaine 2% Viscous Solution (oral)			
Lidocaine patch 5%			
Lidocaine and Prilocaine Ointment			
Lisinopril 10mg # 15			
Loperamide 2 mg tablets			
Loratadine 10mg			
Losartan 50 mg tabs # 15			
Lubricating KY Jelly (Tube)			
Med-Honey wound and burn			
Methyl Prednisone 40mg/ml			
Meclizine HCL 12.5mg caplets			
Metoprolol tartrate 25mg # 30			
Milk of magnesia 12 fl oz			
Mupirocin ointment 2%			
Nicotine Gum 2mg			
Mylanta			
Nystatin topical powder			
Nitrostat tablets 0.4mg sublingual			
Omeprazole DR 40 mg capsule			
Orajel / Anbesol			
Oseltamivir Phosphate 30mg			
Oseltamivir Phosphate 45mg			
Oseltamivir Phosphate 75mg			
Pain Ease (Spray)			
Permethrin cream 5% x 1			
Pneumovax 23			
Potassium CL /ER 10 MEQ tabs # 30			
Prednisone 10 mg tablets # 15			
Procardia 10mg capsules # 15			
Prevnar 13			

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Prochlorperazine suppositories 25 mg			
Salonpas Hot Capsicum patch			
Salonpas hot gel patch			
SalonPas			
Santyl 30grams ointment			
Senna 8.6mg			
Silver Sulfadiazine Cream			
Sodium chloride 10ml vials			
Sodium Polystyrene Sulfonate susp. 15g/60ml (Kayexalate)			
Solarcaine			
Solumedrol 125 mg vials			
Sore Throat Lozenges			
Tdap			
Terbinafine Hydrochloride cream1% (Antifungal cream)			
Triamcinolone ointment			
Tuberculin			
Tums			
Urea20 Hydrating cream			
Tussin DM			
vitamin K 5 mg # 10			
Warfarin Sodium 5mg tabs # 30			
Zinc Oxide 40% ointment			
Zofran(Ondansetron) disintegrating tabs 4mg			
Zofran 4 mg tablets (Ondansetron)			

Signature: _____
Signature: _____
Signature: _____

RN/LVN Initials: _____
RN/LVN Initials: _____

Title:_____ Date: _____

Monthly Review done by: _____

Stock Medication Supply Record of Use Log

PACE CalOptima A Public Agency Better. Together.

Date	Time	Participant Name	Drug and Dose	RN #1 Signature	RN #2 Signature

Reviewed by: _____ _____ _____

Name / Title Signature Date

G:\PACE\PACE Clinical\PACE Clinic Logs\Stock medication supply log
Reviewed 8/2017

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Strep A Quality Control Log

Instructions: Quality control shall be performed upon opening a new box.

Date	Strep A Test Lot#	Exp. Date	Positive (+) Control Test Results w/in 5 Minutes	Lot#	Exp. Date	Negative (-) Control Test Results w/in 5 Minutes	Lot#	Exp. Date	Checked by

Date	Correction Required:	Action Taken:

Initial Signature Initial Signature

Initial Signature Initial Signature

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TEMPERATURE LOG FOR FREEZER- FAHRENHEIT
Days 1-15

Month: _____ **Year:** _____ **Room:** Medication Room Freezer

Monitor temperatures closely!

1. Write your initials below in "Staff Initials," and note the time in "Exact Time."
2. Record temps twice each workday.
3. Record the min/max temps once each workday – preferably in the morning.
4. Put an "**X**" in the row that corresponds to the freezer's temperature.
5. If any out of range temp, see instructions to the right.

Take Action if temp is out of range – too warm (above 5°F) or too cold (below -58°F)

1. Label vaccines/ medications "do not use" and store under proper conditions as quickly as possible.
2. Do not discard unless directed by your supervisor.
3. Record out-of-range temps in the "Action" area of the bottom of the log.
4. Notify the Clinic Supervisor immediately.

Day of Month	1		2		3		4		5		6		7		8		9		10		11		12		13		14		15	
Staff Initials																														
Exact Time	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM
Min/Max Temp (since previous reading)																														

DANGER! Temperatures above 5°F are too warm! Write any out-of-range temps and room temp on the lines below and notify clinic supervisor immediately.

TEMPERATURES ACCEPTABLE	5°F																													
	4°F																													
	3°F																													
	2°F																													
	1°F																													
	0°F																													
	-1°F																													
	-2°F																													
	-3°F																													
	-4°F																													
	-58°F to -5°F																													
ACTION	Write any out-of-range- temps (above 5°F or below -58°F) here:																													
	Room Temperature																													

Initial: _____ **Signature:** _____ **Monthly Audit Reviewed by:** _____

Initial: _____ **Signature:** _____

G:\PACE\PACE Clinical\PACE Clinic Logs\temp log for clinic freezer\ updated 1/2020

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TEMPERATURE LOG FOR FREEZER- FAHRENHEIT
Days 16-31

Month/Year: _____

Monitor temperatures closely!

1. Write your initials below in "Staff Initials," and note the time in "Exact Time."
2. Record temps twice each workday.
3. Record the min/max temps once each workday – preferably in the morning.
4. Put an "**X**" in the row that corresponds to the freezer's temperature.
5. If any out of range temp, see instructions to the right

Take Action if temp is out of range – too warm (above 5°F) or too cold (below -58°F)

1. Label vaccines/ medications "do not use" and store under proper conditions as quickly as possible
2. Do not discard unless directed by your supervisor.
3. Record out-of-range temps in the "Action" area of the bottom of the log.

Day of Month	16		17		18		19		20		21		22		23		24		25		26		27		28		29		30		31	
Staff Initials																																
Exact Time	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM
Min/Max Temp (since previous reading)																																
DANGER! Temperatures above 5°F are too warm! Write any out-of-range temps and room temp on the lines below and notify the clinic supervisor immediately!																																
TEMPERATURES / **5°F**																																
4°F																																
3°F																																
2°F																																
1°F																																
0°F																																
-1°F																																
-2°F																																
-3°F																																
-4°F																																
ACCEPTABLE / **-58°F to -5°F**																																
ACTION / **Write any out-of-range-temps (above 5°F or below -58°F) here:**																																
Room Temperature																																

Initial: _____ Signature: _____ **Monthly Audit Reviewed by: _____**

Initial: _____ Signature: _____

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TEMPERATURE LOG FOR CLINIC REFRIGERATOR **Month: _____ Year: _____ Room: Lab Freezer**

Monitor temperature closely!
Record temps twice each workday
Put an "**X**" in the row that corresponds to the refrigerator's temperature
If any out of range temp, see instructions to the right

Take actions if temp is out of range – too warm (above 46°F) or too cold (below 35°F)

1. Move medication to another refrigerator promptly.
2. Note time of last recorded temperature.
3. Notify Clinic Supervisor immediately.

Day of Month	1		2		3		4		5		6		7		8		9		10		11		12		13		14		15	
Staff Initials																														
Exact Time	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM
Min/Max Temp (since previous reading)																														
DANGER! Temperatures above 46°F are too warm! Write any out-of-range temps and room temp on the lines below and report to clinic supervisor																														
TEMPERATURES **46°F**																														
45°F																														
44°F																														
43°F																														
42°F																														
41°F																														
Aim for 40°F **40°F**																														
39°F																														
38°F																														
37°F																														
36°F																														
ACCEPTABLE **35°F**																														
DANGER! Temperatures below 35°F are too cold! Write any out-of-range temps and room temp on the lines below and report t to clinic supervisor																														
ACTION **Write any out-of-range- temps (above 46°F or below 35°F) here:**																														
Room Temperature																														

Initial: _____ Signature: _____ **Monthly Audit Reviewed by: _____**

Initial: _____ Signature: _____

G:\PACE\PACE Clinical\PACE Clinic Logs\temp log for clinic refrigerator\ updated 1/2020

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Day of Month	16		17		18		19		20		21		22		23		24		25		26		27		28		29		30	
Staff Initials																														
Exact Time	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM
Min/Max Temp (since previous reading)																														
DANGER! Temperatures above 40°F are too warm! Write any out-of-range temps and room temp on the lines below and report to clinic supervisor																														
TEMPERATURES **46°F**																														
45°F																														
44°F																														
43°F																														
42°F																														
41°F																														
Aim for 40°F **40°F**																														
ACCEPTABLE **39°F**																														
38°F																														
37°F																														
36°F																														
35°F																														
DANGER! Temperatures below 35°F are too cold! Write any out-of-range temps and room temp on the lines below and report to clinic supervisor																														
ACTION **Write any out-of-range- temps (above 46°F or below 35°F) here:**																														
Room Temperature																														

Initial: _____ Signature: _____ Monthly Audit Reviewed by: _____

Initial: _____ Signature: _____

Day of Month	31																														
Staff Initials																															
Exact Time	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM
Min/Max Temp (since previous reading)																															
DANGER! Temperatures above 40°F are too warm! Write any out-of-range temps and room temp on the lines below and report to clinic supervisor																															
TEMPERATURES **46°F**																															
45°F																															
44°F																															
43°F																															
42°F																															
41°F																															
Aim for 40°F **40°F**																															
ACCEPTABLE **39°F**																															
38°F																															
37°F																															
36°F																															
35°F																															
DANGER! Temperatures below 35°F are too cold! Write any out-of-range temps and room temp on the lines below and report to clinic supervisor																															
ACTION **Write any out-of-range- temps (above 46°F or below 35°F) here:**																															
Room Temperature																															

Initial: _____ Signature: _____ Monthly Audit Reviewed by: _____

Initial: _____ Signature: _____

PACE CLINIC URINE DIPSTICK QUALITY CONTROL

YEAR: 20__

MONTH: _____

Discard Controls after 30 days

Notify Supervisor for any out of range control readings

Staff to (√) after testing controls then initial

Day of the Month	Control #1 – Negative (√) Comments	Control # 2 – Positive (√) Comments	Initials
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			
11			
12			
13			
14			
15			
16			
17			
18			
19			
20			
21			
22			
23			
24			
25			
26			
27			
28			
29			
30			
31			

Initials: _____ Signature: _____

Initials: _____ Signature: _____

Monthly Audit Reviewed by: _____ Title: _____

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken October 7, 2021
Regular Meeting of the CalOptima Board of Directors

Consent Calendar

8. Consider Authorizing and Directing Execution of Amendments to CalOptima's Primary and Secondary Agreements with the California Department of Health Care Services

Contacts

Carmen Dobry, Executive Director, Compliance, (657) 235-6997
Nancy Huang, Chief Financial Officer, (657) 235-6935

Recommended Action

Authorize and direct the Chairman of the Board of Directors to execute Amendments to the Primary Agreement between the California Department of Health Care Services (DHCS) and CalOptima related to the Fall and Base Amendments for Calendar Year (CY) 2021 and extend the termination dates of the Primary and Secondary Agreements between the DHCS and CalOptima.

Background

As a County Organized Health System (COHS), CalOptima contracts with DHCS to provide health care services to Medi-Cal beneficiaries in Orange County. In January 2009, CalOptima entered into a new five (5) year agreement with the California Department of Health Care Services (DHCS). Amendments to this agreement are summarized in the attached appendix, including Amendment 49, which extends the agreement through December 31, 2021. The agreement contains, among other terms and conditions, the payment rates CalOptima receives from DHCS to provide health care services. The Secondary Agreement's effective and expiration dates are consistent with CalOptima's Primary Agreement.

Discussion

CY 2021 Fall and Base Contract Amendments to the Primary Agreement (January 1, 2021 through December 31, 2021)

On June 18, 2021, DHCS provided managed care plans (MCPs) with a draft version of the Calendar Year (CY) 2021 Fall agreement amendment and notified MCPs that they will submit the amendment to the Centers for Medicare & Medicaid Services (CMS) at the end of November 2021. On February 4, 2021, DHCS provided MCPs with a draft version of the CY 2021 base agreement amendment and subsequently notified MCPs that they submitted this amendment to CMS on May 17, 2021. Both amendments will bring MCP agreements, including CalOptima's, into alignment with requirements effective January 1, 2021.

The agreement amendments contain notable language changes, and it is worth noting that DHCS has generally already implemented the requirements of the Fall and base agreement amendments by issuing sub-regulatory guidance such as All Plan Letters (APLs). Simultaneously, DHCS has

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been working with CMS to formalize the requirements in DHCS's agreements with MCPs, including CalOptima. DHCS's implementation of these requirements via sub-regulatory guidance prior to the formal inclusion of the requirements in MCP agreements is largely due to the lengthy CMS review process. While the contractual obligations are retroactive, CalOptima staff has implemented the required operational changes and other contractual requirements by following the DHCS APL guidance.

DHCS had already included CY 2021 Medi-Cal Classic, Optional Expansion (OE) and Coordinate Care Initiative (CCI) rate updates in its previous amendments. CY 2021 Fall and Base Contract Amendments do not contain any additional rate changes or otherwise set any rates DHCS has only shared boilerplate agreement amendments with CalOptima at this time and has noted that certain provisions of the boilerplate will be absent in the MCP-specific amendments that are ultimately provided for signature, as appropriate. If the final agreement amendments are not consistent with staff's understanding as presented in this document, or if it includes substantive and unexpected language changes, staff will return to the Board of Directors for subsequent consideration.

Following is a description of the changes contained within the CY 2021 Fall Amendment, sorted by category:

Category	Requirement	Sub-Regulatory Guidance
Provider Exclusions	-Verify that subcontractors and network providers have not been terminated as Medi-Cal or Medicare providers or have not been placed on provider exclusion lists. -MCPs must not maintain contracts with network providers or subcontractors who have been terminated by either Medicare or Medi-Cal, placed on the Suspended and Ineligible Provider List, or placed on a temporary suspension on the Restricted Provider Database	DHCS All-Plan Letter (APL) 21-003: Medi-Cal Network Provider and Subcontractor Terminations

Provider Network	-Attempt to contract with providers in adjoining counties outside of the service area, if necessary to ensure compliance with network adequacy standards. - Maintain an adequate network of adult and pediatric providers located within provider-specific time or distance standards. - Demonstrate how to arrange for Covered Services to Members through use of Non-Emergency Medical Transportation (NEMT), Non-Medical Transportation (NMT) and telehealth if time or distance standards are not met.	-DHCS APL 21-006: Network Certification Requirements
Network Provider Agreements and Subcontractor Agreements	-Updated language changes to better align Network Provider and Subcontractor distinction set forth in federal regulations. -Includes contract provisions incorporated into CalOptima's professional and health network boilerplate contracts.	-DHCS APL 19-001: Medi-Cal Managed Health Care Plan Guidance on Network Provider Status, Attachment A: Network Provider Agreement Boilerplate Checklist
Covered Services	-Establishes for those under 21 years of age that a treatment or service is medically necessary if it is necessary to correct or ameliorate defects and physical and mental illnesses or conditions under the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) standard. -All children's preventive services, including all confidential screening and billing reports for EPSDT screening, treatment and care coordination shall be reported as part of encounter data submissions. -Establishes that all covered and carved-out EPSDT services must be provided in a timely manner, but no later than 60 calendar days following the preventive screening or visit identifying a need for diagnosis or treatment.	DHCS APL 19 – 010: Requirements for Coverage of EPSDT Services for Medi-Cal Members Under the Age of 21 DHCS APL 20 – 012: Private Duty Nursing Case Management Responsibilities for Medi-Cal Eligible Members Under the Age of 21

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Capitation Payments	-Final capitation payment rates may be adjusted during or subsequent to the applicable rating period. -Annually provide satisfactory evidence of, and maintain a Financial Performance Guarantee in the form specified by DHCS.	N/A
Supplemental Payments	-Submit all required data to DHCS within 12 months of the month of service. -Include diagnosis date earlier than or equal to the service date for BHT supplemental payments.	N/A
Terminology Changes	Update terms and definitions used in the agreement.	N/A

Following is a description of the changes contained within the 2021 Base Amendment, sorted by category:

Category	**Requirement**	**Sub-Regulatory Guidance**
Access and Availability	- Provide notification to DHCS immediately upon discovery of a Provider initiated termination or at least 60 calendar days before making any changes in the availability or location of covered services to be provided under this agreement. - Provide notification to DHCS within 10 calendar days of learning of a Provider's exclusionary status from any database.	DHCS All-Plan Letter (APL) 21-003: Medi-Cal Network Provider and Subcontractor Terminations
Covered Services	-Ensure that members under the age of 21 receive all medically necessary care as required under Early and Periodic Screening, Diagnostic and Treatment (EPSDT). -Establishes that MCPs shall identify on a quarterly basis, all members under the age of six (6) with no record of receiving a blood lead screening test and the age in which the test was missed. -MCPs shall maintain records of all members identified quarterly as having no documentation of receiving a required blood	DHCS APL 20-016: Blood Lead Screening of Young Children

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	lead screening test, and provide those records to DHCS at least annually, and upon request. -Establishes that Network Providers shall document the reason for not obtaining a signed statement of voluntary refusal in the member's medical record.	
Written Member Information	-Updated guidance on the implementation of nondiscrimination and language assistance requirements.	DHCS APL 21-004: Standards for Determining Threshold Languages, Nondiscrimination Requirements, and Language Assistance Services
Budget Detail and Payment Provisions	-MCPs must cease work on any part of the scope of work under this agreement relating to a State program receiving Federal Financial Participation (FFP) that is no longer authorized by law.	
Cost Avoidance and Post – Payment Recovery (PPR)	- Updates to both MCP Cost Avoidance and PPR requirements including the following: -Relying on the Medi-Cal eligibility record for Cost Avoidance and PPR purposes. -Coordinating benefits for Other Health Coverage (OHC) programs or entitlements, recognizing OHC as primary and the Medi-Cal program as payor of last resort except for services in which Medi-Cal is required to be the primary payor. -Demonstrating to DHCS where MCPs do not perform PPR that the reasonably aggregate costs of PPR would exceed the total revenues the MCPs projects it would receive from PPR annually. -Updates to MCP Cost Avoidance requirements including the following: -Not paying claims for services provided to a member whose eligibility record indicates third party coverage,	-DHCS APL 21-002: Cost Avoidance and Post-Payment Recovery for Other Health Coverage

	designated by an OHC code or Medicare coverage, without proof that the provider has exhausted all sources of other payments. -Ensure providers do not refuse customer service to members when OHC is indicated on the member's Medi-Cal eligibility record. -Allow providers to direct bill services that meet DHCS's requirements for direct billing without attempting to Cost Avoid those services. - Inclusion of the OHC information for claims denied due to OHC. -Report new OHC information not found on the Medi-Cal eligibility file or is different from what is reflected on the Medi-Cal eligibility file to DHCS within ten (10) calendar days of discovery. Updates to MCP PPR requirements including the following: -Billing the OHC for the cost of actual services rendered for services that were not properly Cost Avoided. -Submission of a monthly PPR report to DHCS.	
Third – Party Tort Liability	-Information to DHCS must contain provider and member information as set forth in DHCS APL 21-007, or as provided in a form supplied by DHCS. -MCPs must include an attestation, signed by the custodian of records, or designee with knowledge of the member information provided to DHCS. -Refer requests from attorneys, insurers, or members for a lien to DHCS's Third Party Liability and Recovery Division. -Submission of service and utilization information through DHCS's secure file transfer protocol (SFTP) site.	DHCS APL 21-007: Third Party Tort Liability Reporting Requirements

Extension of the Termination Dates of the Primary and Secondary Agreements
DHCS will request CalOptima's execution of amendments to extend the termination date of CalOptima's Primary and Secondary Agreements from the current termination date of December 31, 2021 to December 31, 2022, or a later date identified by DHCS.

In order to be prepared to execute extensions to the Primary and Secondary Agreements, staff is requesting that the Board provide authority and direction to the Chair to execute amendments to the Primary and Secondary agreements to December 31, 2022, or a later end date as stated by DHCS. If the amendments are not consistent with Staff's understanding as presented in this document or if it includes substantive and unexpected language changes, staff will return to the Board of Directors for subsequent consideration.

Fiscal Impact
The recommended action to execute Fall and Base amendments to the Primary Agreement with DHCS and amendments to both the Primary and Secondary Agreements extending the termination dates to December 31, 2022, or at a later end date as stated by DHCS, are budgeted items, with no additional fiscal impact through June 30, 2022. Management plans to include funding for the period of July 1, 2022, through the end date of the agreements in future operating budgets.

Rationale for Recommendation
CalOptima's execution of the CY 2021 agreement amendments to its Primary Agreement and the extensions of the Primary and Secondary Agreements with DHCS are necessary for the continued operation of CalOptima's Medi-Cal program.

Concurrence
Gary Crockett, Chief Counsel

Attachments
1. Appendix summary of amendments to Primary Agreements with DHCS
2. 2021 Fall Amendment Final MCP Draft 6.17.21
3. 2021 Base Amendment Final MCP Draft 2.4.21

/s/ Richard Sanchez — *09/29/2021*
Authorized Signature — **Date**

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APPENDIX TO AGENDA ITEM 8

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

Amendments to Primary Agreement	Board Approval
A-01 provided language changes related to Indian Health Services, home and community-based services, and addition of aid codes effective January 1, 2009.	October 26, 2009
A-02 provided rate changes that reflected implementation of the gross premiums tax authorized by AB 1422 (2009) for the period January 1, 2009, through June 30, 2009.	October 26, 2009
A-03 provided revised capitation rates for the period July 1, 2009, through June 30, 2010; and rate increases to reflect the gross premiums tax authorized by AB 1422 (2009) for the period July 1, 2009, through June 30, 2010.	January 7, 2010
A-04 included the necessary contract language to conform to AB X3 (2009), to eliminate nine (9) Medi-Cal optional benefits.	July 8, 2010
A-05 provided revised capitation rates for the period July 1, 2010, through June 30, 2011, including rate increases to reflect the gross premium tax authorized by AB 1422 (2009), the hospital quality assurance fee (QAF) authorized by AB 1653 (2010), and adjustments for maximum allowable cost pharmacy pricing.	November 4, 2010
A-06 provided revised capitation rates for the period July 1, 2010, through June 30, 2011, for funding for legislatively mandated rate adjustments to Long Term Care facilities effective August 1, 2010; and rate increases to reflect the gross premiums tax on the adjusted revenues for the period July 1, 2010, through June 30, 2011.	September 1, 2011
A-07 included a rate adjustment that reflected the extension of the supplemental funding to hospitals authorized in AB 1653 (2010), as well as an Intergovernmental Transfer (IGT) program for Non-Designated Public Hospitals (NDPHs) and Designated Public Hospitals (DPHs).	November 3, 2011
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

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A-10 included contract language and capitation rates related to the transition of Healthy Families Program (HFP) subscribers into CalOptima's Medi-Cal program	December 6, 2012
A-11 provided capitation rates related to the transition of HFP subscribers into CalOptima's Medi-Cal program.	April 4, 2013
A-12 provided capitation rates for the period July 1, 2011 to June 30, 2012.	April 4, 2013
A-13 provided capitation rates for the period July 1, 2012 to June 30, 2013	June 6, 2013
A-14 extended the Primary Agreement until December 31, 2014	June 6, 2013
A-15 included contract language related to the mandatory enrollment of seniors and persons with disabilities, requirements related to the Balanced Budget Amendment of 1997 (BBA) and Health Insurance Portability and Accountability Act (HIPAA) Omnibus Rule	October 3, 2013
A-16 provided revised capitation rates for the period July 1, 2012, through June 30, 2013 and revised capitation rates for the period January 1, 2013, through June 30, 2014 for Phases 1, 2 and 3 transition of Healthy Families Program (HFP) children to the Medi-Cal program	November 7, 2013
A-17 included contract language related to implementation of the Affordable Care Act, expansion of Medi-Cal, the integration of the managed care mental health and substance use benefits and revised capitation rates for the period July 1, 2013 through June 30, 2014.	December 5, 2013
A-18 provided revised capitation rates for the period July 1, 2013, through June 30, 2014.	June 5, 2014
A-19 extended the Primary Agreement until December 31, 2015 and included language that incorporates provisions related to **Medicare Improvements for Patients and Providers Act** (MIPPA)-compliant contracts and eligibility criteria for Dual Eligible Special Needs Plans (D-SNPs)	August 7, 2014
A-20 provided revised capitation rates for the period July 1, 2012, through June 30, 2013, for funding related to the Intergovernmental Transfer (IGT) Agreement between CalOptima and the University of California, Irvine and Optional Targeted Low-Income Child Members	September 4, 2014
A-21 provided revised 2013-2014 capitation rates.	November 7, 2013
A-22 revised capitation rates for Fiscal Year (FY) 2013-14 and added an aid code to implement Express Lane/CalFresh Eligibility	November 6, 2014
A-23 revised ACA 1202 rates for January – June 2014, established base capitation rates for FY 2014-2015, added an aid code related to the OTLIC and AIM programs, and contained language revisions related to supplemental payments for coverage of Hepatitis C medications.	December 4, 2014
A-24 revises capitation rates to include SB 239 Hospital Quality Assurance Fees for the period January 1, 2014 to June 30, 2014.	May 7, 2015
A-25 extends the contract term to December 31, 2016. DHCS is obtaining a continuation of the services identified in the original agreement.	May 7, 2015

A-26 adjusts the 2013-2014 Intergovernmental Transfer (IGT) rates.	May 7, 2015
A-27 adjusts 2013-2014 capitation rates for Optional Expansion and SB 239.	May 7, 2015
A-28 incorporates language requirements and supplemental payments for BHT into primary agreement.	October 2, 2014
A-29 added optional expansion rates for January- June 2015; also added updates to MLR language.	April 2, 2015
A-30 incorporates language regarding Provider Preventable Conditions (PPC), determination of rates, and adjustments to 2014-2015 capitation rates with respect to Intergovernmental Transfer (IGT) Rate Range and Hospital Quality Assurance Fee (QAF).	December 1, 2016
A-31 extends the Primary Agreement with DHCS to December 31, 2020.	December 1, 2016
A-32 incorporates base rates for July 2015 to June 2016 with Behavioral Health Treatment (BHT) and Hepatitis–C supplemental payments, and Partial Dual/Medi-Cal only rates, and added aid codes 4U, and 2P–2U as covered aid codes.	February 2, 2017
A-33 incorporates base rates for July 2016 to June 2017.	February 2, 2017
A-34 incorporates revised Adult Optional Expansion rates for January 2015 to June 2015. These rates were revised to include the impact of the Hospital Quality Assurance Fee (HQAF) required by Senate Bill (SB) 239.	June 1, 2017
A–35 incorporates Managed Long–Term Services and Supports (MLTSS) into CalOptima's Primary Agreement with the DHCS.	March 6, 2014 February 2, 2017
A–36 incorporates revised base rates for July 2015 to June 2016.	December 7, 2017
A–37 incorporates revised base rates for July 2016 to June 2017.	February 7, 2019
A–38 incorporates full dual rates for Calendar Year (CY) 2015	August 1, 2019
A–39 incorporates full dual rates for Calendar Year (CY) 2016	August 1, 2019
A-40 incorporates Final Rule contract language.	June 1, 2017 February 6, 2020
A-41 incorporates base rates for July 2017 to June 2018, Transportation, American Indian Health Program, Mental Health Parity, CCI updates and Adult Expansion Risk Corridor language for SFY 2017-18.	December 7, 2017 June 7, 2018 February 6, 2020
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

The following is a summary of amendments to the Secondary Agreement approved by the CalOptima 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-10 extends the Secondary Agreement with DHCS to December 31, 2021	November 5, 2020

The following is a summary of amendments to Agreement 16-93274 approved by the CalOptima 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, 2023.	June 3, 2021

The following is a summary of amendments to Agreement 17–94488 approved by the CalOptima 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

V. Exhibit A, Attachment 1, ORGANIZATION AND ADMINISTRATION, Provision 5, is amended to read:

5. Medical Decisions

Contractor shall ensure that medical decisions, including those by ~~Sub-contractors~~ **Subcontractors, Network Providers,** and **other** rendering Providers, are not unduly influenced by fiscal and administrative management.

VI. Exhibit A, Attachment 2, FINANCIAL INFORMATION, Provision 11, is amended to read:

11. Fiscal Viability of ~~Subcontracting Entities~~ Subcontractors

Contractor shall maintain a system to evaluate and monitor the financial viability of ~~all risk-bearing subcontracting Provider groups~~ **Network Providers and Subcontractors that accept financial risk for the provision of Covered Services** including, but not limited to, ~~HMOs,~~ **Medi-Cal manage care plans,** independent ~~p~~**P**hysician/~~p~~**P**rovider associations ~~(IPAs)~~, medical groups, **risk-bearing organizations,** ~~and~~ Federally Qualified Health Centers (FQHC)**, and other clinics**.

VII. Exhibit A, Attachment 3, MANAGEMENT INFORMATION SYSTEM, is amended to read:

2. Encounter Data Reporting

B. Contractor shall implement policies and procedures for ensuring complete, accurate, ~~reasonable,~~ and timely submission of Encounter Data to DHCS for all items and services furnished to a Member under this Contract, whether directly or through ~~Subcontracts or other arrangements, including capitated Providers~~ **Network Provider Agreements or Subcontractor Agreements**. Encounter Data shall be submitted on at least a monthly basis in a form and manner specified by DHCS.

C. Contractor shall require Subcontractors**, Network** ~~and non-contracting~~ Providers**, and single-service Providers** to submit claims and Encounter Data to Contractor to meet its administrative functions and the requirements set forth in this Section. Contractor shall have in place mechanisms, including edit and reporting systems sufficient to assure Encounter Data is complete, accurate, ~~reasonable,~~ and timely prior to submission to DHCS. Contractor shall ensure the completeness, accuracy, ~~reasonability,~~ and timeliness of all **Network Provider,**

Subcontractor**, and single-service Provider** Encounter Data regardless of whether Subcontractor**, Network Provider, or single-service Provider** is reimbursed on a Fee-For-Service (FFS) or capitated basis.

D. Contractor shall submit complete, accurate, ~~reasonable,~~ and timely Encounter Data within six (6) business 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 shall review and validate the Encounter Data for completeness, accuracy, ~~reasonability,~~ and timeliness.

F. If DHCS finds deficiencies regarding the completeness, accuracy, ~~reasonability,~~ and timeliness of the Encounter Data, DHCS may notify Contractor in writing of the deficiency and request correction and resubmission of the relevant Encounter Data. Contractor shall ensure that corrected Encounter Data is resubmitted within 15 calendar days of the date of DHCS' notice. Upon Contractor's written request, DHCS may grant an extension for submission of corrected Encounter Data.

G. Contractor shall ensure all Encounter Data is submitted to DHCS within two (2) months of adjudication of a FFS claim or receipt of a capitated Encounter. Subcontractors**, Network Providers,** and **single-service** Providers must comply with this Provision for submission of Encounter Data to Contractor. All Encounter Data shall be submitted to Contractor no later than 12 months from the date of service.

6. Network Data Submissions

Contractor shall maintain a health information system that collects and reports Network data to DHCS in compliance with 42 CFR 438.207, 438.604(a)(5), 438.606, and in accordance with APL 1~~8~~**7**-005.

A. Contractor shall ensure the complete, accurate, ~~reasonable,~~ and timely submission of **its** Network data to DHCS for all data that represents Contractor's Network, whether through direct**ly or through Subcontractor Agreements or Network Provider Agreements** ~~Subcontracts, a Subcontractor's network , or other arrangements~~. Network data shall be submitted on at least a monthly basis**,** in the form and manner specified by DHCS.

B. For all data submissions required by 42 CFR 438.604, Contractor shall submit its certification of compliance concurrently with the submission of its data, documentation or information pursuant to 42

CFR 438.606(c). Contractor's certification(s) shall be certified by Contractor's Chief Executive Officer; Chief Financial Officer; or an individual who reports directly to the Chief Executive Officer or Chief Financial Officer with delegated authority to sign for the Chief Executive Officer or Chief Financial Officer. Contractor's Chief Executive Officer or Chief Financial Officer is solely responsible for the certification.

~~B~~**C**. Contractor shall require ~~subcontracting Providers~~ **all Network Providers and Subcontractors** to submit Network data to Contractor to meet its administrative functions and the requirements set forth in this Provision. Contractor shall have in place mechanisms, including edit and reporting systems sufficient to assure Network data is complete, accurate, ~~reasonable,~~ and timely prior to submission to DHCS. Contractor shall ensure the completeness, accuracy, ~~reasonability,~~ and timeliness of all Subcontractor ~~provider network~~ **and Network Provider** data regardless of contracting arrangements.

~~C~~**D**. Contractor shall submit complete, accurate, ~~reasonable,~~ and timely Network data within ten (10) calendar days following the end of each month under this Contract or as otherwise agreed upon by DHCS, and in the format specified by DHCS. Contractor shall certify all Network data as set forth in 42 CFR 438.606.

~~D~~**E**. DHCS shall review and validate Network data for completeness, accuracy, ~~reasonability,~~ and timeliness. If DHCS finds deficiencies regarding the completeness, accuracy, ~~reasonability,~~ and timeliness of the Network data, DHCS may notify Contractor in writing of the deficiency and request correction and resubmission of the relevant data. Contractor shall ensure that corrected Network data is resubmitted within 15 calendar days of the date of the DHCS notice. Upon Contractor's written request, DHCS may grant an extension for submission of corrected Network data.

VIII. Exhibit A, Attachment 4, PROVIDER NETWORK, is amended to read:

1. General Requirement

Contractor shall implement an effective Quality Improvement System (QIS) in accordance with the standards set forth in Title 28, CCR, Section 1300.70 and 42 CFR 438.330. Contractor shall monitor, evaluate, and take effective action to address any needed improvements in the quality of care delivered by all Providers rendering services on its behalf, in any setting. Contractor shall be

accountable for the quality of all Covered Services regardless of the number of contracting ~~and subcontracting~~ layers between Contractor and the Provider. ~~-~~This provision does not create a cause of action against ~~the~~ Contractor on behalf of a Medi-Cal beneficiary for malpractice committed by a Subcontractor **or a Network Provider**.

2. Accountability

Contractor shall maintain a system of accountability which includes the participation of the governing body of ~~the~~ Contractor's organization, the designation of a quality improvement committee with oversight and performance responsibility, the supervision of activities by the medical director, and the inclusion of contracted physicians and ~~contracted~~ **Network** Providers in the process of QIS development and performance review. ~~-~~Participation of non-contracting Providers is discretionary.

4. Quality Improvement Committee

A. Contractor shall implement and maintain a Quality Improvement Committee (QIC) designated by, and accountable to, the governing body; the committee shall be facilitated by the medical director or a physician designee. ~~-~~Contractor must ensure that Subcontractors **and Network Providers**, who are representative of the composition of the Provider Network including but not limited to ~~Subcontractors~~ **Network Providers** who provide health care services to Seniors and Persons with Disabilities and chronic conditions (such as asthma, diabetes, congestive heart failure), actively participate on the committee or medical sub-committee that reports to the QIC.

5. Provider Participation

Contractor shall ensure that ~~contracting physicians~~ **Network Providers** and other Providers from the community shall be involved as an integral part of the QIS. ~~-~~Contractor shall maintain and implement appropriate procedures to keep ~~contracting~~ **Network** Providers informed of the written QIS, its activities, and outcomes.

6. Delegation of Quality Improvement Activities

A. Contractor is accountable for all quality improvement functions and responsibilities (e.g. Utilization Management, Credentialing and Site Review) that are delegated to Subcontractors. ~~-~~If Contractor delegates quality improvement functions, Contractor and ~~delegated entity~~

~~(~~Subcontractor~~)~~ shall include in their Subcontract**or Agreement**, at a minimum:

B. Contractor shall maintain a system to ensure accountability for delegated quality improvement activities, that at a minimum:

3) Includes ~~the~~ **Contractor's** continuous monitoring, evaluation and approval of the delegated functions.

7. Written Description

Contractor shall implement and maintain a written description of its QIS that shall include the following:

D. ~~A description of the system for Provider review of QIS findings, which at a minimum, demonstrates physician and other appropriate professional involvement and includes provisions for providing feedback to staff and Providers, regarding QIS study outcomes.~~ **A process for sharing QIS findings with its Subcontractors and Network Providers.**

G. A description of the mechanisms used to continuously review, evaluate, and improve access to and availability of services. -The description shall include methods to ensure that Members are able to obtain appointments within established standards for time ~~and~~ **or** distance, timely access, and alternative access as defined in APL ~~20-003~~**21-006**, and W&I Code ~~s~~**S**ections 14197 and 14197.04.

9. External Quality Review Requirements

At least annually or as designated by DHCS, DHCS shall arrange for External Quality Review of Contractor by an entity qualified to conduct such reviews in accordance with Title 22 CCR Section 53860(d), Title 42, USC, Section 1396u-2(c)(2), and 42 CFR 438.350, 438.358, and 438.364. Contractor shall cooperate with and assist the External Quality Review Organization (EQRO) contracted with DHCS in the conduct of this review. Contractor shall comply with the following requirements, as well as the activities specified in APL 17-014, including the external quality review protocol issued by CMS which provides detailed instructions on how to complete the activities.

F. Encounter Data Validation

At intervals determined by DHCS, its contracted EQRO will conduct a validation of Encounter Data assessing the completeness, accuracy,

~~reasonability,~~ and timeliness of Encounter Data submitted by Contractor to DHCS.

10. Site Review

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 ~~the~~ Contractor's Provider Network. ~~-~~If a Provider is added to Contractor's Provider Network, and the Provider site has a current passing site review survey score, a site survey need not be repeated for **Network** Provider credentialing or recredentialing.

F. Continuing Oversight

Contractor shall retain accountability for all site review activities whether carried out by Contractor, completed by other Medi-Cal Managed Care contractors or ~~delegated to other entities~~ **Subcontractors**.

12. Credentialing and Recredentialing

Contractor shall implement and maintain written policies and procedures concerning the initial credentialing, recredentialing, recertification, and reappointment of Network Providers, developed by the Department in accordance with 42 CFR 438.214 and APL 16-012, and including but not limited to: ~~-~~Primary Care Physicians (PCP); Specialists; Providers for acute, behavioral health, and substance use disorders; and MLTSS Providers as appropriate per the requirements in Exhibit A, Attachment 21, Managed Long Term Services and Supports, Provision 4, Provider Network. ~~-~~Contractor shall ensure those policies and procedures are reviewed and approved by the governing body, or designee. Contractor shall ensure that the responsibility for recommendations regarding credentialing decisions will rest with a credentialing committee or other peer review body.

C. Credentialing Provider Organization Certification

Contractor and their Subcontractors ~~(e.g. a medical group or independent physician organization)~~ **and Network Providers** may obtain credentialing provider organization certification (POC) from the National Committee on Quality Assurance (NCQA). ~~-~~Contractor may accept evidence of NCQA POC certification in lieu of a monitoring visit at delegated physician organizations.

E. Medi-Cal and Medicare Provider Status

Contractor will verify that ~~their subcontracted~~ **its Subcontractors and Network** Providers have not been terminated as Medi-Cal or Medicare Providers or have not been placed on the Suspended and Ineligible Provider List **or Restricted Provider Database**. ~~Terminated providers in either Medicare or Medi-Cal or on the Suspended and Ineligible Provider List, cannot participate in Contractor's Provider Network.~~ **Contractor must not maintain contracts with Network Providers or Subcontractors who have been terminated by either Medicare or Medi-Cal, placed on the Suspended and Ineligible Provider List, or placed on a temporary suspension on the Restricted Provider Database.**

IX. Exhibit A, Attachment 5, UTILIZATION MANAGEMENT, is amended to read:

1. Utilization Management Program

Contractor shall develop, implement, and continuously update and improve, a Utilization Management (UM) program that ensures appropriate processes are used to review and approve the provision of Medically Necessary Covered Services. Contractor is responsible to ensure that the UM program includes:

B. The separation of medical decisions from fiscal and administrative management to assure those medical decisions will not be unduly influenced by fiscal and administrative management. Compensation of ~~staff or Subcontractors~~ **individuals or entities** that conduct UM activities shall not be structured to provide incentives to deny, limit, or discontinue Medically Necessary services.

D. Established criteria for approving, modifying, deferring, or denying requested services. Contractor shall utilize evaluation criteria and standards to approve, modify, defer, or deny services. Contractor shall document the manner in which **Subcontractors and Network** Providers are involved in the development and or adoption of specific criteria used by Contractor.

F. An established specialty referral system to track and monitor referrals requiring prior authorization through Contractor. The system shall include authorized, denied, deferred, or modified referrals, and the timeliness of the referrals. This specialty referral system should include non-contracting Providers.

Contractor shall ensure that all ~~contracting health care practitioners~~ **Network Providers** are aware of the referral processes and tracking procedures.

I. Contractor shall make its UM or utilization review policies and procedures available to Members and Providers. These policies and procedures shall cover how Contractor, Subcontractors, or ~~any contracted entity,~~ **Network Providers** authorize, modify, delay, or deny health care services via Prior Authorization, concurrent authorization, or retrospective authorization, under the benefits provided by Contractor.

3) Contractor shall notify ~~contracting health care~~ **Network** Providers, as well as Members and Potential Enrollees upon request, of all services that require Prior Authorization, concurrent authorization, or retrospective authorization, and ensure that all ~~contracting health care~~ **Network** Providers are aware of the procedures and timeframes necessary to obtain authorization for these services**.**

These activities shall be done in accordance with Health and Safety Code Sections 1363.5 and 1367.01 and Title 28~~,~~ CCR~~,~~ Section 1300.70(b)(2)(H) & (c).

3. Timeframes for Medical Authorization

H. Expedited Authorizations: ~~For requests in which a Provider indicates, or Contractor or a Subcontractor~~ **Contractor must make expedited authorization decisions for service requests where a Member's Provider indicates, or Contractor, Subcontractor, or Network Provider** determines that, following the standard timeframe for Prior Authorizations could seriously jeopardize the Member's life or health or ability to attain, maintain, or regain maximum function, ~~the~~ Contractor must make an expedited authorization decision and provide notice as expeditiously as the Member's health condition requires and not later than 72 hours after receipt of the request for services. ~~The~~ Contractor may extend the 72 hours' time period by up to 14 calendar days if the Member requests an extension, or if ~~the~~ Contractor justifies, to the satisfaction of DHCS upon request, a need for additional information and how the extension is in the Member's interest. ~~-~~Any decision delayed beyond the time limits is considered a denial and must be immediately processed as such.

X. Exhibit A, Attachment 6, PROVIDER NETWORK, is amended to read:

2. Network Composition

~~Within each Service Area,~~ Contractor shall ensure and monitor an appropriate Provider Network **within its Service Area in compliance with W&I Code Section 14197, and if necessary to ensure compliance with Network adequacy requirements in this Contract, attempt to contract with Providers in adjoining counties outside of Contractor's Service Area. Contractor's Network must** ~~including~~ **include**, but not **be** limited to, adult and pediatric PCPs, OB/GYN, adult and pediatric behavioral health Providers, adult and pediatric Specialists, professional, Allied Health Personnel, supportive paramedical personnel, hospitals, pharmacies and an adequate number of accessible inpatient facilities and service sites. In addition, Contractor shall ensure and monitor MLTSS Providers, American Indian Health Service Programs, Federally Qualified Health Centers (FQHCs), Rural Health Clinics (RHCs), and Freestanding Birthing Centers (FBCs), where available. Contractor shall submit assurances to DHCS regarding its Network composition in accordance with 42 CFR 438.207.

7. Federally Qualified Health Center (FQHC), Rural Health Clinic (RHC), and Freestanding Birth Center (FBC) Services

Contractor shall meet federal requirements for access to FQHC, RHC, and FBC services as a mandatory service and benefit, including those in 42 USC Section 1396 b(m). Contractor must include at least one (1) FQHC, one (1) RHC, and one (1) FBC in the Provider Network within Contractor's Service Area, to the extent that the FQHC, RHC and FBC Providers are licensed and recognized under State law and they are available within Contractor's Service Area. Contractor shall reimburse FQHCs, RHCs, and FBCs in accordance with Exhibit A, Attachment 8, Provider Compensation Arrangements, Provision 7. ~~-~~If FQHC, RHC, or FBC services are not available in the Provider Network, Contractor shall reimburse FQHCs, RHCs, and FBCs for services provided out-of-Network to Contractor's Members at a rate determined by DHCS. ~~-~~If FQHC, RHC, or FBC services are not available in Contractor's Provider Network, but are available within DHCS' time ~~and~~ **or** distance standards for access to Primary Care for Contractor's Members in the Service Area, Contractor shall not be obligated to reimburse FQHCs, RHCs, or FBCs for services provided out-of-Network to Members, unless authorized by Contractor.

8. Time ~~and~~ or Distance Standards

A. Contractor shall meet time ~~and~~ **or** distance standards for adult and pediatric PCPs, adult and pediatric core Specialists, OB/GYN primary and specialty care, adult and pediatric **outpatient** mental ~~outpatient~~ health

Providers, hospitals, and pharmacies based on county population density and as required by W&I Code Section 14197. For MLTSS, Contractor shall adhere to timely access standards in accordance with ~~Welfare and Institutions~~ **W&I** Code~~,~~ Section 14197(d)(2).

B. Contractor must either exhaust all other reasonable options for contracting with Providers**, including Providers in adjoining counties outside of Contractor's Service Area,** ~~such as a Member-specific case agreement with an Out-of-Network Provider~~ or demonstrate to DHCS that its delivery structure is capable of delivering the appropriate level of care and access as required by W&I Code **S**~~s~~ection 14197 prior to submitting an Alternate Access Standard (AAS) request to DHCS to meet time ~~and~~ **or** distance standards.

C. If Contractor is unable to comply with the time ~~and~~ **or** distance standards set forth in W&I Code ~~s~~**S**ection 14197, Contractor must submit an AAS request to DHCS for review and approval in accordance with APL ~~20-003~~ **21-006** detailing how it intends to arrange for Covered Services in accordance with W&I Code ~~s~~**S**ection 14197(e)(3).

D. If Contractor has received an AAS approval for a core Specialist from DHCS, upon a Member's request**,** Contractor shall assist the Member in obtaining an appointment with the appropriate core **S**~~s~~pecialist in accordance with W&I Code **S**~~s~~ection 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 the next closest county within the time ~~and~~ **or** distance standards in accordance with W&I Code **Section** 14197.04. ~~If needed, Contractor must assist in arranging transportation for the Member.~~ **Contractor shall 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 Specialists, and outpatient mental health Providers, in accordance with W&I Code Section 14197(f)(2).** Contractor shall not be held liable for fulfilling these requirements if either there is no core Specialist within the time ~~and~~ **or** distance standards of this Contract, or the core Specialist has refused such efforts within the previous 12 months.

11. Provider Network Reports

Contractor shall submit to DHCS, in a format specified by DHCS, a report summarizing changes in the Provider Network.

A. The report shall be submitted at a minimum:

2) At the time of a Significant Change, as defined in this Contract and set forth in 42 CFR 438.207 and APL ~~20-003~~ **21-006**, to the Network affecting Provider capacity and services, including:

D. Contractor shall participate annually in the submission to DHCS of its Provider Network composition report to demonstrate its capacity to serve the current and expected membership in its Service Area in accordance with State standards for access and timeliness of care, 42 CFR 438.207(b), and APL ~~20-003~~ **21-006**.

1) Contractor shall demonstrate how it will arrange for Covered Services to Members through the use of NEMT, NMT, and Telehealth if Contractor does not meet time ~~and~~ **or** distance standards for adult and pediatric PCPs, core ~~s~~**S**pecialist and outpatient mental health ~~p~~**P**roviders in accordance with W&I ~~s~~**S**ection 14197(f)(2).

12. ~~Plan Subcontractors~~ Subcontractor Reports

Contractor shall submit to DHCS, a quarterly report containing the names of all ~~direct subcontracting provider groups~~ **Subcontractors,** including health maintenance organizations, independent physician associations, medical groups, and FQHCs and their ~~sub~~contracting health maintenance organizations, independent physician associations, medical groups, and FQHCs. ~~-~~The report must be sorted by Subcontractor type, indicating the county or counties in which Members are served. ~~-~~In addition, the report should also indicate where relationships or affiliations exist between direct and indirect Subcontractors. ~~-~~The report shall be submitted within 30 calendar days following the end of the reporting quarter.

14. ~~Subcontracts~~ Network Provider Agreements and Subcontractor Agreements

Contractor may enter into ~~Subcontracts~~ **Network Provider Agreement and Subcontractor Agreements** with other entities in order to fulfill the obligations of the Contract. Contractor shall maintain policies and procedures, approved by DHCS, to ensure that **Network Providers and** Subcontractors fully comply with all terms and conditions of this Contract. Contractor shall evaluate the prospective **Network Providers and** Subcontractor's ability to perform the ~~sub~~contracted services, shall oversee and remain responsible and accountable

for any functions and responsibilities delegated and shall meet the ~~sub~~contracting requirements as stated in 42 CFR 438.230(b)(1), (c)(1)(i)-(iv), (c)(2), (c)(3), Title 22 CCR Section 53867, APL 17-004 and this Contract.

A. Laws and Regulations

All ~~Subcontracts~~ **Network Provider Agreements and Subcontractor Agreements** shall be in writing and in accordance with the requirements of the 42 CFR 438.230(c)(1)(i)-(iv), Knox-Keene Health Care Services Plan Act of 1975, Health and Safety Code Section 1340 et seq.; Title 28 CCR Section 1300 et seq.; W&I Code Section 14200 et seq.; Title 22 CCR Section 53800 et seq.; and other applicable federal and State laws and regulations.

~~B. Subcontract Requirements~~

~~Each Subcontract as defined in Exhibit E, Attachment 1, shall contain:~~

~~1) Specification of the services to be provided by the Subcontractor.~~

~~2) Specification that the Subcontract shall be governed by and construed in accordance with all laws and applicable regulations governing this Contract.~~

~~3) Specification that the Subcontract or Subcontract amendments shall become effective only as set forth in Paragraph C. Departmental Approval – Non-Federally Qualified HMOs, or Paragraph D, Departmental Approval – Federally Qualified HMOs.~~

~~4) Specification of the term of the Subcontract, including the beginning and ending dates as well as methods of extension, renegotiation and termination.~~

~~5) Language comparable to Exhibit A, Attachment 8, Provision 13. Contracting & Non-Contracting Emergency Service Providers & Post-Stabilization, for those Subcontractors at risk for non-contracting emergency services.~~

~~6) Subcontractor's agreement to submit reports as required by Contractor.~~

~~7) Specification that the Subcontractor shall comply with all monitoring provisions of this Contract and any monitoring requests by DHCS.~~

8) ~~Subcontractor's agreement to make all of its premises, facilities, equipment, books, records, contracts, computer and other electronic systems pertaining to the goods and services furnished under the terms of the Subcontract, 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, Attachment 2, Provision 20. Inspection Rights:~~

   a) ~~By DHCS, CMS, Department of Health and Human Services (DHHS) Inspector General, the Comptroller General, Department of Justice (DOJ), DMHC, or their designees.~~

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

   c) ~~In a form maintained in accordance with the general standards applicable to such book or record keeping.~~

   d) ~~For a term of at least 10 years from the final date of the Contract period or from the date of completion of any audit, whichever is later.~~

   e) ~~Including all Encounter Data for a period of at least 10 years.~~

   f) ~~If DHCS, CMS, or the DHHS Inspector General determines there is a reasonable possibility of fraud or similar risk, DHCS, CMS, or the DHHS Inspector General may inspect, evaluate, and audit the Subcontractor at any time.~~

   g) ~~Upon resolution of a full investigation of fraud, DHCS reserves the right to suspend or terminate the Subcontractor from participation in the Medi-Cal program; seek recovery of payments made to the Subcontractor; impose other sanctions authorized by State and federal law, this Contract and the State Plan, and direct Contractor to terminate their Subcontract due to fraud.~~

9) ~~Full disclosure of the method and amount of compensation or other consideration to be received by the Subcontractor from Contractor.~~

10) ~~Subcontractor's agreement to maintain and make available to~~

~~DHCS, upon request, copies of all sub-subcontracts and to ensure that all sub-subcontracts are in writing and require that the Subcontractor:~~

~~a) Make all premises, facilities, equipment, applicable books, records, contracts, computer, or other electronic systems related to this Contract, available at all reasonable times for audit, inspection, examination, or copying by DHCS, CMS, or the DHHS Inspector General, the Comptroller General, DOJ, and DMHC, or their designees.~~

~~b) Retain all records and documents for a minimum of 10 years from the final date of the Contract period or from the date of completion of any audit, whichever is later.~~

~~11) Subcontractor's agreement to assist Contractor in the transfer of care pursuant to Exhibit E, Attachment 2, Provision 15. Phase out Requirements, Subparagraph B in the event of Contract termination.~~

~~12) Subcontractor's agreement to assist Contractor in the transfer of care in the event of sub-subcontract termination for any reason.~~

~~13) Subcontractor's agreement to notify DHCS in the event the agreement with Contractor is amended or terminated. Notice is considered given when properly addressed and deposited in the United States Postal Service as first-class registered mail, postage attached.~~

~~14) Subcontractor's agreement that assignment or delegation of the Subcontract will be void unless prior written approval is obtained from DHCS.~~

~~15) Subcontractor's agreement to hold harmless both the State and Members in the event Contractor cannot or will not pay for services performed by the Subcontractor pursuant to the Subcontract.~~

~~16) Subcontractor's agreement to timely gather, preserve and provide to DHCS, any records in the Subcontractor's possession, in accordance with Exhibit E, Attachment 2, Provision 25. Records Related to Recovery for Litigation.~~

~~17) Subcontractor's agreement to provide interpreter services for~~

~~Members at all Provider sites.~~

~~18) Subcontractor's right to submit a grievance and Contractor's formal process to resolve Provider Grievances.~~

~~19) Subcontractor's agreement to participate and cooperate in Contractor's Quality Improvement System.~~

~~20) If Contractor delegates Quality Improvement activities, Subcontract shall include those provisions stipulated in Exhibit A, Attachment 4, Provision 6. Delegation of Quality Improvement Activities.~~

~~21) Subcontractor's agreement to comply with all applicable requirements of the DHCS, Medi-Cal Managed Care Program.~~

~~22) Subcontractor's agreement to revoke the delegation of activities or obligations, or specify other remedies in instances where DHCS or Contractor determine that the Subcontractor has not performed satisfactorily.~~

~~23) To the extent that the Subcontractor is responsible for the coordination of care for Members, Contractor's agreement to share with the Subcontractor any utilization data that DHCS has provided to Contractor, and the Subcontractor's agreement to receive the utilization data provided and use as they are able for the purpose of Member care coordination.~~

~~24) Contractor's agreement to inform the Subcontractor of prospective requirements added by DHCS to this Contract before the requirement would be effective, and Subcontractor's agreement to comply with the new requirements within 30 days of the effective date, unless otherwise instructed by DHCS and to the extent possible.~~

B. 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) Specification of the term of the agreement, including the beginning and ending dates as well as methods of extension, renegotiation, Phaseout, and termination;

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

4) Specification that the agreement shall be governed by and construed in accordance with all applicable laws and regulations governing this Contract, including but not limited to, Knox-Keene Health Care Services Plan Act of 1975, Health and Safety Code Section 1340 *et seq.* (unless expressly excluded under this Contract); Title 28 CCR Section 1300.43 *et seq.*; W&I Code Sections 14000 and 14200 *et seq.*; and Title 22 CCR Sections 53800 *et seq.*;

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

7) Network Providers 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 Providers 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, Attachment 2, Provision 19,

Audit and Exhibit E, Attachment 2, Provision 20, Inspection Rights:

a) In accordance with inspections and audits, as directed by DHCS, CMS, DHHS Inspector General, the Comptroller General, Department of Justice (DOJ), DMHC, or their designees; and

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

9) Network Providers 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 of at least ten (10) years from the final date of the Contract period or from the date of completion of any audit, whichever is later;

10) Network Providers will timely gather, preserve and provide to DHCS, CMS, 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, Attachment 2, Provision 25, Records Related to Recovery for Litigation;

11) Network Providers will assist Contractor, or if applicable a Subcontractor, in the transfer of a Member's care in accordance with Exhibit E, Attachment 2, Provision 15, Phaseout Requirements, in the event of Contract termination, or in the event of termination of the Network Provider for any reason;

12) Specification that the Network Provider Agreement will be terminated, or subject to other remedies, if DHCS or Contractor determine that the Network Provider has not performed satisfactorily;

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

14) Network Providers will not bill Members for Medi-Cal Covered Services;

15) Contractor must inform Network Providers 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 Providers to comply with the new requirements within 30 calendar days of the effective date, unless otherwise instructed by DHCS;

16) Network Providers to ensure that cultural competency, sensitivity, health equity, and diversity training is provided for employees and staff at key points of contact with Members;

17) Network Providers to provide interpreter services for Members and comply with language assistance standards developed pursuant to Health and Safety Code Section 1367.04;

18) Network Providers must notify Contractor, and Contractor's Subcontractor, within ten (10) 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 E, Attachment 2, Provision 26, Fraud and Abuse Reporting;

19) Network Providers must:

a) Report to Contractor or Contractor's Subcontractor when it has received an Overpayment;

b) Return the Overpayment to Contractor or Contractor's Subcontractor within 60 calendar days of the date the Overpayment was identified; and

c) Notify Contractor or Contractor's Subcontractor in writing, the reason for the Overpayment in accordance with Exhibit E, Attachment 2, Provision 34, Treatment of Recoveries, and 42 CFR section 438.608(d)(2); and

20) Confirmation of a Network Provider's right to all protections afforded them under the Health Care Providers' Bill of Rights,

including, but not limited to a Network Provider's right to access Contractor's dispute resolution mechanism and submit a grievance pursuant to Health and Safety Code Section 1367(h)(1).

C. Subcontractor Agreement Requirements

Subcontractor Agreements must contain the following provisions, as applicable to the specific obligations and functions that Contractor delegates in the Subcontractor Agreement:

1) Specification of Contractor's obligations and functions undertaken by the Subcontractor;

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

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

4) Specification that the Subcontractor Agreement and amendments thereto shall become effective only as set forth in Exhibit A, Attachment 6;

5) Subcontractor's assignment or delegation of the Subcontractor Agreement is void unless prior written approval is obtained from DHCS;

6) Specification that the Subcontractor Agreement shall be governed by and construed in accordance with all applicable laws and regulations governing this Contract, including but not limited to 42 CFR section 438.230; Knox-Keene Health Care Services Plan Act of 1975, Health and Safety Code Section 1340 *et seq.* (unless otherwise expressly excluded under this Contract); Title 28 CCR Section 1300.43 *et seq.*; W&I Code Section 14000 *et seq.*; and Title 22 CCR Section 53800 *et seq.*;

7) Subcontractor 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, including but not limited to, all applicable Medicaid and Medi-Cal laws, regulations, sub-

regulatory guidance, APLs, and the provisions of this Contract;

8) Language comparable to Exhibit A, Attachment 8, Provision 13, Contracting and Non-Contracting Emergency Providers & Post-Stabilization, for those Subcontractors obligated to reimburse Providers of Emergency Services;

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

10) Subcontractor will comply with all monitoring provisions of this Contract and any monitoring requests by DHCS;

11) Subcontractor will 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;

12) Subcontractor must make all of its premises, facilities, equipment, books, records, contracts, computer and other electronic systems pertaining to the obligations and functions undertaken pursuant to the Subcontractor Agreement, available for the purpose of an audit, inspection, evaluation, examination or copying, including but not limited to Access Requirements and State's Right to Monitor, as set forth in Exhibit E, Attachment 2, Provision 19, Audit, and Exhibit E, Attachment 2, Provision 20, Inspection Rights:

a) In accordance with inspections and audits, as directed by DHCS, CMS, DHHS Inspector General, the Comptroller General, DOJ, DMHC, or their designees; and

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

13) Subcontractor 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 of at least ten (10) years from the final date of the Contract period or from the date of completion of any audit, whichever is later;

14) Subcontractor will 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, Attachment 2, Provision 25, Records Related to Recovery for Litigation;

15) Subcontractor will assist Contractor in the transfer of a Member's care as needed, and in accordance with Exhibit E, Attachment 2, Provision 15, Phaseout Requirements, in the event of Contract termination for any reason;

16) Subcontractor will notify DHCS in the event the Subcontractor Agreement is amended or terminated for any reason;

17) Subcontractor will hold harmless both the State and Members in the event Contractor, or another Subcontractor as applicable, cannot or will not pay for the obligations and functions undertaken pursuant to the Subcontractor Agreement;

18) Subcontractor will participate and cooperate in Contractor's Quality Improvement System;

19) If Subcontractor takes on Quality Improvement activities, the Subcontractor Agreement shall include those provisions stipulated in Exhibit A, Attachment 4, Provision 6, Delegation of Quality Improvement Activities;

20) To the extent Subcontractor undertakes coordination of care obligations and functions for Members, an agreement to share with Subcontractor any utilization data that DHCS has provided to Contractor, and agreement by the Subcontractor's to receive the utilization data provided and use it solely for the purpose of Member Care Coordination;

21) Contractor will 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;

22) Subcontractor will ensure that cultural competency, sensitivity, health equity, and diversity training is provided for Subcontractor's staff at key points of contact with Members;

23) Subcontractor, to the extent Subcontractor communicates with Members, will provide interpreter services for Members, and to comply with language assistance standards developed pursuant to Health and Safety Code Section 1367.04;

24) Subcontractor will notify Contractor within ten (10) 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 E, Attachment 2, Provision 26, Fraud and Abuse Reporting;

25) Subcontractor will:

a) Report to Contractor when it has received an Overpayment;

b) Return the Overpayment to Contractor within 60 calendar days after the date the Overpayment was identified; and

c) Notify Contractor in writing, the reason for the Overpayment (42 CFR section 438.608(d)(2));

26) Subcontractor will perform the obligations and functions of Contractor undertaken pursuant to the 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

27) Express agreement and acknowledgement by Subcontractor that DHCS is a direct beneficiary of the Subcontractor Agreement with respect to all obligations and functions undertaken pursuant to that Subcontractor Agreement, and that DHCS may directly enforce any and all provisions of the Subcontractor Agreement.

~~C~~**D**. Departmental Approval - Non-Federally Qualified HMOs

1) Except as provided in Exhibit A, Attachment 8, Provider Compensation Arrangements, Provision 7 regarding Federally Qualified Health Centers and Rural Health Clinics, ~~a Provider or management~~ Subcontract**or Agreement** entered into by Contractor which is not a federally qualified HMO shall become effective upon approval by DHCS in writing, or by operation of law where DHCS has acknowledged receipt of the proposed Subcontract**or Agreement**, and has failed to approve or disapprove the proposed Subcontract**or Agreement** within 60 calendar days of receipt. Within five (5) ~~working days~~ **Working Days** of receipt, DHCS shall acknowledge in writing the receipt of any material sent to DHCS by Contractor for approval.

2) Subcontract**or Agreement** amendments shall be submitted to DHCS for prior approval at least 30 calendar days before the effective date of any proposed changes governing compensation, services, or term. ~~-~~Proposed changes which are neither approved or disapproved by DHCS, shall become effective by operation of law 30 calendar days after DHCS has acknowledged receipt or upon the date specified in the Subcontract**or Agreement** amendment, whichever is later.

~~D~~**E**. Departmental Approval - Federally Qualified HMOs

Except as provided in Exhibit A, Attachment 8, Provider Compensation Arrangements, Provision 7 regarding Federally Qualified Health Centers and Rural Health Clinics, ~~Subcontracts~~ **Subcontractor Agreements** entered into by Contractor which is a federally qualified HMO shall be:

~~E~~**F**. Public Records

~~Subcontracts~~ **Network Provider Agreements and Subcontractor Agreements** entered into by Contractor and all information received in accordance with the ~~Subcontract~~ **Network Provider Agreements and**

Subcontractor Agreements, to the extent such agreements are received by DHCS, will be public records on file with DHCS, except as specifically exempted in statute. ~~-~~DHCS shall ensure the confidentiality of information and contractual provisions filed with DHCS which are specifically exempted by statute from disclosure, in accordance with the statutes providing the exemption. ~~-~~The names of the officers and owners of the Subcontractor, stockholders owning more than five (5) percent of the stock issued by the Subcontractor and major creditors holding more than five (5) percent of the debt of the Subcontractor will be attached to the Subcontract**or Agreement** at the time the Subcontract**or Agreement** is presented to DHCS.

15. ~~Subcontracts~~ Network Provider Agreements and Subcontractor Agreements with Federally Qualified Health Centers and Rural Health Clinics (FQHC/RHC)

~~Subcontracts~~ **Network Provider Agreements and Subcontractor Agreements** with FQHCs shall also meet ~~Subcontract~~ **the** requirements of Provision ~~13~~ **14** above and reimbursement requirements in Exhibit A, Attachment 8, Provision 7. In ~~Subcontracts~~ **Network Provider Agreements and Subcontractor Agreements** with FQHCs and RHCs where a negotiated reimbursement rate is agreed to as total payment, a provision that such rate constitutes total payment shall be included in the ~~Subcontract~~ **Network Provider Agreements and Subcontractor Agreements**.

17. Network Provider Agreements with Safety-Net Providers ~~Subcontracts~~

Contractor shall offer a ~~Subcontract~~ **Network Provider Agreement** to any Safety-Net Provider that agrees to provide its scope of services in accord with the same terms and conditions that ~~the~~ Contractor requires of other similar Providers.

18. Termination of Safety-Net Provider ~~Subcontract~~ Network Provider Agreement

Contractor shall notify DHCS of intent to terminate a ~~Subcontract~~ **Network Provider Agreement** with a Safety-Net Provider at least 30 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 shall be effective immediately, without DHCS prior approval, and Contractor shall notify DHCS concurrently with the termination.

XI. Exhibit A, Attachment 7, PROVIDER RELATIONS, is amended to read:

1. Exclusivity

Contractor shall not, by use of an exclusivity provision, clause, agreement, or in any other manner, prohibit any ~~Subcontractor~~ **Network Provider Agreement** from providing services to Medi-Cal beneficiaries who are not Members of ~~the~~ Contractor's plan. This prohibition is not applicable to contracts entered into between Contractor and Knox-Keene licensed health care service plans.

2. Provider Grievance

Contractor shall have a formal procedure to accept, acknowledge, and resolve Provider grievances. ~~-~~A Provider of medical services may submit to Contractor a grievance concerning the authorization or denial of a service; denial, deferral or modification of a prior authorization request on behalf of a Member; or the processing of a payment or non-payment of a claim by ~~the~~ Contractor. ~~-~~This process shall be communicated to ~~contracting, subcontracting,~~ **Network Provider Agreement** and non-contracting Providers.

4. Contractor's Provider Manual

Contractor shall issue a provider manual to ~~the contracting and subcontracting Providers of health care services~~ **Network Provider Agreement** that includes information and updates regarding Medi-Cal services, policies and procedures, statutes, regulations, telephone access, special requirements, and the Member Grievance, Appeal, and State Fair Hearing process. Contractor's provider manual shall include the following Member rights information:

XII. Exhibit A, Attachment 8, PROVIDER COMPENSATION ARRANGEMENTS, is amended to read:

1. Compensation

Contractor may compensate Providers as Contractor and Provider negotiate and agree. ~~-~~Unless DHCS objects, compensation may be determined by a percentage of ~~the~~ Contractor's payment from DHCS. ~~-~~This provision will not be construed to prohibit ~~Subcontracts~~ **Contractor from entering into agreements** in which compensation or other consideration is determined to be on a capitation basis.

2. Capitation Payments

~~Capitation p~~**P**ayments by a Contractor to a ~~Primary Care Provider or clinic contracting with the Contractor~~ **Network Provider** on a capitation basis shall be payable effective the date of the Member's enrollment where the Member's assignment to or selection of a ~~Primary Care Provider or clinic~~ **Network Provider** has been confirmed by ~~the~~ Contractor. ~~-~~However, capitation payments by a Contractor to a ~~Primary Care Provider or clinic~~ **Network Provider** for a Member whose assignment to or selection of a ~~Primary Care Provider or clinic~~ **Network Provider** was not confirmed by ~~the~~ Contractor on the date of the ~~beneficiary's~~ **Member's** enrollment, but is later confirmed by ~~the~~ Contractor, shall be payable no later than 30 calendar days after the Member's enrollment.

4. Identification of Responsible Payor

Contractor shall provide the information that identifies the payor responsible for reimbursement of services provided to a Member enrolled in Contractor's Medi-Cal Managed Care health plan to DHCS' Fiscal Intermediary (FI) contractor. Contractor shall identify the **Network Provider or** Subcontractor ~~(if applicable) or Independent Physician Association (IPA)~~ responsible for payment, and the ~~Primary Care~~ Provider name and telephone number responsible for providing care. ~~-~~Contractor shall provide this information in a manner prescribed by DHCS once DHCS and the FI contractor have implemented the enhancement to the California Automated Eligibility Verification and Claims Management System (CA-AEV/CMS).

5. Claims Processing

Contractor shall pay all claims submitted by ~~contracting~~ **Network** Providers in accordance with this section, unless the ~~contracting~~ **Network** Provider and Contractor have agreed in writing to an alternate payment schedule.

C. Contractor shall maintain procedures for prepayment and post payment claims review, including review of data related to **Network** Provider, Member and Covered Services for which payment is claimed.

7. Federally Qualified Health Centers (FQHC), Rural Health Clinics (RHC), and American Indian Health Service Programs~~.~~

A. FQHCs Availability and Reimbursement Requirement

If FQHC services are not available in the Provider Network of any Medi-Cal Managed Care Health Plan in the county, Contractor shall reimburse non-contracting FQHCs for services provided to Contractor's Members at a level and amount of payment that is not less than ~~the~~ Contractor makes

for the same scope of services furnished by a Provider that is not a FQHC or RHC. If FQHC services are not available in Contractor's Provider Network, but are available within DHCS' time ~~and~~ **or** distance standards for access to Primary Care for Contractor's Members within the Provider Network in the county, Contractor shall not be obligated to reimburse non-contracting FQHCs for services provided to Contractor's Members (unless authorized by Contractor).

B. **Required Terms and Conditions for Network Provider Agreements with** Federally Qualified Health Centers/Rural Health Clinics (FQHC/RHC)

Contractor shall submit to DHCS, within 30 calendar days of a request and in the form and manner specified by DHCS, the services provided and the reimbursement level and amount for each of Contractor's FQHC and RHC ~~Subcontracts~~ **Network Provider Agreements**. Contractor shall certify in writing to DHCS within 30 calendar days of DHCS' written request that, pursuant to Welfare and Institutions Code Section 14087.325(b) and (d), as amended by Chapter 894, Statutes of 1998, FQHC and RHC ~~Subcontracts~~ **Network Provider Agreement** terms and conditions are the same as offered to other ~~Subcontractors~~ **Network Providers** providing a similar scope of service and that reimbursement is not less than the level and amount of payment that Contractor makes for the same scope of services furnished by a Provider that is not a FQHC or RHC. Contractor is not required to pay FQHCs and RHCs the Medi-Cal per visit rate for that facility. At its discretion, DHCS reserves the right to review and audit Contractor's FQHC and RHC reimbursement to ensure compliance with State and federal law and shall approve all FQHC and RHC ~~Subcontracts~~ **Network Provider Agreements** consistent with the provisions of Welfare and Institutions Code, Section 14087.325(h).

To the extent that American Indian Health Service Programs qualify as FQHCs or RHCs, the above reimbursement requirements shall apply to ~~Subcontracts~~ **Network Provider Agreements** with American Indian Health Service Programs. Contractor must also pay an amount equal to what Contractor would pay a ~~sub~~contracted FQHC or RHC and DHCS must pay any supplemental payment, pursuant to 42 CFR 438.14(c), to an American Indian Health Service Program that qualifies as a FQHC or ~~RCH~~ **RHC** but is not a ~~subcontracted~~ **Network** Provider.

C. American Indian Health Service Programs

1) Contractor shall attempt to contract with each American Indian Health Service Program as set forth in Title 22 CCR Sections

55120-55180. Contractor shall reimburse American Indian Health Service Programs at the applicable Fee-For-Service Medi-Cal rate for services provided prior to January 1, 2018 to Members who are qualified to receive services from an American Indian Health Service Program as set forth in 42 USC Section 1396u-2(h)(2), and Section 5006 of Title V of the American Recovery and Reinvestment Act of 2009. Contractor shall reimburse an American Indian Health Service Program that qualifies as a FQHC but is not a ~~subcontracted~~ **Network** Provider as set forth in 42 CFR 438.14(c)(1).

13. Contracting & Non-Contracting Emergency Service Providers & Post-Stabilization

H. Post Stabilization Services: -Post stabilization care services are covered and paid for in accordance with provisions set forth at 42 CFR 422.113(c). Contractor is financially responsible for post-stabilization services obtained within or outside Contractor's Network that are pre-approved by a ~~plan~~ **Network** Provider or other entity representative. Contractor is financially responsible for post-stabilization care services obtained within or outside Contractor's Network that are not pre-approved by a Network Provider or other Contractor representative, but administered to maintain the enrollee's stabilized condition within one (1) hour of a request to Contractor for pre-approval of further post-stabilization care services.

I. Contractor is also financially responsible for post-stabilization care services obtained within or outside Contractor's Network that are not pre-approved by a Network Provider or other entity representative, but administered to maintain, improve or resolve the Member's stabilized condition if Contractor does not respond to a request for pre-approval within 30 minutes; Contractor cannot be contacted; or Contractor's representative and the treating physician cannot reach an agreement concerning the Member's care and a plan physician is not available for consultation. In this situation, Contractor must give the treating physician the opportunity to consult with a ~~plan physician~~ **Network Provider** and the treating physician may continue with care of the patient until a ~~plan physician~~ **Network Provider** is reached or one of the criteria of 42 CFR 422.133(c)(3) is met.

J. Contractor's financial responsibility for post-stabilization care services it has not pre-approved ends when a ~~plan physician~~ **Network Provider** with privileges at the treating hospital assumes responsibility for the Member's care, a ~~plan physician~~ **Network Provider** assumes responsibility for the

Member's care through transfer, a plan representative and the treating physician reach an agreement concerning the Member's care; or the Member is discharged.

14. Provider-Preventable Conditions

Contractor shall not pay any provider claims nor reimburse a provider for a Provider-Preventable Condition (PPC), in accordance with 42 CFR 438.3(g). Contractor shall report, and require any and all of its ~~subcontracted providers~~ **Network Providers and Subcontractors** to report, PPCs in the form and frequency required by APL 17-009.

XIII. Exhibit A, Attachment 9, ACCESS AND AVAILABILITY, is amended to read:

1. General Requirement

B. Contractor shall ensure Members access to Specialists for Medically Necessary Covered Services. Contractor shall ensure adequate staff within the Service Area, including physicians, administrative and other support staff directly and/or through ~~Subcontracts~~ **Network Provider Agreements and Subcontractor Agreements**, sufficient to assure that health services will be provided in accordance with Title 22 CCR Section 53853(a) and consistent with all specified requirements.

4. Access Standards

Contractor shall ensure timely access to services in accordance with W&I Code ~~s~~**S**ection 14197, Title 28 CCR Section 1300.67.2.2 and as specified below. Contractor shall communicate, enforce, and monitor Network Providers' compliance with timely access standards.

D. Provider Shortage

Contractor shall arrange for a Member to receive timely care as necessary for their health condition if timely appointments within the time ~~and~~ **or** distance standards required in Attachment 6, Provision 8 of this contract are not available. Contractor shall refer Members to, or assist Members in locating, available and accessible ~~contracted~~ **Network** Providers in neighboring service areas or Out-of-Network Providers for obtaining health care services in a timely manner appropriate for the Member's needs.

5. Access to Services to Which Contractor or Subcontractor Has a Moral Objection

Contractor shall arrange for the timely referral and coordination of Covered Services to which ~~Contractor or~~ **a Network Provider or** Subcontractor has religious or ethical objections to perform or otherwise support. Contractor shall demonstrate ability to arrange, coordinate and ensure provision of services through referrals at no additional expense to DHCS or the Member. Contractor shall identify these services in its Member Services Guide.

7. Emergency Care

Contractor shall ensure that a Member with an emergency condition will be seen on an emergency basis and that emergency services will be available and accessible within the Service Area 24-hours-a-day.

C. Contractor shall ensure that a ~~plan~~ **Subcontractor** or contracting physician is available 24 hours a day, seven (7) days a week, to authorize Medically Necessary post-stabilization care and coordinate the transfer of stabilized Members in an emergency department, if necessary.

14. Linguistic Services

A. Contractor shall comply**, and ensure that its Network Providers and Subcontractors comply** with Title 22 CCR Section 53853(c) and (d), and ensure that all monolingual, non-English-speaking, or LEP Members and Potential Enrollees receive 24-hour oral interpreter services at all key points of contact, as defined in Paragraph D of this ~~p~~**P**rovision, either through interpreters, telephone language services, or any electronic options Contractor chooses to utilize. Contractor shall ensure that lack of interpreter services does not impede or delay timely access to care.

B. Contractor shall comply with 42 CFR 438.10(d)(4) and provide, at minimum, the following linguistic services at no cost to Medi-Cal Members or Potential Enrollees:

1) Oral Interpreters, signers, or bilingual **Network** Providers**, Network** ~~and~~ Provider staff**, and Subcontractors,** at all key points of contact. These services shall be provided in all languages spoken by Medi-Cal Members and Potential Enrollees and not limited to those that speak the threshold or concentration standards languages.

XIV. Exhibit A, Attachment 10, SCOPE OF SERVICES, is amended to read:

2. Medically Necessary Services

For purposes of this Contract, the term "Medically Necessary" when applied to Members 21 years of age or older will include all Covered Services that are reasonable and necessary to protect life, 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 **Section** 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 21 years of age, a **treatment or** service is Medically Necessary if it **is necessary to correct or ameliorate defects and physical and mental illnesses or conditions under** ~~meets~~ the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) standard ~~of medical necessity~~ set forth in **42 USC** Section 1396d(r)(5)~~ of Title 42 of the United States Code~~, as required by W&I Code **Section** 14059.5(b)**(1)** and W&I Code Section 14132 (v)**, and as described in APL 19-010**. ~~Without limitation,~~ Medically Necessary Services ~~for Members under 21 years of age include Covered Services necessary to achieve or maintain age-appropriate growth and development, attain, regain or maintain functional capacity, or improve, support or maintain the Member's current health condition.~~ Contractor shall determine Medical Necessity on a case-by-case basis, taking into account the individual needs of the child.

5. Services for Members under Twenty-One (21) Years of Age

Contractor shall cover and ensure the provision of all screening, preventive and Medically Necessary diagnostic and treatment services for Members under 21 years of age required under the ~~Early and Periodic Screening, Diagnostic and Treatment (~~EPSDT~~) services~~ benefit described in 42 USC Section 1396d(r), and W&I Code~~,~~ Section 14132(v). The EPSDT benefit includes all Medically Necessary health care, diagnostic services, treatments and other measures listed in 42 USC Section 1396d(a), whether or not covered under the State Plan. All EPSDT services are Covered Services, unless excluded under this Contract.

B. Children's Preventive Services

4) All children's preventive services**, including all confidential screening and billing reports for EPSDT screening, treatment, and Care Coordination** shall be reported as part of the Encounter Data submittal required in Exhibit A, Attachment 3, Management

Information System Capability, Provision 2. Encounter Data Submittal.

E. Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Services

1) For Members under the age of 21 years, Contractor shall provide or arrange and pay for all **preventive and** Medically Necessary EPSDT services, **which include any services set forth** ~~including all Medicaid services listed~~ in 42 USC Section 1396d(a), **unless otherwise carved out of this Contract, when the services are necessary to correct or ameliorate defects and physical and mental illnesses or conditions, regardless of** whether ~~or not~~ **such services are** covered under the State Plan, **as required by W&I Code Section 14059.5(b)(1) and W&I Code Section 14132(v), and as described in APL 19-010.** ~~unless expressly excluded in this Contract.~~ Covered Services shall include without limitation, in-home nursing provided by home health agencies or individual nurse providers, as required by APL 20-012, ~~care coordination~~ **Care Coordination**, case management, and Targeted Case Management (TCM) services as defined in Attachment 11, Provision 3 of this Contract. If Members under age 21 are not eligible for or accepted for Medically Necessary TCM services by a Regional Center or local government health program, Contractor shall ensure the Members' access to comparable services under the EPSDT benefit in accordance with APL 19-010.

2) Contractor shall arrange for any Medically Necessary **diagnostic and** treatment **services** identified at a ~~preventative~~ **preventive** screening or other visit ~~identifying~~ **indicating** the need for **diagnosis or** treatment, either directly or through referral to appropriate agencies, organizations, or individuals, as required by 42 ~~U.S.C. section~~ **USC Section** 1396a(a)(43)(C) **and APLs 19-010 and 20-012**. Contractor shall ensure that all Medically Necessary **EPSDT** services**, including all Covered Services set forth in Provision 5, Paragraph E, Subparagraph 1 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**.** ~~whether or not the services are Covered Services under this Contract.~~ Without limitation, Contractor shall 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 shall provide appointment scheduling assistance and necessary transportation, including Non-Emergency Medical Transportation (NEMT) and Non-Medical Transportation (NMT), to and from medical appointments for Medically Necessary services, including all services **available** through the Medi-Cal program, whether or not they are Covered Services under this Contract.

3) Covered Services do not include California Children's Services (CCS) pursuant to Exhibit A, Attachment 11, Provision 9, regarding CCS, or mental health services pursuant to Exhibit A, Attachment 11, Provision 6 (subject to Provision 8 below), regarding Specialty Mental Health Services. Contractor shall ensure that the case management for Medically Necessary services authorized by CCS or county mental health agencies under this paragraph is equivalent to that provided by Contractor for Covered Services for Members under the age 21 under this Contract and shall, if indicated or upon the Member's request provide additional ~~care coordination~~ **Care Coordination** and case management services as necessary to meet the Member's medical needs.

8. Services for All Members

A. Health Education

3) Contractor shall provide health education programs and services at no charge to Members directly and/or through ~~Subcontracts or other formal agreements~~ **contracts** with Providers that have expertise in delivering health education services to the Member population.

XV. Exhibit A, Attachment 11, CASE MANAGEMENT AND COORDINATION OF CARE, is amended to read:

7. Alcohol and Substance Use Disorder Treatment Services

Alcohol and substance use disorder treatment services available under Drug Medi-Cal program as defined in Title 22 CCR 51341.1, and outpatient heroin detoxification services defined in Title 22 CCR 51328 are excluded from this Contract. These Excluded Services include all medications used for the treatment of alcohol and substance use disorders covered by DHCS, as well as specific medications not currently covered by DHCS, but reimbursed through the

Medi-Cal FFS Program.

Contractor shall identify individuals requiring alcohol and or substance use disorder treatment services and arrange for their referral to the county department responsible for substance use treatment, or other community resources when services are not available through counties, and to outpatient heroin detoxification Providers available through the Medi-Cal FFS program, for appropriate services. Contractor shall assist Members in locating available treatment service sites. To the extent that treatment slots are not available within ~~the~~ Contractor's Service Area, ~~the~~ Contractor shall pursue placement outside the area. Contractor shall continue to cover and ensure the provision of primary care and other services unrelated to the alcohol and substance use disorder treatment and coordinate services between ~~the Primary Care Providers~~ **its Network Providers** and the treatment programs.

Contractor shall execute a MOU with the county department for alcohol and substance use disorder treatment services.

8. Services for Children with Special Health Care Needs

Children with Special Health Care Needs (CSHCN) are ~~defined as~~ "those who have or are at increased risk for a chronic physical, ~~behavioral,~~ developmental, **behavioral,** or emotional condition~~s~~ and who also require health or related services of a type or amount beyond that required by children generally".

9. California Children's Services (CCS)

Services provided by the CCS program are not covered under this Contract. Upon adequate diagnostic evidence that a Medi-Cal Member under 21 years of age may have a CCS-eligible condition, Contractor shall refer the Member to the local CCS office for determination of eligibility.

A. Contractor shall develop and implement written policies and procedures for identifying and referring children with CCS-eligible conditions to the local CCS program. The policies and procedures shall include, but not be limited, to those which:

1) Ensure that Contractor's **Network** Providers perform appropriate baseline health assessments and diagnostic evaluations which provide sufficient clinical detail to establish, or raise a reasonable suspicion, that a Member has a CCS-eligible medical condition;

2) Assure that ~~contracting~~ **Network** Providers understand that CCS reimburses only CCS-paneled Providers and CCS-approved hospitals within Contractor's Network; and only from the date of referral;

C. The CCS program authorizes Medi-Cal payments to ~~Contractor~~ Network ~~physicians~~ **Providers** who currently are members of the CCS panel and to other **Network** Providers who provided CCS-covered services to the Member during the CCS-eligibility determination period who are determined to meet the CCS standards for paneling. ~~-~~Contractor shall inform **Network** Providers, except as noted above, that CCS reimburses only CCS paneled **Network** Providers. ~~-~~Contractor shall submit information to the CCS program on all Providers who have provided services to a Member thought to have a CCS-eligible condition.

Authorization for payment shall be retroactive to the date the CCS program was informed about the Member through an initial referral by Contractor or a ~~Contractor~~ Network ~~physician~~ **Provider**, via telephone, fax, or mail. ~~-~~In an emergency admission, Contractor or ~~Contractor~~ Network ~~physician~~ **Provider** shall be allowed until the next Working ~~d~~**D**ay to inform the CCS program about the Member. ~~-~~Authorization shall be issued upon confirmation of panel status or completion of the process described above.

13. School Linked CHDP Services

B. Cooperative Arrangements

Contractor shall enter into one or a combination of the following arrangements with the local school district or school sites:

1) Cooperative arrangements (e.g. ~~Subcontracts~~ **Network Provider Agreements and Subcontractor Agreements**) with school districts or school sites to directly reimburse schools for the provision of some or all of the CHDP services, including guidelines for sharing of critical medical information. ~~-~~The arrangements shall also include guidelines specifying coordination of services, reporting requirements, quality standards, processes to ensure services are not duplicated, and processes for notification to Member/student/parent on where to receive initial and follow-up services.

2) Cooperative arrangements whereby ~~the~~ Contractor agrees to

provide or contribute staff or resources to support the provision of school linked CHDP services.

3) Referral protocols/guidelines between ~~the~~ Contractor and the school sites, which merely screen, for the need of CHDP services, including strategies for ~~the~~ Contractor to follow-up and document if services are being provided to the Member within the required State and Federal time frames.

4) Any innovative approach that ~~the~~ Contractor may develop to assure access to CHDP services and coordination with and support for school based health care services.

C. **Network Provider Agreements and** Subcontracts**or Agreements**

Contractor shall ensure that the **Network Provider Agreements and** Subcontract**or Agreement**s with the local school districts or school sites meet the requirements of Exhibit A, Attachment 6, Provision 13**4**, regarding **Network Provider Agreements and** Subcontract**or Agreement**s, and address the following: the population covered, beginning and end dates of the agreement, services covered, practitioners covered, outreach, information dissemination, educational responsibilities, utilization review requirements, referral procedures, medical information flows, patient information confidentiality, quality assurance interface, data reporting requirements, and Grievance and Appeal procedures.

16. Direct Observed Therapy (DOT) for Treatment of Tuberculosis (TB)

A. DOT is offered by LHDs and is not covered under this Contract. Contractor shall assess the risk of noncompliance with drug therapy for each Member who requires placement on anti-tuberculosis drug therapy.

The following groups of individuals are at risk for non-compliance for the treatment of TB: Members with demonstrated multiple drug resistance (defined as resistance to Isoniazid and Rifampin); Members whose treatment has failed or who have relapsed after completing a prior regimen; children and adolescents; and, individuals who have demonstrated noncompliance (those who failed to keep office appointments). Contractor shall refer Members with active TB and who have any of these risks to the TB Control Officer of the LHD for DOT. Contractor shall assess the following groups of Members for potential noncompliance and for consideration for DOT: substance users, persons with mental illness, the elderly, persons with unmet housing needs, and

persons with language and/or cultural barriers. ~~-~~If, in the opinion of ~~Contractor's~~ **the Network** Provider~~s~~, a Member with one **(1)** or more of these risk factors is at risk for noncompliance, the Member shall be referred to the LHD for DOT.

Contractor shall provide all Medically Necessary Covered Services to the Member with TB on DOT and shall ensure joint case management and coordination of care with the LHD TB Control Officer.

XVI. Exhibit A, Attachment 12, LOCAL HEALTH DEPARTMENT COORDINATION, is amended to read:

1. Network Provider Agreements and Subcontractor Agreements

Contractor shall negotiate in good faith and execute a **Network Provider Agreement and** Subcontract**or Agreement, as appropriate,** for public health services listed in Paragraph A through Paragraph D below with the Local Health Department (LHD) in each county that is covered by this Contract. ~~-~~The **Network Provider Agreement and** Subcontract**or Agreement** shall 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 ~~the~~ Contractor, including exchange of medical information as necessary. ~~-~~The **Network Provider Agreement and** Subcontract**or Agreement** shall meet the requirements contained in Exhibit A, Attachment 6, Provision 1~~3~~**4**, regarding **Network Provider Agreements and** Subcontract**or Agreement**s.

A. Family Planning Services: as specified in Exhibit A, Attachment 8, Provision 9.

B. STD services for the disease episode, as specified in Exhibit A, Attachment 8, Provision 10, by DHCS, for each STD, including diagnosis and treatment of the following STDs: syphilis, gonorrhea, chlamydia, herpes simplex, chancroid, trichomoniasis, human papilloma virus, non-gonococcal urethritis, lymphogranuloma venereum and granuloma inguinale.

C. HIV Testing and Counseling as specified in Exhibit A, Attachment 8, Provision 11.

D. Immunizations as specified in Exhibit A, Attachment 8, Provision 12.

To the extent that Contractor does not meet this requirement on or before four (4)

months after the effective date of this Contract, Contractor shall submit documentation substantiating reasonable efforts to enter into **Network Provider Agreements and** Subcontract**or Agreement**s**, as appropriate**.

2. Network Provider Agreements, Subcontractor Agreements, or Memoranda of Understanding

If reimbursement is to be provided for services rendered by the following programs or agencies, Contractor shall execute ~~a Subcontract~~ **Network Provider Agreements and Subcontractor Agreements, as appropriate,** with the LHD or agency as stipulated in Provision 1 above. If no reimbursement is to be made, Contractor or agency shall negotiate in good faith and execute a Memorandum of Understanding (MOU) for services provided by these programs and agencies.

XVII. Exhibit A, Attachment 13, MEMBER SERVICES, is amended to read:

1. Members Rights and Responsibilities

A. Member Rights and Responsibilities

Contractor shall develop, implement and maintain written policies that address the Member's rights and responsibilities and shall communicate these to its Members, Providers, **Subcontractors,** and, upon request, Potential Enrollees.

1) Contractor's written policies regarding Member rights shall include the following:

q) Freedom to exercise these rights without adversely affecting how they are treated by Contractor, **Network** Providers, **Subcontractors,** or the State.

2) Contractor's written policy regarding Member responsibilities shall include providing accurate information to the professional staff, following instructions, and cooperating with the **Network** Providers **and Subcontractors**.

3. Written Member Information

F. Contractor shall provide each Member, or family unit, a Member Services Guide/EOC that constitutes a fair disclosure of the provisions of, and the

right to obtain, available and accessible covered health care services. DHCS shall provide Contractor with a template for the Member Services Guide/EOC prior to distribution to Members. Contractor shall submit a complete Member Services Guide/EOC to DHCS for review and approval prior to implementing. Contractor shall ensure that the Member Services Guide/EOC includes the following information:

2) A description of the full amount, duration, and scope of Medi-Cal Managed Care covered benefits and all available services including health education, interpretive services provided by Contractor's personnel and at service sites, and an explanation of "carve out" services and any service limitations and exclusions from coverage or charges for services. ~~-~~Include information and identification of services to which ~~the~~ Contractor**,** or Subcontractor**, or Network Provider** has a moral objection to perform or support.

3) Procedures for accessing Covered Services, which explain that Covered Services shall be obtained through Contractor's **Network** Providers unless otherwise allowed under this Contract, and the process for Members selecting and changing their PCP. Include any applicable ~~Subcontractor~~ **Network Provider** arrangements that may restrict access.

4) A description of the Member identification card issued by ~~the~~ Contractor, if applicable, and an explanation as to its use in authorizing or assisting Members to obtain services.

8) The availability and procedures for obtaining after hours services (24-hour basis) and care, including the appropriate **Network** Provider locations and telephone numbers. ~~-~~This shall include an explanation of the Members' right to interpretive services, at no cost, to assist in receiving after hours services.

11) Process for referral to Specialists in sufficient detail so the Member can understand how the process works, including timeframes and alternative access standards as required by W&I Code **Section** 14197.04 and APL ~~20-003~~ **21-006**.

24) Information concerning the provision and availability of services covered under the CCS program from **Out-of-Network** Providers ~~outside Contractor's Provider Network~~ and how to access these services.

30) A statement as to whether ~~the~~ Contractor uses ~~Provider~~ financial bonuses or other incentives ~~with~~ **to** its ~~contracting~~ **Network** Providers ~~of health care services~~ and that the Member may request additional information about these bonuses or incentives from the plan, the Member's **Network** Provider**,** or the **Network** Provider's medical group or independent practice association, pursuant to California Health and Safety Code, Section 1367.10.

4. Notification of Changes in Access to Covered Services

B. Pursuant to 42 CFR 438.10(f)(1) Contractor shall make a good faith effort to give written notice of termination of a ~~contracted~~ **Network** Provider within 15 calendar days after receipt or issuance of the termination notice to each Member who received his or her primary care from, or was seen on a regular basis by, the terminated **Network** Provider. This notification must also be presented to and approved in writing by DHCS prior to its release.

5. Primary Care Provider Selection

A. Contractor shall implement and maintain DHCS approved procedures to ensure that each new Member has an appropriate and available Primary Care Physician.

4) Contractor shall provide a mechanism for SPD beneficiaries to select a Specialist or clinic that meets DHCS ~~subcontracting~~ **Network Provider Agreement** requirements as stated in Attachment 6 of this ~~c~~**C**ontract as a Primary Care Physician if the Specialist or clinic agrees to serve as a Primary Care Provider and is qualified to treat the required range of conditions of the SPD beneficiary, per W~~&~~I Code Section 14182 (b)(11).

C. Contractor shall ensure that Members with an established relationship with a **Network** Provider ~~in Contractor's Network~~, who have expressed a desire to continue their patient/**Network** Provider relationship, are assigned to that **Network** Provider without disruption in their care.

XVIII. Exhibit A, Attachment 14, MEMBER GRIEVANCE AND APPEAL SYSTEM, is amended to read:

1. Member Grievance and Appeal System

Contractor shall have in place a system in accordance with Title 28, CCR,

Section 1300.68 and 1300.68.01, Title 22 CCR Section 53858, Exhibit A, Attachment 13, Provision 4, Paragraph F.13), and 42 CFR 438. 402-424. Contractor shall follow Grievance and Appeal requirements, and use all notice templates included in APL ~~17-006~~ **XX-XXX**. Contractor shall ensure that its Grievance and Appeal system meets the following requirements:

I. Provide its Grievance and Appeal system requirements to Subcontractors at the time that they enter into a Subcontract**or Agreement, to Network Providers at the time that they enter into a Network Provider Agreement,** and ensure ~~they~~ **that Subcontractors and Network Providers** are informed of any new requirements in a timely manner.

3. Grievance and Appeal Log and Quarterly Grievance and Appeal Report

A. Contractor shall accurately maintain and make accessible to DHCS, and have available for CMS upon request, Grievance and Appeal logs, including copies of Grievance and Appeal logs of any ~~subcontracting entity~~ **Subcontractor** delegated ~~the~~ responsibility to maintain and resolve Grievances. Grievance and Appeal logs shall include all the required information set forth in Title 22 CCR Section 53858(e).

D. Contractor shall submit complete, accurate, ~~reasonable,~~ and timely Grievance and Appeal data within ten (10) calendar days following the end of each month under this Contract or as otherwise agreed upon by DHCS, and in the format specified by DHCS. Contractor shall certify all Network data as set forth in 42 CFR 438.606.

9. Discrimination Grievances

Contractor shall process a Grievance for discrimination as required by federal and State nondiscrimination law stated in 45 CFR § **Section** 84.7; ~~45 CFR § 92.7;~~ 34 CFR § **Section** 106.8; 28 CFR § **Section** 35.107; and W&I Code § **Section** 14029.91(e)(4).

XIX. Exhibit A, Attachment 17, REPORTING REQUIREMENTS, is amended to read:

Contract Section	Requirement	Frequency
Exhibit A - SCOPE OF WORK		
Attachment 1 ORGANIZATION AND ADMINISTRATION OF THE PLAN		
2. A. Key Personnel (Disclosure Form)	Key Personnel (Disclosure Form)	Annually
Attachment 2 FINANCIAL INFORMATION		

Contract Section	Requirement	Frequency
2. Financial Audit Reports B. 1) **or** B. 2)	Annual certified Financial Statements and DMHC required reporting forms **or** Financial Statement	Annually
2. Financial Audit Reports B. 2)	Quarterly Financial Reports	Quarterly
4. Monthly Financial Statements	Monthly Financial Statements (If applicable)	Monthly
Attachment 3 MANAGEMENT INFORMATION SYSTEM		
2. Encounter Data Submittal C.	Encounter Data Submittal	Monthly
6. Network Data ~~Reporting~~ **Submissions**	Network Data Submittal in the 274 Provider File	Monthly
Attachment 4 QUALITY IMPROVEMENT SYSTEM (QIS)		
4. Quality Improvement Committee C.	Quality Improvement Committee meeting minutes	Quarterly
8. Quality Improvement Annual Report	Quality Improvement Annual Report	Annually
9. External Quality Review Requirements A. External Accountability Set (EAS) Performance Measures 2) b)	EAS Performance Measurement Rates	Annually
9. External Quality Review Requirements B. Under/Over-Utilization Monitoring	Reported rates	Annually
9. External Quality Review Requirements C. Performance Improvement Projects (PIPs)	QIP Proposals or Status Reports	Annually
10. Site Review E. Data Submission	Site Review Data	Semi-Annually
Attachment 6 PROVIDER NETWORK		
11. Provider Network Reports	Provider Network Changes Report	Quarterly
11. Annual Provider Network Report	Provider Network Capacity Report	Annually
12. ~~Plan~~ Subcontractor~~s~~ **Report**	~~Plan~~ Subcontractor~~s~~ Report	Quarterly
Attachment 9 ACCESS AND AVAILABILITY		
13. Cultural and Linguistic Program C. Population Needs Assessment 4)	Population Needs Assessment Summary Report	Every 5 years
Attachment 10 SCOPE OF SERVICES		

Contract Section	Requirement	Frequency
5. Services for Members under Twenty-One (21) Years of Age B. Children's Preventive Services 4)	Confidential Screening/Billing Report	Monthly
8. Services for All Members G. Pharmaceutical Services and Provision of Prescribed Drugs 5)	Report of Changes to the Formulary	Annually
8. Services for All Members G. Pharmaceutical Services and Provision of Prescribed Drugs 7)	Report of DUR Program Activities	Annually
Attachment 12 LOCAL HEALTH DEPARTMENT COORDINATION		
4. MOU Monthly Reports	Local Health Department - MOU's County Mental Health - MOU's (If deemed necessary)	Monthly until MOU is signed
Attachment 13 MEMBER SERVICES		
4. Written Member Information ~~B~~**D**.	Member Services Guide	Annually
Attachment 14 MEMBER GRIEVANCE AND APPEAL SYSTEM		
3. Grievance and Appeal Log and Quarterly Grievance and Appeal Report	Grievance and Appeal Report	Quarterly
3. Grievance and Appeal Log and Grievance and Appeal Report D.	Grievance and Appeal Data	Monthly
Attachment 15 MARKETING		
3. Marketing Plan A.	Marketing Plan	Annually
Attachment 16 ENROLLMENTS AND DISENROLLMENTS		
1. Enrollment Program (PL 11-009)	Provider Directory	Semi-Annually
Attachment 19 COMMUNITY BASED ADULT SERVICES (CBAS)		
1. Provider Network F.	Subcontracted CBAS Providers and Accessibility Standards Report	Annually
4. Required Reports for the CBAS Program A.	Provision of the ECM Report	Quarterly
4. Required Reports for the CBAS Program B.	CBAS Enrollment Report	Quarterly
4. Required Reports for the CBAS Program C.	Addition to Grievance and Appeal Report	Quarterly

Contract Section	Requirement	Frequency
Attachment 20 MENTAL HEALTH AND SUBSTANCE USE DISORDER BENEFITS		
3. Provider Network Reports A.	Addition to the Provider Network Report	Quarterly
3. Provider Network Reports B.	Outpatient Mental Health Services Providers Report	Monthly
Attachment 21 MANAGED LONG-TERM SERVICES AND SUPPORTS (MLTSS)		
10. Required Reports for Managed Long Term Services and Supports A.	Support and Retention of Community Placement	Quarterly
10. Required Reports for Managed Long Term Services and Supports B.	Continuity of Care Requests	Monthly
10. Required Reports for Managed Long Term Services and Supports C.	Addition to the Provider Network Report	Quarterly
10. Required Reports for Managed Long Term Services and Supports D.	Addition to Grievances and Appeals Report	Monthly
10. Required Reports for Managed Long Term Services and Supports E.	PCP Assignment	Monthly
Exhibit E - ADDITIONAL PROVISIONS		
Attachment 2 PROGRAM TERMS AND CONDITIONS		
34. Treatment of Recoveries C. Recovery of Overpayment	Recovery of Overpayment Report	Annually

XX. Exhibit A, Attachment 18, IMPLEMENTATION PLAN AND DELIVERABLES, is amended to read:

2. Financial Information

All submitted financial information must adhere to Generally Accepted Accounting Principles (GAAP), unless otherwise noted.

Note: Where Knox-Keene license exhibits are requested, the descriptions of exhibit content may have been amended to address Medi-Cal program needs or industry terminology.

G. Describe systems for ensuring that Subcontractors **and Network Providers**, who are at risk for providing services to Medi-Cal Members, as well as any obligations or requirements delegated pursuant to a Subcontract**or Agreement or Network Provider Agreement**, have the administrative and financial capacity to meet its contractual obligations. Title 28~~,~~ CCR Section 1300.70(b)(2)(H)1.~~—~~**and** Title 22 CCR Section 53250.

J. Submit policies and procedures for a system to evaluate and monitor the financial viability of all ~~subcontracting entities~~ **Network Providers and Subcontractors that accept financial risk for the provision of Covered Services**.

3. Management Information System (MIS)

J. Submit policies and procedures for the submission of complete, accurate, ~~reasonable,~~ and timely Network data to DHCS.

4. Quality Improvement System

F. Submit boilerplate Subcontract**or Agreement** language showing accountability of delegated QIS functions and responsibilities.

6. Provider Network

G. Submit a GeoAccess report (or similar) showing that the proposed Provider Network meets the appropriate time ~~and~~ **or** distance standards set forth in the Contract.

J. Submit a report containing the names of all ~~subcontracting Provider groups~~ **Subcontractors** (see Exhibit A, Attachment 6, Provision 12).

L. Submit policies and procedures for ensuring **Network Providers and** Subcontractors fully comply with all terms and conditions of this Contract.

M. Submit all boilerplate **Network Provider Agreements and** Subcontract**or Agreement**s.

7. Provider Relations

B. Submit a written description of how Contractor will communicate the Provider ~~g~~**G**rievance process to ~~subcontracting~~ **Network Providers** and ~~non-contracting~~ **Out-of-Network** Providers.

C. Submit protocols for payment and communication with ~~non-contracting~~ **Out-of-Network** Providers.

D. Submit copy of Contractor's **Network** ~~p~~**P**rovider manual.

8. Provider Compensation Arrangements

E. Submit FQHC, RHC, and American Indian Health Service Programs Subcontract**or Agreement**s **and Network Provider Agreements**.

9. Access and Availability

J. Submit policies and procedures regarding Contractor**, Network Provider,** and Subcontractor compliance with the Civil Rights Act of 1964.

N. Submit policies and procedures for providing cultural competency, sensitivity or diversity training for staff~~,~~ **and Network** Providers~~, and Subcontractors~~.

P. Submit policies and procedures for the provision of 24-hour interpreter services at all **Network** Provider sites.

R. Submit policies and procedures for providing Medically Necessary services through Out-of-Network Providers, including allowing access for the completion of Covered Services by an Out-of-Network Provider or terminated **Network** Provider.

S. Submit policies and procedures to ensure access for up to 12 months for SPD beneficiaries who have an ongoing relationship with a**n Out-of-Network** Provider.

11. Case Management Including Coordination of Care

Q. Submit a description of the cooperative arrangement Contractor has with the local school districts, including the **Network Provider Agreements,** Subcontract**or Agreement**s**,** or written protocols/guidelines, if applicable.

12. Local Health Department Coordination

A. Submit executed **Network Provider Agreements and** Subcontract**or Agreement**s**,** or documentation substantiating Contractor's efforts to enter

into **these agreements** ~~Subcontracts~~ with the LHD for the following public health services:

B. Submit executed **Network Provider Agreements and** Subcontract**or Agreement**s, Memoranda of Understanding, or documentation substantiating Contractor's efforts to negotiate an agreement with the following programs or agencies:

19. Mental Health and Substance Use Disorder Benefits

Submit the following consistent with the requirements of Exhibit A, Attachment 20.

C. Submit any **Network Provider Agreement and** Subcontract**or Agreement** boilerplate developed for a county mental health plan.

D. Submit policies and procedures for ~~subcontracting~~ **entering into agreements** with county mental health plans in order to comply with access standards.

XXI. Exhibit A, Attachment 19, COMMUNITY BASED ADULT SERVICES (CBAS), is amended to read:

1. Provider Network

In addition to Exhibit A, Attachment 6, Provider Network, Contractor also agrees to the following:

A. ~~Subcontracting~~ **Contract** with a sufficient number of available CBAS Providers in Contractor's Services Area to meet the expected utilization without a waitlist and ensure timely access, within one hour's transportation time, for Members who meet the CBAS eligibility criteria in the 2020 Waiver Special Terms and Conditions, Section VIII.A.48. ~~Subcontracted~~ CBAS **Network** Providers must be appropriate for and proficient in addressing CBAS-eligible Members' specialized health care needs, and their acuity, communication, cultural and language needs and preferences.

B. Contractor may, but is not obligated to, ~~sub~~contract with CBAS Providers licensed as ADHCs and certified by the CDA to provide CBAS on or after April 1, 2012.

F. Contractor shall provide DHCS with a list of its subcontracted CBAS **Network** Providers and its CBAS accessibility standards on an annual basis.

XXII. Exhibit A, Attachment 20, MENTAL HEALTH AND SUBSTANCE USE DISORDER, is amended to read:

1. Outpatient Mental Health Services Providers

In addition to Exhibit A, Attachment 6, Provider Network, Provision 1. Network Capacity, Contractor shall also include Outpatient Mental Health Services Providers in its Provider Network in accordance with 42 CFR 438.206, 207, and 208, as applicable. The number of Outpatient Mental Health Services Providers shall be adequate to serve Members within its Service Area and provide covered Outpatient Mental Health Services benefits. Contractor's Outpatient Mental Health Services Providers shall support current and desired service utilization trends for its Members.

A. Contractor shall increase the number of Outpatient Mental Health Services Providers within its Network as necessary to accommodate enrollment growth. Contractor may ~~sub~~contract with any mental health care Provider within their scope of practice.

B. The number of Outpatient Mental Health Services Providers available shall be sufficient to meet referral and appointment access standards for routine care and shall meet the Timely Access Regulation per Healthy and Safety Code, Section 1367.03, Rule 1300.67.2.2, in accordance with the requirements set forth in Exhibit A, Attachment 9, Access and Availability, Provision 4. Access Standards.

1) Contractor may ~~sub~~contract with a county mental health plan to ensure access to Outpatient Mental Health Services. A ~~sub~~contracted Network shall be deemed adequate upon submission and approval of Contractor's ~~subcontract~~ boilerplate **Subcontractor Agreement or Network Provider Agreement** for a county mental health plan.

XXIII. Exhibit A, Attachment 21, MANAGED LONG-TERM SERVICES AND SUPPORTS, is amended to read:

4. Provider Network

In addition to Exhibit A, Attachment 6, Provider Network, Contractor also agrees

to the following:

A. Contractor shall ensure that every contracted Long Term Care (LTC) Provider and MSSP site within the Service Area approved by the California Department of Public Health (CDPH) and CDA as a qualified Provider is included in their Network, to the extent that the Provider remains licensed, certified, operating, and is willing to enter into a ~~subcontract~~ **Network Provider Agreement** with Contractor on mutually agreeable terms and meets ~~the~~ Contractor's credentialing and quality standards.

D. In addition to the ~~subcontract~~ **Network Provider Agreement and Subcontractor Agreement** termination requirements in Exhibit A, Attachment 6, Provision 14. **Network Provider Agreements and** Subcontract**or Agreement**s, and the Member notification requirements in Exhibit A, Attachment 13, Member Services, Provision 5. Notification of Changes in Access to Covered Services, Contractor shall notify DHCS upon termination of an LTC Provider contract:

E. Any ~~subcontract~~ **Network Provider Agreement or Subcontractor Agreement** that Contractor enters into with a CDA qualified MSSP site, for either the provision of health care service or to perform an administrative function, shall be submitted to DHCS for prior approval at least 60 calendar days prior to the effective date of the contract. DHCS shall acknowledge in writing the receipt of any ~~subcontract~~ **Network Provider Agreement or Subcontractor Agreement** sent to DHCS by Contractor for approval within five (5) ~~w~~**W**orking ~~d~~**D**ays of receipt. These ~~subcontracts~~ **Network Provider Agreements or Subcontractor Agreements** shall not be effective until written approval is provided by DHCS and CDA or by operation of law where DHCS has acknowledged receipt of the proposed ~~subcontract~~ **Network Provider Agreement or Subcontractor Agreement**, and has neither approved nor rejected the proposed ~~subcontract~~ **Network Provider Agreement or Subcontractor Agreement** within 60 calendar days of receipt.

1) Contractor shall also submit a ~~subcontract~~ **Network Provider Agreement or Subcontractor Agreement** for MSSP to DHCS for approval even if the **Network Provider or** Subcontractor has been previously approved by DHCS and CDA for another program.

2) Any new or updated subcontract that makes a material change to the subcontract must be re-submitted to DHCS. Previous ~~subcontract~~ **Network Provider Agreement or Subcontractor**

Agreement approval shall be valid only until such time as the new or amended ~~subcontract~~ **Network Provider Agreement or Subcontractor Agreement** is approved by DHCS and CDA.

F. ~~Subcontract~~ **Network Provider Agreement or Subcontractor Agreement** amendments shall be submitted to DHCS for prior approval at least 30 calendar days before the effective date of any proposed changes governing compensation, services, or term. Proposed changes which are neither approved nor rejected by DHCS and CDA shall become effective by operation of law 30 calendar days after DHCS has acknowledged receipt or upon the date specified in the ~~subcontract~~ **Network Provider Agreement or Subcontractor Agreement** amendment, whichever is later.

6. Provider Compensation Arrangements

In addition to Exhibit A, Attachment 8, Provider Compensation Arrangements, Contractor also agrees to the following:

B. MSSP invoices submitted by ~~sub~~contracted MSSP sites for MSSP services are to be paid in a timely manner upon verification of the accuracy and validity of the services invoiced therein, and in accordance with Contractor's ~~subcontract~~ **Network Provider Agreement or Subcontractor Agreement** with the MSSP site.

8. Coordination of Care

In addition to Exhibit A, Attachment 11, Case Management and Coordination of Care, Contractor also agrees to the following:

K. Contractor shall provide coordination of care services or ensure that they are performed by the health plan or ~~delegated~~ **contracted** Provider care coordinators, in conjunction with the appropriate Network Providers including, but is not limited to Providers for behavioral health, CBAS, MSSP, and LTC.

9. Member Services

A. In addition to Exhibit A, Attachment 13, Member Services, Provision 4, Written Member Information, Contractor shall include in its **Network** Provider Directory MSSP Provider sites and all contracted LTC **Network** Providers.

XXIV. Exhibit B, BUDGET DETAIL AND PAYMENT PROVISIONS, Provision 4, is amended to read:

4. Capitation Rates

A. DHCS shall remit to Contractor a Capitation Payment each month for each Member that appears on the approved list of Members supplied to Contractor by DHCS. The payment period for health care services shall commence on the first day of operations, as determined by DHCS. Capitation Payments shall be made in accordance with the following schedule of capitation rates. ~~-~~For aid codes, see DEFINITIONS, Eligible Beneficiary:

For the period ~~07/01/19 –12/31/2020~~ 01/01/2021-12/31/2021	**County**
Groups	**Rates**
Adult & Family/Optional Targeted Low-Income Child (Under 19)	
Adult & Family/Optional Targeted Low-Income Child (19 & Older)	
Adult & Family/Optional Targeted Low-Income Child (Dual)	
SPD	
SPD/Dual	
SPD/Dual (Non-CCI)	
Long Term Care/Full Dual	
Long Term Care/Non-Full Dual	
Long Term Care/Full Dual (Non-CCI)	
Breast and Cervical Cancer Treatment Program (BCCTP)	
Maternity	
Adult Expansion	
Maternity Expansion	
Hepatitis C/340B	
Hepatitis C/Non-340B	
HCBS High	
BHT/Ages 0-6	
BHT/Ages 7-20	

C. In accordance with 42 CFR section 438.7, the actuarial basis for the computation of the Capitation Payment rates shall be set forth in DHCS' rate certification**(s)** for the applicable ~~rate~~ **Rating** ~~p~~**P**eriod. ~~The~~ **Subject to**

approval by CMS, the rate certification**(s)** ~~is~~ **are** incorporated by reference in Exhibit E, Attachment 2, Provision 1 **and made part of this Contract by this reference as if attached hereto in full**.

5. Capitation Payment Rates Constitute Payment In Full

Except as otherwise specified in this Contract, the ~~c~~**C**apitation **Payment** rates for each Rating Period, as calculated by DHCS **and approved by CMS**, are prospective rates and constitute payment in full, subject to any stop loss reinsurance provisions, 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 the Contract, DHCS is not responsible for making payments associated with Contractor's losses.

6. Determination of Capitation Payment Rates

A. ~~DHCS shall determine the capitation rates for the Contract effective date of Operations, through the duration of the Contract. DHCS shall redetermine rates in accordance with W&I Code Section 14301.1 for each Rating Period. All payments and rate adjustments are subject to appropriations of funds by the Legislature and the Department of Finance approval.~~ **In accordance with W&I Code Section 14301.1, DHCS shall 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.** Further, all payments are subject to the availability of Federal congressional appropriation of funds.

B. Pursuant to 42 CFR 457.1201(c), and 42 CFR 457.1203(a), DHCS shall identify and develop final Capitation Payment rates based upon services covered under the State Plan and this Contract. Capitation Payment rates shall be, to the extent possible, consistent with and based on actuarially sound principles as defined by 42 CFR 457.10. Once DHCS establishes rates on an actuarially sound basis, it shall determine whether the rates shall be increased, decreased, or remain the same. If DHCS determines that Contractor's capitation rates shall be increased or decreased, the increase or decrease shall be effectuated through an amendment or change order to this Contract. These amendments or change orders with final Capitation Payment rates shall be submitted to CMS in accordance with the provisions of Exhibit E, Attachment 2, Provision 4, Change Requirements, or upon request by the Secretary, and are subject to the following provisions:

2) In the event there is any delay in a determination **or redetermination** to increase or decrease ~~c~~**C**apitation **Payment** rates, so that an amendment~~/~~ **or** change order may not be processed in time to permit payment of new rates commencing the first day of the Rating Period, ~~the~~ payment to Contractor shall continue at the rates stated in an R Letter sent to ~~the~~ Contractor by DHCS. The R Letter shall serve as notification from DHCS to Contractor of the capitated rates, and the time period for which these rates will be applied. The R Letter shall not be considered exempt from any requirement of this Contract. ~~-~~Those continued payments shall constitute interim payment only. ~~-~~Upon CMS final approval of the amendment~~/~~ **or** change order and rate certification**(s)**, providing for the rate change, DHCS shall make retroactive adjustments for those months for which interim payment was made.

3) By accepting payment of new ~~c~~**C**apitation **Payment** rates prior to full approval by CMS of the amendment~~/~~ **or** 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:

   b) Unless otherwise required by CMS, any overpayment to Contractor shall be offset by ~~the State's~~ **DHCS'** withholding from Contractor's future Revenues of any amount due. DHCS may, at its discretion, withhold up to 100 percent of Contractor's Revenues for each month until any overpayment is fully recovered by the State.

4) If mutual agreement between DHCS and Contractor cannot be attained on ~~c~~**C**apitation **Payment** rates for Rating Periods subsequent to September 30, 2005 resulting from a rate change pursuant to this Provision 6 or Provision 7 below, Contractor shall retain the right to terminate the Contract. **Contractor's n**~~N~~otification of intent to terminate ~~a~~ **this** Contract shall 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 Exhibit E, Attachment 2, Provision 14, regarding Termination – Contractor. ~~-~~DHCS shall pay the ~~c~~**C**apitation **Payment** rates last offered for that Rating Period until the Contract is terminated.

7. Redetermination of Capitation Payment Rates - Obligation Changes

~~The~~ **Final** ~~c~~**C**apitation **Payment** rates may be adjusted ~~to provide for a change~~**s** ~~in obligations in accordance with W & I Code section 14301.1 and 42 CFR section 438.4, or as deemed necessary by DHCS~~ **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 Code Section 14301.1 and 42 CFR Section 438.4, or as deemed necessary by DHCS**. ~~-~~Any adjustments shall be effectuated through a**n amendment or** change order to the Contract subject to the following provisions:

A. The **amendment or** change order shall be effective as of the first day of the month in which the change in obligations is effective, as determined by DHCS~~.~~**;**

B. In the event DHCS is unable to process the **amendment or** change order in time to permit payment of the adjusted rates as of the month in which the change in obligations is effective, payment to Contractor shall continue at the rates then in effect. ~~-~~Continued payment shall constitute interim payment only. Upon final approval of the **amendment or** change order providing for the change in obligations, DHCS shall make adjustments for those months for which interim payment was made~~.~~ **and;**

C. DHCS and Contractor may negotiate an earlier termination date, pursuant to Exhibit E, Attachment 2, Provision 14, regarding Termination – Contractor, if a change in contractual obligations is created by a State or ~~F~~**f**ederal 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 ~~until the termination date that would otherwise be established under this provision~~ **through the termination date provided by this Contract**.

10. Financial Performance Guarantee

~~Contractor shall provide satisfactory evidence of, and maintain Financial Performance Guarantee in, an amount equal to at least one Capitation Payment, in a manner specified by DHCS.~~ **In accordance with Title 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 at least one million dollars or equal to at least three (3) months' Contract Revenues based on Contractor's average monthly Contract Revenues for last 12 months, whichever is higher, subject to approval by DHCS. At ~~the~~ 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. The Financial Performance Guarantee shall remain in effect for a period not exceeding 90 calendar days following termination or expiration of this Contract unless DHCS has a financial claim against Contractor. Further rights and obligations of the Contractor and DHCS, in regards to the Financial Performance Guarantee, shall be as specified in Title 22 CCR Section 53865.~~ **Unless DHCS has a financial claim or offset against Contractor, the Financial Performance Guarantee shall remain in effect through the completion of the phaseout period in accordance with Exhibit E, Provision 15 of this Contract. DHCS shall take possession of the Financial Performance Guarantee in an amount sufficient to indemnify DHCS in the event that Contractor materially breaches or defaults on one or more terms this Contract.**

11. Recovery of Amounts Paid to Contractor

DHCS shall have the right to recover from Contractor amounts paid to Contractor in the following circumstances as specified:

A. If DHCS determines that a Member has either 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 a Member should have been disenrolled with an effective date in a prior month, DHCS may recover amounts paid to Contractor ~~for~~ **associated with** the Member for the month**(**s**)** in question. In such event, 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 shall 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.

Upon request by Contractor, DHCS may allow Contractor to retain amounts paid to Contractor for Members that are eligible to enroll in Contractor's Medi-Cal Managed Care Health Plan, but should have been retroactively disenrolled pursuant to Exhibit A, Attachment 11, Provision 18~~.~~**,** Excluded Services Requiring Member Disenrollment, or under other

circumstances as approved by DHCS. ~~-~~In such event, Contractor shall provide or arrange and pay for all Medically Necessary Covered Services for the Member, until the Member is disenrolled on a non-retroactive basis pursuant to **the terms set forth in** Exhibit A, Attachment 16, Provision 3, Disenrollment**, of this Contract**.

B. As a result of Contractor's failure to perform contractual responsibilities to comply with mandatory ~~F~~**f**ederal Medicaid requirements, the ~~F~~**f**ederal 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 an offset to Contractor's Revenues. ~~-~~If recovery of the full amount at one time imposes a financial hardship on Contractor, ~~DHCS at its discretion may grant a Contractor's request to repay the recoverable amounts in monthly installments over a period of consecutive months not to exceed six (6) months~~ **Contractor may request to repay the recoverable amounts in monthly installments over a period of consecutive months not to exceed six (6) months. DHCS, at its discretion, may grant or deny such a request**.

12. Medical Loss Ratio (MLR)

The Medical Loss Ratio (MLR) as described in this Provision shall be done in accordance with 42 CFR 438.8, and shall be considered separate and distinct from the Adult Expansion Medical Loss Ratio (AE-MLR) and risk corridor as required in Exhibit B, Provision 14 of this Contract.

H. MLR Reporting requirements.

3) Contractor shall require any third party vendor providing claims adjudication activities to provide all underlying data associated with MLR reporting to Contractor within 180 days from the end of the MLR Reporting Year, or within 30 days of being requested by Contractor, whichever comes sooner, regardless of current ~~sub~~contracting limitations, to calculate and validate the accuracy of MLR reporting.

14. Supplemental Payments

A. Contractor shall be entitled to Supplemental Payments stated within this Provision **in accordance with**~~, based on~~ the payment schedules **set forth in this** ~~identified within~~ Exhibit B. Contractor must maintain on file evidence of payment for qualified services entitling them to the

Supplemental Payments. **Upon audit, f**~~F~~ailure to have supporting records may~~, upon audit,~~ result in recoupment by DHCS of the Supplemental Payments **paid to Contractor**.

1) On a monthly basis, by **no later than** the twentieth (20th) calendar day following the end of each month**,** and in a format specified by DHCS, Contractor shall submit a report for Supplemental Payments. This report shall identify the Members receiving services qualifying for ~~s~~**S**upplemental ~~p~~**P**ayment and for whom ~~the~~ **Contractor is claiming** payment ~~amount is being claimed~~.

2) ~~When Contractor receives and submits data to DHCS:~~

~~a) Within 14 months of the month of service, Contractor will receive the full Supplemental Payments.~~

~~b)~~ **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.** After the ~~fourteenth~~ **twelfth** month following the month of service, Contractor will not receive ~~a~~ Supplemental Payments.

E. Supplemental Payment**s** for BHT Services

~~Contractor shall be paid a monthly Supplemental Payment for each Member who receives BHT services. Payments shall be based on the Member's utilization as reported by Contractor in accordance with the requirements in Exhibit B. The payment period for health care services shall commence on September 15, 2014.~~

1) Contractor shall receive Supplemental Payments for Members less than 21 years of age who receive qualified BHT services. Payments are based on the Member's utilization as reported by Contractor.

2) Contractor is required to submit a diagnosis date that can be earlier than or equal to the service date. If the diagnosis date is unknown, then Contractor is permitted to use the service date. Payment to Contractor is contingent upon Contractor claiming with the appropriate and most current diagnosis codes, as regularly updated.

15. Additional Payments

B. ~~American~~ Indian Health Service **(IHS)** Program Payment

1) ~~Commencing on January 1, 2018,~~ Contractor shall be entitled to receive an ~~American Indian Health Service~~ **IHS** Program payment for Members qualified to receive services in accordance with Exhibit A, Attachment 8, Provision 7, Paragraph C of this Contract ~~and who utilize such services on or after January 1, 2018~~.

2) The ~~payment~~ **IHS Program** shall reimburse Contractor for the amount paid to ~~American Indian Health Service~~ **IHS** Programs as required in Exhibit A, Attachment 8, Provision 7, Paragraph C of this Contract. Payments shall be based on Member utilization of qualifying services at ~~American Indian Health Service~~ **IHS** Programs as reported by Contractor.

16. Special Contract Provisions Related to Directed Payment Initiatives and Pass-Through Payment Programs

A. Contractor ~~shall~~ **must** comply**, and require its Subcontractors to comply,** with the terms of each applicable Directed Payment Initiative **established in accordance with** ~~under~~ 42 CFR 438.6(c), in a form and manner specified by DHCS through All Plan Letters or other technical guidance. For applicable ~~State Fiscal Years (SFY) or~~ Rating Periods, ~~commencing with SFY 2017-18,~~ DHCS shall make the terms of each Directed Payment Initiative available on the DHCS website at www.dhcs.ca.gov.

B. Contractor ~~shall~~ **must** comply**, and require its Subcontractors to comply,** with the terms of each applicable Pass-Through Payment established pursuant to 42 CFR 438.6(d) in accordance with the CMS approved rate certification, and in a form and manner specified by DHCS through All Plan Letter or other technical guidance.

17. Special Contract Provisions Related to Incentive Arrangements

Contractor ~~shall~~ **must** comply with the terms of any Incentive Arrangements approved by CMS under 42 CFR 438.6(b)(2), in a form and manner specified by DHCS through All Plan Letters or other technical guidance. For applicable Rating Periods, commencing with the Rating Period starting July 1, 2019, DHCS shall make the terms of each approved Incentive Arrangement available on the DHCS website at www.dhcs.ca.gov.

XXV. Exhibit E, Attachment 1, DEFINITIONS, is amended to read:

As used in this Contract, unless otherwise expressly provided or the context otherwise requires, the following definitions of terms will govern the construction of this Contract:

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

External Quality Review means an analysis and evaluation by the EQRO of aggregated information on quality, timeliness and access to the Covered Services that Contractor or its Subcontractors **or Network Providers** furnish to Members, as referenced for related activities in Exhibit A, Attachment 4 of this Contract.

Incentive Arrangement means any payment mechanism approved by CMS in accordance with 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 ~~the~~ **this** Contract**, including but not limited to Exhibit B, Provision 17**.

Medically Necessary or **Medical Necessity** means 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 21 years of age, a **treatment or** service is Medically Necessary if it **is necessary to correct or ameliorate defects and physical and mental illnesses or conditions under** ~~meets~~ the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) standard ~~of medical necessity~~ set forth in **42 USC** Section 1396d(r)(5)~~ of Title 42 of the United States Code~~, as required by W&I Code **Section** 14059.5(b)**(1)** and W&I Code Section 14132(v). ~~Without limitation, Medically Necessary services for Members under 21 years of age include Covered Services necessary to achieve or maintain age-appropriate growth and development, attain, regain or maintain functional capacity, or improve, support or maintain the Member's current health condition.~~ Contractor shall determine Medical Necessity on a case-by-case basis, taking into account the individual needs of the child.

Network means PCPs, Specialists, hospitals, pharmacy, ancillary Providers, facilities, and any other Providers that ~~Subcontract~~ **have a Network Provider Agreement** with Contractor for the delivery of Medi-Cal Covered Services.

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

Significant Change means changes in Covered Services, benefits, the geographic Service Area, composition of payments to its Network, or enrollment of a new population, as stated in APL ~~20-003~~**21-006**.

Staff Model Providers means a Staff Model Contractor that has ~~subcontracted~~ **an agreement** with Contractor to provide Covered Services to Contractor's Members.

~~**Subcontract** means a written agreement entered into by the Contractor with any of the following:~~

~~A. A Provider of health care services who agrees to furnish Covered Services to Members.~~

~~B. Any other organization or person(s) who agree(s) to perform any administrative function or service for the Contractor specifically related to fulfilling the Contractor's obligations to DHCS under the terms of this Contract.~~

Subcontractor means an individual or entity ~~who~~ **that** has a Subcontract**or Agreement** with Contractor **or Contractor's Subcontractor** that relates directly or indirectly to the performance of Contractor's obligations under this Contract ~~with DHCS~~. **A Network Provider is not a Subcontractor by virtue of a Network Provider Agreement.**

Subcontractor Agreement means a written agreement between Contractor or Contractor's Subcontractor and a Subcontractor.

~~**Sub-Subcontractor** means any party to an agreement with a Subcontractor descending from and subordinate to a Subcontract, which is entered into for the purpose of providing any goods or services connected with the obligations under this Contract.~~

Working ~~d~~Day(s) mean State calendar (State Appointment Calendar, Standard 101) working day(s).

XXVI. Exhibit E, Attachment 2, PROGRAM TERMS AND CONDITIONS, is amended to read:

9. Certifications

A. Contractor shall certify all data, information, and documentation submitted to DHCS pursuant to 42 CFR 438.604, APL 17-005, and as listed below, in a form and manner specified by DHCS:

6) Contractor's information on ownership and control, including its Subcontractors **and Network Providers**;

15. Phaseout Requirements

A. DHCS shall retain the lesser of an amount equal to 10% of the last month's Service Area Capitation Payment or one million dollars ($1,000,000) for each Service Area unless provided otherwise by the Financial Performance Guarantee, from the Capitation Payment of the last month of the ~~O~~**o**perations ~~P~~**p**eriod for each Service Area until all activities required during the ~~P~~**p**haseout ~~P~~**p**eriod for each Service Area are fully completed to the satisfaction of DHCS, in its sole discretion.

If all ~~P~~**p**haseout activities for each Service Area are completed by the end of the ~~P~~**p**haseout ~~P~~**p**eriod, the withhold will be paid to ~~the~~ Contractor. ~~I~~If ~~the~~ Contractor fails to meet any requirement(s) by the end of the ~~P~~**p**haseout ~~P~~**p**eriod 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 ~~P~~**p**haseout ~~P~~**p**eriod is to ensure that, at the termination of this Contract, the orderly transfer of necessary data and history records is made from ~~the~~ Contractor to DHCS or to a successor Contractor. ~~The~~ Contractor shall not provide services to Members during the ~~P~~**p**haseout ~~P~~**p**eriod.

90 calendar days prior to termination or expiration of this Contract and through the ~~P~~**p**haseout ~~P~~**p**eriod for each Service Area, ~~the~~ Contractor shall assist DHCS in the transition of Members and in ensuring, to the extent possible, continuity of Member-Provider relationships. ~~I~~In doing this, ~~the~~ Contractor will make available to DHCS copies of Medical Records, patient files, and any other pertinent information, including information maintained by any Subcontractor **or Network Provider**, necessary for

efficient case management of Members, as determined by the Director. In no circumstances will a Medi-Cal Member be billed for this activity.

C. Phaseout for this Contract will consist of the processing, payment and monetary reconciliation(s) necessary regarding claims for payment for Covered Services.

Phaseout for this Contract will consist of the completion of all financial and reporting obligations of ~~the~~ Contractor. ~~The~~ 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 pursuant to this Contract prior to the expiration or termination. ~~The~~ Contractor will submit to DHCS all reports required in Exhibit A, Attachment 17, Reporting Requirements, for the period from the last submitted report through the expiration or termination date.

All data and information provided by ~~the~~ Contractor will be accompanied by letter, signed by the responsible authority, certifying, under penalty of perjury, to the accuracy and completeness of the materials supplied.

D. Phaseout ~~P~~**p**eriod will commence on the date the ~~O~~**o**perations ~~P~~**p**eriod of the Contract or Contract extension ends. ~~-~~Phaseout related activities are non-payable items.

19. Audit

In addition to Exhibit C, Provision 4, Audit, Contractor also agrees to the following:

Pursuant to 42 CFR 438. 3(h), DHCS, CMS, the DHHS Office of the Inspector General, the Comptroller General, and their designees may, at any time, inspect and audit any of Contractor's, or its Subcontractors**' and Network Providers**, records or documents and may, at any time, inspect the premises, physical facilities, and equipment where Medi-Cal-related activities or work is conducted. The right to audit under this Section exists for **ten (**10**)** years from the final date of the Contract period or from the date of completion of any audit, whichever is later.

~~The~~ Contractor will maintain such records and documents necessary to disclose how ~~the~~ Contractor discharged 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 ~~the~~ Contractor administered its daily business, and the cost thereof.

B. Records Retention

Notwithstanding any other records retention time period set forth in this Contract, Contractor**,** and all of its Subcontractors **and Network Providers,** shall maintain all of these records and documents for a minimum of ten (10) years from the final date of the Contract period or from the date of completion of any audit, whichever is later**.**

C. Additional Recordkeeping Requirements

2) Contractor shall also require Subcontractors **and Network Providers** to be compliant, as applicable, with 42 CFR 438.3(u).

20. Inspection Rights

In addition to Exhibit D(F), Provision 2, Site Inspection, Contractor also agrees to the following:

Through the end of the records retention period specified in Provision 19, Audit, Paragraph B, Records Retention above, Contractor shall allow the DHCS, the DHHS Office of the Inspector General, the Comptroller General of the United States, the DOJ Bureau of Medi-Cal Fraud, DMHC, and other authorized State agencies, or their duly authorized representatives or designees, including DHCS' EQRO contractor, to audit, inspect, monitor or otherwise evaluate the quality, appropriateness, and timeliness of services performed under this Contract, and to inspect, evaluate, and audit any and all premises, books, records, equipment, facilities, contracts, computers, or other electronic systems maintained by Contractor**,** ~~and~~ Subcontractors**, and Network Providers** pertaining to these services at any time, pursuant to 42 CFR 438.3(h).

Records and documents include, but are not limited to, all physical records originated or prepared pursuant to the performance under this Contract, including working papers, reports, financial records, and books of account, medical records, prescription files, laboratory results, ~~Subcontracts~~ **Subcontractor Agreements and Network Provider Agreements**, information systems and procedures, and any other documentation pertaining to medical and non-medical services rendered to Members. Upon request, through the end of the records retention period specified in Provision 19, Audit, Paragraph B, Records Retention above, Contractor shall furnish any record, or copy of it, to DHCS or any other entity listed in this section, at Contractor's sole expense.

If DHCS, CMS, or the DHHS Inspector General determines that there is a reasonable possibility of fraud or similar risk, DHCS, CMS, or the DHHS Inspector General may inspect, evaluate, and audit a Subcontractor **or Network Provider** at any time.

B. Access Requirements and State's Right to Monitor

Authorized State and federal agencies will have the right to monitor all aspects of ~~the~~ Contractor's operation for compliance with the provisions of this Contract and applicable Federal and State laws and regulations. Such monitoring activities will include, but are not limited to, inspection and auditing of Contractor, Subcontractor, **Network Provider,** and Provider facilities, management systems and procedures, and books and records as the Director deems appropriate, at any time, pursuant to 42 CFR 438.3(h). ~~-~~The monitoring activities will be either announced or unannounced.

To assure compliance with the Contract and for any other reasonable purpose, the State and its authorized representatives and designees will have the right to premises access, with or without notice to ~~the~~ Contractor. This will include the MIS operations site or such other place where duties under the Contract are being performed.

Staff designated by authorized State agencies will have access to all security areas and ~~the~~ Contractor will provide, and will require any and all of its Subcontractors **and Network Providers** to provide, reasonable facilities, cooperation and assistance to State representative(s) in the performance of their duties. ~~-~~Access will be undertaken in such a manner as to not unduly delay the work of ~~the~~ Contractor and/or the Subcontractor(s) **and Network Provider(s)**.

21. Confidentiality of Information

In addition to Exhibit D(F), Provision 4, 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., Section 14100.2, W&I Code, and regulations adopted thereunder. For the purpose of this Contract, all information, records, data, and data elements collected and maintained for the operation of the Contract and

pertaining to Members shall be protected by ~~the~~ Contractor from unauthorized disclosure.

Contractor may release ~~m~~**M**edical ~~r~~**R**ecords in accordance with applicable law pertaining to the release of this type of information. ~~-~~Contractor is not required to report requests for Medical Records made in accordance with applicable law.

B. With respect to any identifiable information concerning a Member under this Contract that is obtained by ~~the~~ Contractor or its Subcontractors **or Network Providers**, ~~the~~ Contractor~~: (1)~~ will**:**

1) ~~n~~**N**ot use any such information for any purpose other than carrying out the express terms of this Contract~~,~~**;**

~~(~~2) ~~will p~~**P**romptly transmit to DHCS all requests for disclosure of such information, except requests for Medical ~~r~~**R**ecords in accordance with applicable law~~,~~**;**

~~(~~3) ~~will n~~**N**ot disclose except as otherwise specifically permitted by this Contract, any such information to any party other than DHCS without DHCS' prior written authorization specifying that the information is releasable under Title 42, CFR, Section 431.300 et seq., Section 14100.2, ~~W & I~~ **W&I** Code, and regulations adopted thereunder~~,~~**;** and

~~(~~4) ~~will, a~~**A**t the termination of this Contract, return all such information to DHCS or maintain such information according to written procedures sent to ~~the~~ Contractor by DHCS for this purpose.

22. 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 ~~the~~ Contractor's obligations under this Contract. ~~-~~Any changes in the obligations of ~~the~~ Contractor that are necessary for the operation of a pilot project in ~~the~~ Contractor's Service Area will be implemented through a contract amendment.

25. Records Related To Recovery for Litigation

A. Records

Upon request by DHCS, Contractor shall timely gather, preserve and provide to DHCS, in the form and manner specified by DHCS, any information specified by DHCS, subject to any lawful privileges, in Contractor's or its Subcontractors' **or Network Providers'** possession, relating to threatened or pending litigation by or against DHCS. ~~(~~If Contractor asserts that any requested documents are covered by a privilege, Contractor shall:

1) ~~i~~**I**dentify such privileged documents with sufficient particularity to reasonably identify the document while retaining the privilege; and

2) ~~s~~**S**tate the privilege being claimed that supports withholding production of the document.~~)~~

Such request shall include, but is not limited to, a response to a request for documents submitted by any party in any litigation by or against DHCS. Contractor acknowledges that time may be of the essence in responding to such request. ~~-~~Contractor shall use all reasonable efforts to immediately notify DHCS of any subpoenas, document production requests, or requests for records, received by Contractor or its Subcontractors **or Network Providers** related to this Contract or Subcontract**or Agreement**s **and Network Provider Agreements** entered into under this Contract.

26. Fraud and Abuse Reporting

B. Contractor shall meet the requirements set forth in 42 CFR 438.608 by establishing administrative and management arrangements or procedures, as well as a mandatory compliance plan, which are designed to guard against fraud and abuse. These requirements shall be met through the following:

1) Contractor and its Subcontractor **or Network Provider**, to the extent that its Subcontractor **or Network Provider** is delegated responsibility by Contractor for coverage of services and payment of claims under this Contract, shall implement and maintain procedures that are designed to detect and prevent Fraud, Waste, and Abuse. The procedures must include a compliance program, as set forth in 42 CFR 438.608(a), that at a minimum includes all of the following elements:

6) When Contractor makes or receives annual payments under this

Contract of at least $5,000,000, provide written policies for all of its employees, and for any Subcontractor**, Network Provider,** or agent, that provides detailed information about the False Claims Act and other federal and State laws described in Section 1902(a)(68) of the Act, including information about rights of employees to be protected as whistleblowers.

7) Fraud and Abuse Reporting

Prompt referral of any potential Fraud, Waste, or Abuse that Contractor identifies to the DHCS Audits and Investigations Intake Unit. Contractor shall conduct, complete, and report to DHCS, the results of a preliminary investigation of the suspected fraud and/or abuse within **ten (**10**)** ~~w~~**W**orking ~~d~~**D**ays of the date Contractor first becomes aware of, or is on notice of, such activity.

Fraud reports submitted to DHCS must, at a minimum, include:

8) Tracking Suspended Providers

Contractor shall comply with 42 CFR 438.608(a)(8) and 438.610. Additionally, Contractor ~~is~~ **and its Subcontractors are** prohibited from employing, paying, contracting or maintaining a contract with physicians or other health care providers that are excluded, suspended or terminated from participation in the Medicare or Medi-Cal/Medicaid programs. ~~-~~A list of suspended and ineligible providers is maintained in the Medi-Cal Provider Manual, which is updated monthly and available on line and in print at the DHCS Medi-Cal Web site (http://www.medi-cal.ca.gov) and by the Department of Health and Human Services, Office of Inspector General, List of Excluded Individuals and Entities (http://oig.hhs.gov). ~~-~~Contractor is deemed to have knowledge of any providers on these lists. ~~-~~Contractor must notify the Medi-Cal Managed Care Program/Program Integrity Unit within **ten (**10**)** ~~State working days~~ **Working Days** of removing a suspended, excluded, or terminated provider from its Provider Network and confirm that the ~~p~~**P**rovider is no longer receiving payments in connection with the Medicaid program. ~~-~~A removed, suspended, excluded, or terminated provider report can be sent to DHCS in one of three **(3)** ways:

29. Federal and State Nondiscrimination Requirements

Contractor shall comply with all applicable federal requirements in Title VI of the Civil Rights Act of 1964; Title IX of the Education Amendments of 1972 (regarding education programs and activities, as amended); the Age Discrimination Act of 1975; the Rehabilitation Act of 1973, as amended; Titles I and II of the Americans with Disabilities Act of 1990, as amended; and Section 1557 of the Patient Protection and Affordable Care Act of 2010; and federal implementing regulations issued under the above-listed statutes. Contractor shall also comply with California nondiscrimination requirements, including, without limitation, the Unruh Civil Rights Act, Government Code ~~s~~**S**ections 7405 and 11135, W&I Code ~~s~~**S**ection 14029.91, and ~~s~~**S**tate implementing regulations.~~.~~

XXVII. Exhibit E, Attachment 3, DUTIES OF THE STATE, is amended to read:

5. DHCS Approval Process

B. Within 60 calendar days of receipt, DHCS shall make all reasonable efforts to approve in writing the use of such material provided to DHCS pursuant to Exhibit E, Attachment 2, Provision 8, Obtaining DHCS Approval, provide Contractor with a written explanation why its use is not approved, or provide a written estimated date of completion of DHCS' review process. ~~-~~If DHCS does not complete its review of submitted material within 60 calendar days of receipt, or within the estimated date of completion of DHCS review, Contractor may elect to implement or use the material at Contractor's sole risk and subject to possible subsequent disapproval by DHCS. ~~-~~This Paragraph shall not be construed to imply DHCS approval of any material that has not received written DHCS approval. ~~-~~This paragraph shall not apply to ~~Subcontracts or sub-subcontracts~~ **Subcontractor Agreements or Network Provider Agreements** subject to DHCS approval in accordance with Exhibit A, Attachment 6, Provision 1~~3~~**4**, ~~Subcontracts~~ **Network Provider Agreements and Subcontractor Agreements**, Paragraph ~~C~~**D**. regarding Departmental Approval – Non-Federally Qualified HMOs, and Paragraph ~~D~~**E**. regarding Departmental Approval – Federally Qualified HMOs.

10. Program Integrity

DHCS shall monitor during the Contract term on program integrity standards, in accordance with 42 CFR 438.602, and shall conduct the following:

C. Confirm the identity and determine the exclusion status of Contractor, any Subcontractor **or Network Provider**, as well as any person with an ownership or control interest, or who is an agent or managing employee of this Contract, through routine checks of federal databases. This includes

the Social Security Administration's Death Master File, the National Plan and Provider Enumeration System (NPPES), the List of Excluded Individuals/Entities (LEIE), the System for Award Management (SAM), and any other databases as the State or Secretary may prescribe. These databases must be consulted upon contracting and no less frequently than monthly thereafter. If the State finds a party that is excluded, it must promptly notify Contractor and take action consistent with 42 CFR 438.610(c).

H. Mental Health Parity

2) Ensure that Contractor, Subcontractors, **Network Providers,** and any contracted entities are not applying any financial or treatment limitations to mental health or substance use disorder benefits in any classification that is more restrictive than the predominant financial requirement or treatment limitation applied to medical/surgical benefits in the same classification.

XXVIII. All rights, duties, obligations and liabilities of the parties hereto otherwise remain unchanged.

V. Exhibit A, Attachment 9, ACCESS AND AVAILABILITY, Provision 10, is amended to read:

10. Changes in Availability or Location of Covered Services

1. Contractor must provide notification to DHCS immediately upon discovery of **a Provider initiated termination,** ~~and in any event, no later than~~ **or at least** 60 calendar days ~~prior~~ **before** ~~to~~ making any change in the availability or location of services to be provided under this Contract. In the event of an emergency or other unforeseeable circumstances, Contractor ~~shall~~ **must notify DHCS of the change in the availability or location of services** ~~provide notice of the emergency or other unforeseeable circumstance to DHCS~~ as soon as possible.

~~Network changes as outlined in APL 20-003 due to the change in the availability of location of Covered Services require written approval from DHCS prior to implementing the change.~~

2. Contractor must provide notification to DHCS within 10 calendar days of learning of a Provider's exclusionary status from any database or list included in APL 21-XXX or subsequent revisions.

VI. Exhibit A, Attachment 10, SCOPE OF SERVICES, Provision 5, is amended to read:

5. Services for Members under Twenty-One (21) Years of Age

Contractor shall cover and ensure the provision of all screening, preventive and Medically Necessary diagnostic and treatment services for Members under 21 years of age required under the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services benefit described in 42 USC Section 1396d(r), and W&I Code, Section 14132(v). The EPSDT benefit includes all Medically Necessary health care, diagnostic services, treatments and other measures listed in 42 USC Section 1396d(a), whether or not covered under the State Plan. All EPSDT services are Covered Services, unless excluded under this Contract.

D. ~~Blood Lead Screens~~**Screening for Childhood Lead Poisoning**

1) Contractor shall cover and ensure the provision of ~~a~~ blood lead screening test**s** to Members at **the** ages **and intervals, including ages** one (1) and two (2)**, as specified** in

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~~accordance with~~ Title 17 **CCR**, Division 1, Chapter 9, Articles 1 and 2, commencing with Section 37000**,** and in accordance with APL 20-016. Contractor shall ensure **its Network Providers** ~~their contracted providers~~ follow the CLPPB guidelines when interpreting blood lead levels and determining appropriate follow-up activities.

While the minimum requirements for appropriate follow-up activities, including referral, case management and reporting, are set forth in the CLPPB guidelines, a Network Provider may determine additional services that fall within the EPSDT benefit are Medically Necessary. Contractor must ensure that Members under the age of 21 receive all Medically Necessary care as required under EPSDT.

2) **Starting January 1, 2021,** Contractor **shall identify, on** ~~will be required to identify,~~ at least **a** quarterly **basis**, all **Members under the age of six (6)** ~~children~~ with no record of receiving a required **blood** lead **screening** test~~,~~**. Contractor shall identify the age at which a required blood lead screen test was missed, including Members under the age of six (6) without a record of a completed blood lead screening test at each age. Contractor shall notify the Network Provider, who is** ~~and remind the~~ responsible **for the** ~~health~~ care **of an identified Member,** ~~provider~~ of the requirement to test **that Member and provide the written or oral anticipatory guidance as required pursuant to Title 17 CCR, Section 37100, to the parent or guardian of that Member**~~children~~. **For a period of no less than 10 years, Contractor shall 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 refuses the blood lead screen**ing** test, Contractor shall ensure a signed statement of voluntary refusal by the Member (if an emancipated minor) or the parent(s) or guardian of the Member is documented in the Member's Medical Record. If the Member or authorized representative refuses to sign the statement, the refusal shall be noted in the Member's Medical Record. Documented unsuccessful attempts to provide the **blood**

lead screen**ing** test shall be considered evidence of Contractor meeting this requirement.

4) Contractor shall not require Network Providers to obtain a signed statement of voluntary refusal in limited situations where they are:

a) Unable to obtain a signed statement of voluntary refusal because the parent or guardian who withheld consent refuses or declines to sign; or

b) The parent or guardian is unable to sign (e.g. when services are provided via telehealth modality).

Contractor shall require Network Providers to document the reason for not obtaining a signed statement of voluntary refusal in the Member's Medical Record. DHCS will consider the above-mentioned documented efforts that are noted in the Member's Medical Record as evidence of Contractor's compliance with blood lead screen test requirements.

VII. Exhibit A, Attachment 13, MEMBER SERVICES, Provision 3, is amended to read:

3. Written Member Information

D. Member information shall include the Member Services Guide, provider directory, significant mailings and notices, and any notices related to Grievances, actions, and Appeals. All Member information shall be in a format that is easily understood and in a font size no smaller than 12-point, pursuant to 42 CFR 438.10.

4) Contractor shall post (1) a DHCS-approved nondiscrimination notice, **and** (2) language taglines in **a conspicuously visible font size in English,** the threshold languages**,** and at least the top ~~16~~ **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 ~~(3) a large print tagline in no smaller than 18-point font, explaining~~ **information on** how to request ~~free language assistance services and~~ Auxiliary Aids and services,

including materials in alternative formats. The nondiscrimination notice and taglines shall include Contractor's toll-free and TTY/TDD telephone number for obtaining these services, and shall be posted as follows:

a) In all conspicuous physical locations where Contractor interacts with the public;

b) In a ~~conspicuous~~ location on Contractor's website that is accessible on the Contractor's home page, and in a manner that allows Members, Potential Enrollees, and members of the public to easily locate the information; and

c) In ~~all~~ **the** Member **Services Guide/Evidence of Coverage, all Member** information, ~~and in all~~ **informational notices, and materials critical to obtaining services** ~~other significant communications and significant publications~~ targeted to Members, Potential Enrollees, applicants, and members of the public, ~~except for significant publications and significant communications that are small-sized, such as postcards and tri-fold brochures. (~~**in accordance with APL 21-XXX,** 42 CFR section 438.10(d)(2)-(3)~~; 45 CFR section 92.8(d)(1), (f)(1)(i)-(iii);~~ **, and** W&I Code, section 14029.91(f)~~).~~**.**

~~5) Contractor shall post (1) a DHCS-approved nondiscrimination statement and (2) language taglines in at least the top two non-English languages in the State (as determined by DHCS), explaining the availability of free language assistance services, and the toll-free and TTY/TDD telephone number for obtaining these services, and (3) a large print tagline in no smaller than 18-point font explaining how to request free language assistance services and Auxiliary Aids and services, including materials in alternative formats, as follows:~~

~~a) In all significant publications and significant communications that are small-sized, such as postcards and tri-fold brochures. (42 CFR section 438.10(d)(2)-(3); 45 CFR section 92.8(d)(2), (g)).~~

~~6~~**5**) Contractor's nondiscrimination notice shall include all information required by W&I Code section 14029.91(e), ~~45 CFR section 92.8,~~ any additional information required by DHCS, and shall provide information on how to file a discrimination Grievance with:

b) The United States Department of Health and Human Services Office for Civil Rights if there is a concern of discrimination based on race, color, national origin, sex, age, or disability. (~~45 CFR section 92.8(a)(7);~~ W&I Code section 14029.91(e)).

F. Contractor shall provide each Member, or family unit, a Member Services Guide that constitutes a fair disclosure of the provisions of, and the right to obtain, available and accessible covered health care services. DHCS shall provide Contractor with a template for the Member Services Guide prior to distribution to Members. Contractor shall submit a complete Member Services Guide to DHCS for review and approval prior to implementing. Contractor shall ensure that the Member Services Guide includes the following information:

35) That Auxiliary Aids and services are available upon request and at no cost for Members with disabilities, and how to access these services. ~~Include taglines in large-size print font no smaller than 18-point, on how to request Auxiliary Aids and Member information in alternative formats.~~

VIII. Exhibit A, Attachment 14, MEMBER GRIEVANCE AND APPEAL SYSTEM, Provision 1, is amended to read:

1. Member Grievance and Appeal System

Contractor shall have in place a system in accordance with Title 28 CCR, sections 1300.68 and 1300.68.01; Title 22 CCR section 53858; Exhibit A, Attachment 13, Provision 4, Paragraph F(13); and 42 CFR 438.402-424. Contractor shall follow Grievance and Appeal requirements, and use all notice templates included in APL ~~17-006~~ **XX-XXX**. Contractor shall ensure that its Grievance and Appeal system meets the following requirements:

IX. Exhibit A, Attachment 16, ENROLLMENTS AND DISENROLLMENTS, Provision 5, is amended to read:

5. Disenrollment

The enrollment contractor shall process a Member Disenrollment under the following conditions, subject to approval by DHCS, in accordance with the provisions of 22 CCR 53925.5:

~~B. The problem resolution attempted prior to a Contractor-initiated Disenrollment described in Subprovision B, must be documented by Contractor. A formal procedure for Contractor-initiated Disenrollments shall be established by Contractor and approved by DHCS. As part of the procedure, the Member shall be notified in writing by Contractor of the intent to disenroll the Member for cause and allowed a period of no less than 20 calendar days to respond to the proposed action.~~

~~1) Contractor must submit a written request for Disenrollment and the documentation supporting the request to DHCS for approval. The supporting documentation must establish the pattern of behavior and Contractor's efforts to resolve the problem. DHCS shall review the request and render a decision in writing within 10 working days of receipt of a Contractor request and necessary documentation. If the Contractor-initiated request for Disenrollment is approved by DHCS, DHCS shall submit the Disenrollment request to the enrollment contractor for processing. Contractor shall be notified by DHCS of the decision, and if the request is granted, shall be notified by the enrollment contractor of the effective date of the Disenrollment. Contractor shall notify the Member of the Disenrollment for cause if DHCS grants the Contractor-initiated request for Disenrollment.~~

~~2) Contractor shall continue to provide Covered Services to the Member until the effective date of the Disenrollment.~~

~~C~~**B**. Except as provided in Subprovision A, Paragraph 6, enrollment shall cease no later than midnight on the last day of the first calendar month after the Member's Disenrollment request and all required supporting documentation are received by DHCS. 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 persons no longer enrolled under this Contract.

~~D~~**C**. Contractor shall implement and maintain procedures to ensure that all Members requesting Disenrollment or information regarding the Disenrollment process are immediately referred to the enrollment contractor.

X. Exhibit B, BUDGET DETAIL AND PAYMENT PROVISIONS, Provision 4, is amended to read:

4. Capitation Rates

A. DHCS shall remit to Contractor a Capitation Payment each month for each Member that appears on the approved list of Members supplied to Contractor by DHCS. The payment period for health care services shall commence on the first day of operations, as determined by DHCS. Capitation Payments shall be made in accordance with the following schedule of capitation rates. For aid codes, see DEFINITIONS, Eligible Beneficiary:

For the period ~~07/01/19 –12/31/2020~~ 01/01/2021-03/31/2021	**County**
Groups	**Rates**
Adult & Family/Optional Targeted Low-Income Child (Under 19)	
Adult & Family/Optional Targeted Low-Income Child (19 & Older)	
Adult & Family/Optional Targeted Low-Income Child (Dual)	
SPD	
SPD/Dual	
SPD/Dual (Non-CCI)	
Long Term Care/Full Dual	
Long Term Care/Non-Full Dual	
Long Term Care/Full Dual (Non-CCI)	
~~Breast and Cervical Cancer Treatment Program (BCCTP)~~	
Maternity	
Adult Expansion	
Maternity Expansion	
Hepatitis C/340B	
Hepatitis C/Non-340B	
HCBS High	

BHT/Ages 0-6	
BHT/Ages 7-20	

XI. Exhibit B, BUDGET DETAIL AND PAYMENT PROVISIONS, Provision 15, is amended to read:

15. Special Contract Provisions Related to Directed Payment Initiatives and Pass-Through Payment Programs

A. Contractor shall comply with the terms of each applicable Directed Payment Initiative ~~approved by CMS~~ under 42 CFR 438.6(c), in a form and manner specified by DHCS through All Plan Letters or other technical guidance. For applicable State Fiscal Years (SFY) or Rating Periods, commencing with SFY 2017-18, DHCS shall make the terms of each ~~approved~~ Directed Payment Initiative available on the DHCS website at **www.dhcs.ca.gov**.

XII. Exhibit B, BUDGET DETAIL AND PAYMENT PROVISIONS, Provision 19, is added to read:

19. Capitation Payments for 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 do no work on that part after the effective date of the loss of such program authority. DHCS must adjust capitation rates to remove costs that are specific to any State program or activity receiving FFP that is no longer authorized by law. 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.

XIII. Exhibit E, Attachment 1, DEFINITIONS, is amended to read:

As used in this Contract, unless otherwise expressly provided or the context otherwise requires, the following definitions of terms will govern the construction of this Contract:

Directed Payment Initiative means a payment arrangement **that directs certain expenditures made by Contractor under this Contract that is either** approved by CMS **as** described in 42 CFR **section** 438.6(c)**, or** ~~that directs certain expenditures made by Contractor under this Contract.~~ **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.**

Eligible Beneficiary means any Medi-Cal beneficiary who is residing in Contractor's Service Area with 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, 30, 32, 33, 34, 35, 37, 38, 39, 3A, 3C, 3E, 3F, 3G, 3H, 3L, 3M, 3N, 3P, 3R, 3U, 3W, 47, 54, 59, 72, 7A, 7J, 7S, 7W, 7X, 82, 8P, 8R, E2, E5, K1, M3, M7, P5, P7, P9, 5C, 5D, E6, E7, H1, H2, H3, H4, H5, M5, T1, T2, T3, T4, T5	03, 04, 06, 07, 40, 42, 43, 45, 46, 49, 86, 4A, 4F, 4G, 4H, 4K, 4L, 4M, 4N, 4S, 4T, 4W, 5K
Family/Dual Eligible	0E, 30, 32, 33, 34, 35, 37, 38, 39, 3E, 3F, 3G, 3H, 3L, 3M, 3N, 3P, 3R, 3U, 3W, 47, 54, 59, 72, 7A, 7J, 7W, 7X, 82, 8P, 8R, E2, E5, K1, M3, M7, P5, P7, P9	03, 04, 06, 07, 40, 42, 43, 45, 46, 49, 4A, 4F, 4G, 4H, 4K, 4L, 4M, 4N, 4S, 4T, 4W, 5K
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	**0N, 0P, 0W**
Adult Expansion	L1, M1, 7U	
~~Breast and Cervical Cancer Treatment Program (BCCTP)~~		~~0N, 0P, 0W~~
Long Term Care/Full Dual Eligible	13, 23, 63	

Long Term Care/ Non-Full Dual Eligible	13, 23, 63	
SPD/Dual Eligible	10, 14, 16, 17, 1E, 1H, 1X, 1Y, 20, 24, 26, 27, 2E, 2H, 36, 60, 64, 66, 67, 6A, 6C, 6E, 6G, 6H, 6J, 6N, 6P, 6V, 6W, 6X, 6Y	

XIV. Exhibit E, Attachment 2, PROGRAMS TERMS AND CONDITIONS, Provision 23, is amended to read:

23. Cost Avoidance and Post-Payment Recovery (PPR) of Other Health Coverage (OHC) ~~Sources (OHCS)~~

A. Contractor **must** ~~shall~~ Cost Avoid or make a ~~Post-Payment Recovery~~ **PPR** for the reasonable value of services paid ~~for~~ by Contractor and rendered to a Member whenever a Member's OHC~~S~~ covers the same services, ~~either~~ fully or partially. However, in no event shall Contractor Cost Avoid or seek ~~Post-Payment Recovery~~ **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 rely on the Medi-Cal eligibility record for Cost Avoidance and PPR purposes.

~~B~~**C**. Contractor retains all monies **for PPR when** ~~recovered by~~ Contractor **initiates and completes recovery within 12 months from the Member's date of service**. **Any monies for PPR obtained after the 12 months following the Member's date of service shall be considered DHCS' recoveries and shall be remitted to DHCS.**

~~C~~ **D**. Contractor ~~shall~~ **must** coordinate benefits with other coverage programs or entitlements, recognizing the OHC~~S~~ as primary and the Medi-Cal program as the **payer** ~~payor~~ of last resort**, except for services in which Medi-Cal is required to be the primary payer**.

E. Contractor shall demonstrate to DHCS where Contractor does not perform PPR that the reasonably anticipated aggregate cost of PPR would exceed the total revenues Contractor projects it would receive from PPR annually.

~~B.~~ **F.** Cost Avoidance

1) **Contractor shall 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.** ~~If Contractor reimburses the Provider on a FFS basis, Contractor shall 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.~~ Contractor shall have written **policies and** procedures implementing this requirement. **Acceptable forms of proof that all sources of payment have been exhausted or does 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 that the Provider has billed the OHC and received no response for 90 days.**

2) Contractor must ensure Providers do not refuse customer service to Members, when OHC is indicated on a Member's Medi-Cal eligibility record.

3)~~2)~~ **Contractor must allow Providers to direct bill services that meet DHCS' requirements for direct billing without attempting to Cost Avoid those services. Cost Avoidance** ~~Proof of third party billing~~ 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 Provider Manual section "Other Health Coverage (OHC): CPT-4 and HCPCS Codes (oth hlth cpt)".**

4) When Contractor denies a claim due to OHC, Contractor must include OHC information in its notice of claim denial to the Provider. OHC information includes, but is not limited to, the name of the OHC or Medicare carrier, and contact and billing information of the OHC.

G. Reporting Requirements for Cost Avoidance

Contractor must report new OHC information not found on the Medi-Cal eligibility record or is different from what is reflected on the Medi-Cal eligibility record to DHCS within ten (10) 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 http://dhcs.ca.gov/OHC; or Reporting OHC information to DHCS in batch updates. Batch updates regarding OHC information are processed by DHCS on a weekly basis. MCPs can contact their Managed Care Operations Division (MCOD) Contract Manager for more information regarding this process.

~~E.~~ **H.** Post-Payment Recovery **(PPR)**

1) ~~If Contractor reimburses the Provider on a FFS basis,~~ Contractor shall pay the Provider's claim and then seek to recover the cost of the claim by billing the liable third parties **in either of the following circumstances**:

   a) For services provided to Members with OHC code A; **or**

   b) For ~~services defined by DHCS as prenatal or~~ preventive pediatric services~~; or~~**.**

   ~~c) In child-support enforcement cases, identifiable by Contractor. If Contractor does not have access to sufficient information to determine whether or not the OHC coverage is the result of a child enforcement case, Contractor shall follow the procedures for Cost Avoidance.~~

2) ~~In instances where Contractor does not reimburse the Provider on a FFS basis, Contractor shall pay for services provided to a Member whose eligibility record indicates third party coverage, designated by a OHC code or Medicare coverage, and then shall bill the liable third parties for the cost of actual services rendered.~~ **When Contractor discovers a service has been 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.

3) ~~Contractor shall also bill the liable third parties for the cost of services provided to Members who are retroactively identified by Contractor or DHCS as having OHC.~~ **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 service. Monies recovered by DHCS or its recovery Contractor starting the first day of the 13th month after the date of payment of a service will be retained by DHCS.**

4) Contractor shall have written **policies and** procedures implementing the ~~above~~ requirements **of this provision**.

~~F)~~**I.** Reporting Requirements

~~1)~~ Contractor ~~shall~~ **must** maintain reports ~~that~~ display**ing** claims counts and dollar amounts of costs avoided and the amount of Post-Payment Recoveries, by aid category, as well as the amount of outstanding recovery claims (accounts receivable) by age of account **(Post-Payment Recovery Report)**. -The report shall display separate claim counts and dollar amounts for Medicare Part A, Part B, and Part D. ~~Reports shall be made available upon DHCS request.~~ **Contractor must submit a monthly Post-Payment Recovery Report to DHCS by the 10th day of each month.**

~~2) When Contractor identifies OHC unknown to DHCS, Contractor shall report this information to DHCS within ten (10) calendar days of discovery in automated format as prescribed by DHCS. This information shall be sent to the California Department of Health Care Services, Third Party Liability Branch, Other Coverage Unit, P.O. Box 997422, Sacramento, CA 95899-7422.~~

~~3) Contractor shall demonstrate to DHCS that where Contractor does not Cost Avoid or perform Post-Payment Recovery that the aggregate cost of this activity exceeds the total revenues Contractor projects it would receive from such activity~~

XV. Exhibit E, Attachment 2, PROGRAMS TERMS AND CONDITIONS, Provision 24, is amended to read:

24. Third-Party Tort Liability

~~Contractor shall identify and notify DHCS' Third Party Liability Branch of all instances or cases in which Contractor believes an action by the Medi-Cal Member involving casualty insurance or tort or Workers' Compensation liability of a third party could result in recovery by the Member of funds to which DHCS has lien rights under Article 3.5 (commencing with Section 14124.70), Part 3, Division 9, Welfare and Institutions Code.~~ Contractor shall make no claim for recovery of the value of Covered Services rendered to a Member in ~~such~~ cases or instances **involving casualty insurance, tort, Workers' Compensation, or class action claims.** ~~and such case or instance shall be referred to DHCS' Third Party Liability Branch within ten (10) calendar days of discovery.~~ To assist DHCS in exercising its responsibility for such recoveries, Contractor shall meet the following requirements:

A. If DHCS requests service information and/or copies of paid invoices/claims for Covered Services to an individual Member, Contractor shall deliver the requested information within 30 calendar days of the request. Service information includes Subcontractor and Out-of-Network Provider data. The value of the Covered Services shall be calculated as the usual, customary and reasonable charge made to the general public for similar services or the amount paid to subcontracted Providers or Out-of-Network Providers for similar services.

B. Information to be delivered ~~shall~~ **must contain Provider and Member information as set forth in APL 20-019, or as provided in a form supplied by DHCS.** ~~the following data items:~~

~~1) Member name.~~

~~2) Full 14 digit Medi-Cal number.~~

~~3) Social Security Number.~~

~~4) Date of birth.~~

~~5) Contractor name.~~

~~6) Provider name (if different from Contractor).~~

~~7) Dates of service.~~

~~8) Diagnosis code and description of illness/injury.~~

~~9) Procedure code and/or description of services rendered.~~

~~10) Amount billed by a Subcontractor or Out-of-Network Provider to Contractor (if applicable).~~

~~11) Amount paid by other health insurance to Contractor or Subcontractor (if applicable).~~

~~12) Amounts and dates of claims paid by Contractor to Subcontractor or Out-of-Network Provider (if applicable).~~

~~13) Date of denial and reasons for denial of claims (if applicable).~~

~~14) Date of death (if applicable).~~

C. Contractor must include an attestation, signed by the custodian of records or a designee with knowledge of the **Member information provided to DHCS. This attestation must include a statement that the calculations of the reasonable value of services and** submitted service and utilization information**, including** ~~and~~ copies of paid invoices/claims **are true, correct, and accurate**. Contractor's attestation must comply with the requirements of the Third Party Liability Reporting Requirements APL 20-019.

D. Contractor shall identify to DHCS' Third Party Liability ~~Branch~~ **and Recovery Division** the name, address and telephone number of the person responsible for receiving and complying with requests for mandatory and/or optional at-risk service information.

E. If Contractor receives any requests from attorneys, insurers, or beneficiaries for ~~copies of bills~~ **a lien, pursuant to the Department's recovery rights**, Contractor shall refer the request to the Third Party Liability ~~Branch~~ **and Recovery Division** with the information contained in Paragraph B above, and shall provide the name, address and telephone number of the requesting party. **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 records pursuant to the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

F. **Service and Utilization information** ~~Information~~ submitted to DHCS under this section shall be sent **through** the **DHCS' secure file transfer protocol site: https://etransfer.dhcs.ca.gov.** ~~California Department of Health Care Services, Third Party Liability Branch, Recovery Section, MS 4720, P.O. Box 997425, Sacramento, CA 95899-7425~~.

XVI. All rights, duties, obligations and liabilities of the parties hereto otherwise remain unchanged.

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken October 7, 2021
Regular Meeting of the CalOptima Board of Directors

Consent Calendar

9. Consider Authorizing Execution of an Amendment(s) to CalOptima's Primary Medi-Cal Agreement with the Department of Health Care Services Related to Enhanced Care Management, In Lieu of Services, and Additional Covered Aid Codes

Contacts

Carmen Dobry, Executive Director, Compliance, (657) 235-6997
Mike Herman, Interim Executive Director, Program Implementation, (714) 246-8820

Recommended Action

Authorize and direct the Chairman of the Board of Directors to execute an Amendment(s) to CalOptima's Primary Medi-Cal Agreement with the Department of Health Care Services (DHCS) related to Enhanced Care Management (ECM), In Lieu of Services (ILOS), and additional covered aid codes.

Background

As a County Organized Health System (COHS), CalOptima contracts with DHCS to provide health care services to Medi-Cal beneficiaries in Orange County. In January 2009, CalOptima entered into a new five (5) year agreement with the California Department of Health Care Services (DHCS). Amendments to this agreement are summarized in the attached appendix, including Amendment 49, which extends the agreement through December 31, 2021. The agreement contains, among other terms and conditions, the payment rates CalOptima receives from DHCS to provide health care services.

Discussion

In June 2021, DHCS provided managed care plans (MCPs) with finalized DHCS – MCP Enhanced Care Management (ECM) and In Lieu of Services (ILOS) contract amendment provisions, but did not indicate a date when this contract amendment would be submitted to the Centers for Medicare and Medicaid Services (CMS).

The contract amendment provisions include standardized statewide requirements regarding the administration and delivery of ECM and ILOS that will be incorporated into MCP contracts, including CalOptima's, effective January 1, 2022 as part of DHCS's California Advancing and Innovating Medi-Cal (CalAIM) proposal.

The new ECM benefit transitions successful elements from the current Health Homes Program (HHP) and Whole Person Care (WPC) pilot to provide a whole-person approach to care that addresses the clinical and non-clinical needs of high-need/high-cost Medi-Cal members. The ECM benefit will be available for Medi-Cal managed care members, including CalOptima members, who are at the highest risk level and need long-term and intensive coordination for multiple chronic conditions and who access various system types and delivery systems. The goals of the benefit are to improve care coordination, integrate services, facilitate access to and utilization of community resources, improve health outcomes, address social determinants of health, and decrease inappropriate utilization.

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ILOS are voluntary non-traditional services that are deemed medically appropriate and cost-effective alternatives to existing State Plan benefits. ILOS provides for flexible wrap-around services that Medi-Cal MCPs, including CalOptima, will be able to offer as part of the overall population health management strategy as viable substitutes to more costly services such as hospital inpatient and long-term institutional care.

The amendment does not contain any rate changes or otherwise set any rates Staff anticipates receiving final Calendar Year (CY) 2022 rates from the DHCS in September 2021 and will subsequently request authority from the Board of Directors to authorize and direct the Chairman to execute such an amendment. To date, DHCS has only shared draft boilerplate contract amendments with MCPs at this time. If the final CalOptima-specific contract amendment is not consistent with staff's understanding as presented in this document, or if it includes substantive and unexpected language changes, staff will return to the Board of Directors for further consideration.

Following is a description of the ECM contract amendment requirements sorted by category:

ECM Category	Requirement
Administration of Enhanced Care Management (ECM)	- Take a whole-person approach to offering ECM ensuring that ECM addresses the clinical and non-clinical needs of high-cost and/or high-need members in distinct populations of focus. - Ensure ECM is available throughout CalOptima's service area. - Ensure ECM is offered primarily through in-person interaction where members/family members seek or prefer to access services in their local community. - In-person visits may be supplemented with secure teleconferencing and telehealth, when appropriate and with the member's consent. - Ensure members who may benefit from ECM receive ECM. - Ensure ECM provided to each member encompasses the ECM Core Services Components. - Oversee the delivery of ECM to authorized members through its contracted ECM providers. - Pay contracted ECM providers for the provision of ECM, including outreach to assigned members. - Develop member-facing written material about ECM for use across the ECM provider network.
Populations of Focus for ECM	- Provide ECM to highest risk members who are part of the populations of focus. - Follow all DHCS guidance that further defines the approach to ECM for each population of focus.
ECM Providers	- Ensure ECM is provided primarily through in-person interaction in settings most appropriate for the members. - Contract with ECM providers to provide ECM services.

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	- Contract with each Whole Person Care (WPC) entity or Health Homes Program (HHP) Community-Based Care Management Entities (CB-CMEs) as an ECM provider unless there is an applicable exception. - Ensure ECM providers have processes in place to serve ECM populations of focus. - Ensure ECM providers are Medicaid-enrolled where a State-level pathway exists.
ECM Provider Capacity	- Develop and manage a network of ECM providers. - Ensure sufficient ECM capacity to meet the needs of all ECM populations of focus. - Report ECM provider capacity to DHCS initially with the Model of Care template and on an ongoing basis pursuant to DHCS reporting requirements.
Model of Care (MOC)	- Develop and submit a MOC to DHCS outlining the MCP's framework for providing ECM. - Incorporate MOC requirements into ECM provider contracts.
Transition of Whole Person Care and Health Homes Program to ECM	- Promote continuity from the WPC Pilot and HHP to ECM. - Authorize ECM for members in HHP and WPC Pilot counties, following DHCS's implementation schedule.
Identifying Members for ECM	- Identify members who can benefit from ECM and meet the criteria for ECM populations of focus. - Engage with Network Providers and County agencies to inform these entities of ECM, the ECM populations of focus, and how to request ECM for members. - Encourage ECM providers to identify members who meet the criteria for the ECM populations of focus. - Implement a process for allowing members and/or family members, and authorized representative (AR) to request ECM on the member's behalf and provide information to members regarding the ECM request and approval process.
Authorizing Members for ECM	- Authorize ECM for each member identified as eligible for ECM. - Develop policies and procedures that explain how ECM will be authorized in an equitable and nondiscriminatory manner. - Ensure members are informed of ECM authorization decisions within medical authorization timeframe requirements. - For ECM services not authorized, ensure members are informed of their appeal rights through the Notice of Action (NOA). - Encourage plans to work with ECM providers to define a process and appropriate circumstances for presumptive authorization or preauthorization of ECM.

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Assignment to ECM Provider	- Members authorized for ECM shall be assigned to an ECM provider. - Ensure communication of assignment to the designated ECM provider occurs within ten business days of authorization. - MCPs shall permit members to change ECM providers at any time and must implement any requested ECM provider change within thirty days.
Initiating Delivery of ECM	- MCPs shall not require member authorization for ECM-related data sharing as a condition of initiating delivery of ECM, unless such authorization is required by federal law. - Upon initiation of ECM, ensure each member receiving ECM has a Lead Care Manager, with responsibility for interacting directly with the member and/or family, AR, caretakers, and/or other authorized support person(s) as appropriate. - Ensure accurate and up-to-date Member-level records related to the provision of ECM services are maintained for members authorized for ECM.
Discontinuation of ECM	- Ensure that members are able to decline or end ECM upon initial outreach and engagement, or at any time thereafter. - Providers must notify the MCP when ECM services are being discontinued. - Develop processes to determine if members are no longer authorized to receive ECM and notify ECM providers to initiate discontinuation of services. - Notify members of the discontinuation of ECM and their appeals rights through the NOA process.
Core Service Components of ECM	- Ensure all members receiving ECM receive all core service components including (1) outreach and engagement (2) comprehensive assessment and care management plan, (3) enhanced coordination of care, (4) health promotion, (5) comprehensive transitional care, (6) member and family supports and (7) coordination of and referral to community and social support services.
Data Systems Requirements and Data Sharing to Support ECM	- Have IT infrastructure capabilities to support ECM. - Use defined Federal and State standards, specifications, code sets and terminologies when sharing data with ECM providers and DHCS, to the extent practicable.
Oversight of ECM Providers	- MCPs shall perform oversight of ECM providers, holding them accountable to all ECM requirements contained in these contract provisions. - MCPs shall use ECM Provider Standard Terms and Conditions to develop its ECM contracts with ECM providers and shall incorporate all ECM provider requirements, reviewed and

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	approved by DHCS, as part of the MOC, including all monitoring and reporting expectations and criteria. - Provide ECM training and technical assistance to ECM providers.
Delegation of ECM to Subcontractors	- MCPs may subcontract with other entities to administer ECM in accordance with the contract provisions.
Payment	- MCPs shall pay contracted ECM providers for the provision of ECM in accordance with contracts established between the MCP and each ECM provider.
DHCS Oversight of ECM	- Submission of encounter data and supplemental reporting to DHCS to support DHCS's oversight of ECM. - Track and report to DHCS, in a format defined by DHCS, information about outreach efforts related to potential members to be enrolled in ECM. - DHCS may impose sanctions in the event of underperformance by the MCP in relation to the administration of ECM.
ECM Quality and Performance Incentive Program	- Meet all quality management and quality improvement requirements and any additional quality requirements for ECM as set forth by DHCS.

Following is a description of the ILOS contract amendment requirements sorted by category:

ILOS Category	**Requirement**
Contractor's Responsibility for Administration of In Lieu of Services (ILOS)	- MCPs are authorized and encouraged to provide DHCS pre-approved ILOS. - Adhere to DHCS guidance on eligible populations, code sets, potential ILOS providers, and parameters for each ILOS that the MCP chooses to provide. - Identify members who may benefit from ILOS and for whom ILOS will be a medically appropriate and cost-effective substitute for State Plan covered services and accept requests for ILOS from members and on behalf of members from providers and organizations that serve them.
DHCS Pre-Approved ILOS	- MCPs can choose to offer members one or more of the pre-approved ILOS included in the CalAIM Proposal and any subsequent DHCS – approved ILOS additions. - MCPs must indicate which ILOS it will offer in the MOC template and through MOC amendments. - Ensure ILOS are provided to members in as timely a manner as possible, and develop policies and procedures outlining the approach to managing provider shortages or other barriers to timely provision of ILOS.

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	- MCPs are permitted to begin offering new pre-approved ILOS every six (6) months upon notice and submission of an updated MOC to DHCS. - MCPs may discontinue offering ILOS annually with a notice to DHCS. - Notify members affected by decision to discontinue an ILOS of the change and timing of discontinuation and procedures that will be used to ensure completion of authorized ILOS or transition into other medically necessary services.
ILOS Providers	- Contract with ILOS providers for the delivery of elected ILOS. - Ensure all ILOS providers contracted with the MCP have sufficient experience/training in the provision of ILOS being offered. - Ensure ILOS providers are enrolled in Medi-Cal where a State-level pathway exists pursuant to relevant DHCS All-Plan Letters (APLs).
ILOS Provider Capacity	- Make best efforts to develop a robust network of ILOS providers to deliver all elected ILOS. - MCPs shall take appropriate steps outlined in the contract provision when unable to offer its elected ILOS to all eligible members for whom it is medically appropriate and cost-effective. - Ensure contracted ILOS providers have sufficient capacity to receive referrals for ILOS and provide the ILOS to members authorized for the services on an ongoing basis.
Model of Care	- Develop and submit a MOC to DHCS outlining the MCP's framework for providing ILOS. - Submit any significant MOC changes to DHCS for review and approval 60 days in advance of any changes or updates, consistent with DHCS guidance.
Transition of Whole Person Care (WPC) and Health Homes Program (HHP) to ILOS	- Encourage MCPs to offer ILOS to HHP and WPC participants who are being provided similar services through WPC or HHP to provide continuity of services. - Contract with all WPC Lead Entities and HHP CB-CMEs ILOS providers with various exceptions as specified by DHCS.
Identifying Members for ILOS	- Utilize a variety of methods to identify members who may benefit from ILOS. - Develop policies and procedures defining how MCPs will identify members, accept ILOS requests from providers, other community-based entities, and member and/or their family and inform members of ILOS for which they may be eligible.

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Authorizing Members for ILOS and Communication of Authorization Status	- Develop policies and procedures explaining how the MCP will authorize ILOS for eligible members in an equitable and non-discriminatory manner. - Monitor and evaluate ILOS authorizations to ensure they are equitable and non-discriminatory. - Validate member eligibility for ILOS using a consistent methodology and authorize ILOS for members for whom ILOS is determined to be a medically appropriate and cost-effective alternative to services and settings covered under the State Plan. - Encourage MCPs to work with ILOS providers to define a process and appropriate circumstances for presumptive authorization of ILOS. - Follow standard grievance and appeals processes for ILOS services not authorized. - Notify requesting provider, entity, or member of ILOS authorization decisions.
Referring Members to ILOS Providers for ILOS	- Develop policies and procedures defining the ILOS provider referral process. - If member's preferences for an ILOS provider are known, MCPs shall follow those preferences, to the extent practicable. - MCPs shall not require member authorization for ILOS-related data sharing as a condition of initiating delivery of ILOS unless such authorization is required by federal law. - Track referrals to ILOS providers to verify delivery of authorized service.
Data System Requirements and Data Sharing to Support ILOS	- MCPs shall use systems and processes capable of tracking ILOS referrals, access to ILOS, and grievances and appeals to the MCP. - As part of the referral process to ILOS providers, ensure ILOS providers have access to demographic, administrative, clinical, social service, and billing information. - Use defined Federal and State standards, specifications, code sets and terminologies when sharing data with ILOS providers and DHCS, to the extent practicable.
Oversight of ILOS Providers	- MCPs shall perform oversight of ILOS providers, holding them accountable to all ILOS requirements contained in these contract provisions and associated guidance and the MCP's MOC. - MCPs shall use ILOS Provider Standard Terms and Conditions to develop its ILOS contracts with ILOS providers. - Provide ILOS training and technical assistance to ILOS providers.

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Delegation of ILOS to Subcontractors	- MCPs may contract with other entities to administer ILOS.
Payment of ILOS Providers	- MCPs shall pay contracted ILOS providers for the provision of authorized ILOS to members in accordance with established contracts between the MCP and each ILOS provider. - Utilize claims timeline and process as outlined in the MCP contract with DHCS. - Ensure ILOS providers submit a claim for ILOS rendered, to the greatest extent possible.
DHCS Oversight of ILOS	- The MOC must include details on the ILOS to be provided by the MCP. - Submission of encounter data and supplemental reporting to DHCS to support DHCS's oversight of ILOS. - DHCS may administer sanctions in the event of underperformance by the MCP in relation to the administration of ILOS.
ILOS Quality and Performance Incentive Program	- Meet all quality management and quality improvement requirements and any additional quality requirements for ECM as set forth by DHCS. - MCPs may participate in a performance incentive program related to the adoption of ILOS, building infrastructure and provider capacity for ILOS, related health care quality and outcomes, and/or other performance milestones and measures, to be defined in DHCS guidance.

Aid Code Additions

Additionally, as outlined in DHCS's CalAIM proposal, DHCS is proposing to standardize which aid code groups will require mandatory managed care enrollment versus mandatory Fee-for-Service (FFS) enrollment, across all models of care and aid code groups, statewide. Under the proposal, members in a voluntary aid code or aid code that is excluded from managed care enrollment and are currently accessing the Medi-Cal FFS delivery system, would be required to participate in the Medi-Cal managed care plan delivery system and will not be permitted to remain in FFS. The aid codes outlined below incorporate the populations that currently receive benefits through the FFS delivery system that will transition to Medi-Cal managed care upon implementation of the CalAIM proposal effective January 1, 2022.

New Aid Code – 2V

Effective January 1, 2022, DHCS will begin to enroll newly eligible members into MCPs, including CalOptima, using aid code 2V. Aid code 2V covers non-citizen victims of human trafficking, domestic violence, and other serious crimes. Aid code 2V is considered an "Adult & Family/Optional Targeted Low–Income Child" aid code for payment purposes.

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New Aid Code – 5V
Effective January 1, 2022, DHCS will begin to enroll newly eligible members into MCPs, including CalOptima, using aid code 5V. Aid code 5V covers non-citizen victims of human trafficking, domestic violence, and other serious crimes. Aid code 5V is considered an "Adult & Family/Optional Targeted Low–Income Child" aid code for payment purposes.

New Aid Code 8E
Effective January 1, 2022, DHCS will begin to enroll newly eligible members into MCPs, including CalOptima, using aid code 8E. Aid code 8E provides immediate, temporary, Fee-for-Service (FFS), full-scope Medi-Cal benefits for children age 19 or younger. Aid code 8E is considered an "Adult & Family/Optional Targeted Low–Income Child" aid code for payment purposes.

New Aid Code – 44
Effective January 1, 2022, DHCS will begin to enroll newly eligible members into MCPs, including CalOptima, using aid code 44. Aid code 44 provides eligible pregnant women of any age with family planning, pregnancy-related services, including services for conditions that may complicate the pregnancy, and postpartum services if family income is at or below 213 percent of the federal poverty level (FPL). Aid code 44 is considered an "Adult & Family/Optional Targeted Low–Income Child" aid code for payment purposes.

New Aid Code – M9
Effective January 1, 2022, DHCS will begin to enroll newly eligible members into MCPs, including CalOptima, using aid code M9. Aid code M9 provides family planning, pregnancy-related services, including services for conditions that may complicate the pregnancy, postpartum services, and emergency services to citizens/lawfully present pregnant women with income at 139 up to and including 213 percent of the FPL. Aid code M9 is considered an "Adult & Family/Optional Targeted Low–Income Child" aid code for payment purposes.

DHCS has informed CalOptima that it intends to include language authorizing these aid codes into a forthcoming contract amendment for CalOptima but has not specified the timing or additional content of that contract amendment. If the updated contract amendment is not consistent with staff's understanding as presented in this document, or if it includes substantive and unexpected language changes, staff will return to the Board of Directors for further consideration.

Fiscal Impact
The Fiscal Year (FY) 2021-22 Operating Budget approved by the Board on June 3, 2021, assumes that CalOptima will take on financial risk for the mandatory ECM benefit and optional ILOS effective January 1, 2022. Payments related to these new benefits and services were treated as budget neutral. However, given the limited available information, projected costs for these changes are difficult to predict. DHCS intends to release final ECM rates in late September 2021. CalOptima will continue to advocate for adequate funding with DHCS and will monitor utilization and expenses related to the new benefit and services.

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The net fiscal impact of the additional covered aid codes is not anticipated to have a significant impact and is expected to increase enrollment by approximately 2,500 members. Staff assumes DHCS will provide sufficient Medi-Cal revenue to cover anticipated expenses.

Rationale for Recommendation

CalOptima's execution of the ECM and ILOS contract amendment to its Primary Agreement with the DHCS is necessary to ensure compliance with the ECM and ILOS components of DHCS's CalAIM proposal. The added aid codes will ensure that CalOptima is authorized to provide services for and receive capitation payments for populations deemed eligible by the State of California.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. Appendix summary of amendments to Primary Agreements with DHCS
2. DHCS's California Advancing and Innovating Medi-Cal (CalAIM) Proposal
3. DHCS-MCP ECM and ILOS Contract Template Provisions

/s/ Richard Sanchez — *09/29/2021*

Authorized Signature — **Date**

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APPENDIX TO AGENDA ITEM 9

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

Amendments to Primary Agreement	Board Approval
A-01 provided language changes related to Indian Health Services, home and community-based services, and addition of aid codes effective January 1, 2009.	October 26, 2009
A-02 provided rate changes that reflected implementation of the gross premiums tax authorized by AB 1422 (2009) for the period January 1, 2009, through June 30, 2009.	October 26, 2009
A-03 provided revised capitation rates for the period July 1, 2009, through June 30, 2010; and rate increases to reflect the gross premiums tax authorized by AB 1422 (2009) for the period July 1, 2009, through June 30, 2010.	January 7, 2010
A-04 included the necessary contract language to conform to AB X3 (2009), to eliminate nine (9) Medi-Cal optional benefits.	July 8, 2010
A-05 provided revised capitation rates for the period July 1, 2010, through June 30, 2011, including rate increases to reflect the gross premium tax authorized by AB 1422 (2009), the hospital quality assurance fee (QAF) authorized by AB 1653 (2010), and adjustments for maximum allowable cost pharmacy pricing.	November 4, 2010
A-06 provided revised capitation rates for the period July 1, 2010, through June 30, 2011, for funding for legislatively mandated rate adjustments to Long Term Care facilities effective August 1, 2010; and rate increases to reflect the gross premiums tax on the adjusted revenues for the period July 1, 2010, through June 30, 2011.	September 1, 2011
A-07 included a rate adjustment that reflected the extension of the supplemental funding to hospitals authorized in AB 1653 (2010), as well as an Intergovernmental Transfer (IGT) program for Non-Designated Public Hospitals (NDPHs) and Designated Public Hospitals (DPHs).	November 3, 2011
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

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A-10 included contract language and capitation rates related to the transition of Healthy Families Program (HFP) subscribers into CalOptima's Medi-Cal program	December 6, 2012
A-11 provided capitation rates related to the transition of HFP subscribers into CalOptima's Medi-Cal program.	April 4, 2013
A-12 provided capitation rates for the period July 1, 2011 to June 30, 2012.	April 4, 2013
A-13 provided capitation rates for the period July 1, 2012 to June 30, 2013	June 6, 2013
A-14 extended the Primary Agreement until December 31, 2014	June 6, 2013
A-15 included contract language related to the mandatory enrollment of seniors and persons with disabilities, requirements related to the Balanced Budget Amendment of 1997 (BBA) and Health Insurance Portability and Accountability Act (HIPAA) Omnibus Rule	October 3, 2013
A-16 provided revised capitation rates for the period July 1, 2012, through June 30, 2013 and revised capitation rates for the period January 1, 2013, through June 30, 2014 for Phases 1, 2 and 3 transition of Healthy Families Program (HFP) children to the Medi-Cal program	November 7, 2013
A-17 included contract language related to implementation of the Affordable Care Act, expansion of Medi-Cal, the integration of the managed care mental health and substance use benefits and revised capitation rates for the period July 1, 2013 through June 30, 2014.	December 5, 2013
A-18 provided revised capitation rates for the period July 1, 2013, through June 30, 2014.	June 5, 2014
A-19 extended the Primary Agreement until December 31, 2015 and included language that incorporates provisions related to **Medicare Improvements for Patients and Providers Act** (MIPPA)-compliant contracts and eligibility criteria for Dual Eligible Special Needs Plans (D-SNPs)	August 7, 2014
A-20 provided revised capitation rates for the period July 1, 2012, through June 30, 2013, for funding related to the Intergovernmental Transfer (IGT) Agreement between CalOptima and the University of California, Irvine and Optional Targeted Low-Income Child Members	September 4, 2014
A-21 provided revised 2013-2014 capitation rates.	November 7, 2013
A-22 revised capitation rates for Fiscal Year (FY) 2013-14 and added an aid code to implement Express Lane/CalFresh Eligibility	November 6, 2014
A-23 revised ACA 1202 rates for January – June 2014, established base capitation rates for FY 2014-2015, added an aid code related to the OTLIC and AIM programs, and contained language revisions related to supplemental payments for coverage of Hepatitis C medications.	December 4, 2014
A-24 revises capitation rates to include SB 239 Hospital Quality Assurance Fees for the period January 1, 2014 to June 30, 2014.	May 7, 2015
A-25 extends the contract term to December 31, 2016. DHCS is obtaining a continuation of the services identified in the original agreement.	May 7, 2015

A-26 adjusts the 2013-2014 Intergovernmental Transfer (IGT) rates.	May 7, 2015
A-27 adjusts 2013-2014 capitation rates for Optional Expansion and SB 239.	May 7, 2015
A-28 incorporates language requirements and supplemental payments for BHT into primary agreement.	October 2, 2014
A-29 added optional expansion rates for January- June 2015; also added updates to MLR language.	April 2, 2015
A-30 incorporates language regarding Provider Preventable Conditions (PPC), determination of rates, and adjustments to 2014-2015 capitation rates with respect to Intergovernmental Transfer (IGT) Rate Range and Hospital Quality Assurance Fee (QAF).	December 1, 2016
A-31 extends the Primary Agreement with DHCS to December 31, 2020.	December 1, 2016
A-32 incorporates base rates for July 2015 to June 2016 with Behavioral Health Treatment (BHT) and Hepatitis–C supplemental payments, and Partial Dual/Medi-Cal only rates, and added aid codes 4U, and 2P–2U as covered aid codes.	February 2, 2017
A-33 incorporates base rates for July 2016 to June 2017.	February 2, 2017
A-34 incorporates revised Adult Optional Expansion rates for January 2015 to June 2015. These rates were revised to include the impact of the Hospital Quality Assurance Fee (HQAF) required by Senate Bill (SB) 239.	June 1, 2017
A–35 incorporates Managed Long–Term Services and Supports (MLTSS) into CalOptima's Primary Agreement with the DHCS.	March 6, 2014 February 2, 2017
A–36 incorporates revised base rates for July 2015 to June 2016.	December 7, 2017
A–37 incorporates revised base rates for July 2016 to June 2017.	February 7, 2019
A–38 incorporates full dual rates for Calendar Year (CY) 2015	August 1, 2019
A–39 incorporates full dual rates for Calendar Year (CY) 2016	August 1, 2019
A-40 incorporates Final Rule contract language.	June 1, 2017 February 6, 2020
A-41 incorporates base rates for July 2017 to June 2018, Transportation, American Indian Health Program, Mental Health Parity, CCI updates and Adult Expansion Risk Corridor language for SFY 2017-18.	December 7, 2017 June 7, 2018 February 6, 2020
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

The following is a summary of amendments to the Secondary Agreement approved by the CalOptima 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-10 extends the Secondary Agreement with DHCS to December 31, 2021	November 5, 2020

The following is a summary of amendments to Agreement 16-93274 approved by the CalOptima 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, 2023.	June 3, 2021

The following is a summary of amendments to Agreement 17–94488 approved by the CalOptima 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

State of California—Health and Human Services Agency
Department of Health Care Services

California Advancing & Innovating Medi-Cal (CalAIM) Proposal

January 2021

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1. Executive Summary

The Department of Health Care Services (DHCS) has developed a framework that encompasses broad-based delivery system, program and payment reform across the Medi-Cal program, called CalAIM: California Advancing and Innovating Medi-Cal. CalAIM advances several key priorities of the Administration by leveraging Medicaid as a tool to help address many of the complex challenges facing California's most vulnerable residents, such as homelessness, behavioral health care access, children with complex medical conditions, the growing number of justice-involved populations who have significant clinical needs, and the growing aging population.

This proposal recognizes the opportunity to provide for non-clinical interventions focused on a whole-person care approach via Medi-Cal that targets social determinants of health and reduces health disparities and inequities. Furthermore, the broader system, program, and payment reforms included in CalAIM allow the state to take a population health, person-centered approach to providing services with the goal of improving outcomes for all Californians. Attaining such goals will have significant impact on an individuals' health and quality of life and, through iterative system transformation, will ultimately reduce the per-capita costs over time. DHCS intends to work with the Administration, Legislature and our other partners on these proposals and recognizes the important need to discuss these issues and their prioritization within the state budget process. These are updated proposals based on extensive stakeholder feedback. Implementation will ultimately depend on the availability of funding and the requisite federal approvals.

CalAIM implementation was originally scheduled to begin in January 2021, but was delayed due the impact of the COVID-19 public health emergency. As a result, DHCS is proposing a new CalAIM start date of January 1, 2022.

1.1 Background and Overview

Medi-Cal has significantly expanded and changed over the last ten years, most predominantly because of changes brought by the Affordable Care Act and various federal regulations, as well as state-level statutory and policy changes. During this time, DHCS has also undertaken many initiatives and embarked on innovative demonstration projects to improve the beneficiary experience. In particular, DHCS has increased the number of beneficiaries receiving the majority of their physical health care through Medi-Cal managed care plans. These plans are able to offer more complete care coordination and care management than is possible through a fee-for-service system. They can also provide a broader array of services aimed at stabilizing and supporting the lives of Medi-Cal beneficiaries.

Depending on their needs, some beneficiaries may access six or more separate delivery systems (managed care, fee-for-service, mental health, substance use disorder, dental,

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developmental, In Home Supportive Services, etc.) in order to get their needs addressed. As one would expect, the need for care coordination increases with greater system fragmentation, greater clinical complexity, and/or decreased patient capacity for coordinating their own care. Therefore, in order to meet the behavioral, developmental, physical, and oral health needs of all members in an integrated, patient centered, whole person fashion, DHCS is seeking to integrate our delivery systems and align funding, data reporting, quality and infrastructure to mobilize and incentivize towards common goals.

Together, these CalAIM proposals offer solutions designed to ensure the stability of the Medi-Cal program and allow the critical successes of waiver demonstrations such as Whole Person Care Pilots, the Health Homes Program, the Coordinated Care Initiative, and the public hospital system delivery transformation, that advance the coordination and delivery of quality care to continue and be expanded to all Medi-Cal enrollees.

Our vision is that people served by our programs should have longer, healthier and happier lives. There will be a whole system, person centered approach to health and social care, in which services are only one element of supporting people to have better health and wellbeing throughout their whole lives. It will be an integrated “wellness” system, which aims to support and anticipate health needs, to prevent illness, and to reduce the impact of poor health.

The whole system, person centered approach will be equitable. Services and supports will deliver the same high quality of care, and achieve more equal health outcomes across the entire continuum of care, for all. It will improve the physical, behavioral, developmental, oral and long term services and supports, throughout their lives, from birth to a dignified end of life.

When people need support, care or treatment they will be able to access a range of services which are made seamless, and delivered as close to home as possible. Services will be designed around the individual and around groups of people, based on their unique need and what matters to them, as well as quality and safety outcomes.

To do this, we must change the expectations for our managed care and behavioral health systems. Holding our delivery system partners accountable for a set of programmatic and administrative expectations is no longer enough. We must provide a wider array of services and supports for complex, high need patients whose health outcomes are in part driven by unmet social needs and systemic racism. We must make the system changes necessary to close the gap in transitions between delivery systems, create opportunities for appropriate step-down care and mitigate social determinants of health, all hindering the ability to improve health outcomes and morbidity.

1.2 Guiding Principles

In 2018, the Care Coordination Advisory Committee developed a core set of guiding principles that were refined and established as the principles for the CalAIM initiative:

- Improve the member experience.
- Deliver person-centered care that meets the behavioral, developmental, physical, long term services and supports, and oral health needs of all members.
- Work to align funding, data reporting, quality, and infrastructure to mobilize and incentivize toward common goals.
- Build a data-driven population health management strategy to achieve full system alignment.
- Identify and mitigate social determinants of health and reduce disparities and inequities.
- Drive system transformation that focuses on value and outcomes.
- Eliminate or reduce variation across counties and plans, while recognizing the importance of local innovation.
- Support community activation and engagement.
- Improve the plan and provider experience by reducing administrative burden when possible.
- Reduce the per-capita cost over time through iterative system transformation.

1.3 Key Goals

To achieve these principles, CalAIM has three primary goals:

- Identify and manage member risk and need through whole person care approaches and addressing Social Determinants of Health;
- Move Medi-Cal to a more consistent and seamless system by reducing complexity and increasing flexibility; and
- Improve quality outcomes, reduce health disparities, and drive delivery system transformation and innovation through value-based initiatives, modernization of systems, and payment reform.

Below is an overview of the various proposals and recommendations that make up CalAIM. See **Appendix A: 2021 and Beyond: CalAIM Implementation Timeline** for more information.

1.4 Identify and Manage Member Risk and Need Through Whole Person Care Approaches and Addressing Social Determinants of Health

California continues to strengthen integration within the state's health care delivery system aimed at achieving better care and better health. In line with these objectives, DHCS is proposing reforms that would better identify and manage member risk and need for beneficiaries who may be challenged with medical and behavioral conditions, access to care, chronic illnesses and disabilities, and require multidisciplinary care to regain health and function.

To achieve these goals, DHCS proposes the following whole system, person centered approach that focuses on addressing the needs of beneficiaries across the system with the overarching goal of improving quality of life and health.

- Develop a statewide **population health management** strategy and require plans to submit local population health mangement plans.
- Implement a new statewide **enhanced care management benefit**.
- Implement **in lieu of services** (e.g. housing navigation/supporting services, recuperative care, respite, sobering center, etc.).
- Implement **incentive payments** to drive plans and providers to invest in the necessary infrastructure to build appropriate enhanced care management and in lieu of services capacity statewide.
- Pursue participation in the **Serious Mental Illness/Serious Emotional Disturbance Demonstration Opportunity**.
- Require screening and enrollment for Medi-Cal **prior to release from county jail**.
- **Pilot full integration** of physical health, behavioral health, and oral health under one contracted entity in a county or region.
- Develop a long-term plan for improving health outcomes and delivery of health care for **foster care children and youth**.

Population Health Management

Medi-Cal managed care plans shall develop and maintain a whole system, person-centered population health management strategy, which is a cohesive plan of action for addressing member needs across the continuum of care based on data driven risk stratification, predictive analytics, and standardized assessment processes. Each managed care plan shall provide, at a minimum, a description of how it will:

- Keep all members healthy by focusing on preventive and wellness services;
- Identify and assess member risks and needs on an ongoing basis;
- Manage member safety and outcomes during transitions, across delivery systems or settings, through effective care coordination; and

- Identify and mitigate social determinants of health and reduce health disparities or inequities.

Enhanced Care Management

DHCS proposes to establish a new, statewide enhanced care management benefit. An enhanced care management benefit would provide a whole-person approach to care that addresses the clinical and non-clinical circumstances of high-need Medi-Cal beneficiaries. Enhanced care management is a collaborative and interdisciplinary approach to providing intensive and comprehensive care management services to individuals. The proposed benefit builds on the current Health Homes Program and Whole Person Care Pilots, and transitions those services to this new statewide managed care benefit to provide a broader platform to build on positive outcomes from those programs.

Proposed target populations include:

- Children or youth with complex physical, behavioral, developmental, and oral health needs (e.g. California Children Services, foster care, youth with clinical high-risk syndrome or first episode of psychosis).
- Individuals experiencing homelessness, chronic homelessness or who are at risk of becoming homeless.
- High utilizers with frequent hospital admissions, short-term skilled nursing facility stays, or emergency room visits.
- Individuals at risk for institutionalization who are eligible for long-term care services.
- Nursing facility residents who want to transition to the community.
- Individuals at risk for institutionalization with serious mental illness (SMI), children with serious emotional disturbance (SED) or substance use disorder (SUD) with co-occurring chronic health conditions.
- Individuals transitioning from incarceration who have significant complex physical or behavioral health needs requiring immediate transition of services to the community.

In Lieu of Services & Incentive Payments

In order to build upon and transition the excellent work done under California's Whole Person Care Pilots, DHCS is proposing to implement in lieu of services, which are flexible wrap-around services that a Medi-Cal managed care plan will integrate into its population health strategy. These services are provided as a substitute to, or to avoid, other covered services, such as a hospital or skilled nursing facility admission or a discharge delay. In lieu of services would be integrated with care management for members at high levels of

risk and may fill gaps in state plan benefits to address medical or social determinants of health. The current list of in lieu of services includes:

- Housing Transition Navigation Services
- Housing Deposits
- Housing Tenancy and Sustaining Services
- Short-term Post-Hospitalization Housing
- Recuperative Care (Medical Respite)
- Respite Services
- Day Habilitation Programs
- Nursing Facility Transition/Diversion to Assisted Living Facilities, such as Residential Care Facilities for Elderly (RCFE) and Adult Residential Facilities (ARF)
- Community Transition Services/Nursing Facility Transition to a Home
- Personal Care and Homemaker Services
- Environmental Accessibility Adaptations (Home Modifications)
- Meals/Medically Tailored Meals
- Sobering Centers
- Asthma Remediation

The provision of in lieu of services is voluntary for plans and optional for beneficiaries, but the combination of enhanced care management and in lieu of services allows for a number of integration opportunities, including an incentive for building incremental change to achieve integrated managed long-term services and supports (MLTSS) in the managed care program by 2027 and building the necessary clinically-linked housing continuum for our homeless population. In order to be equipped with the required MLTSS and housing infrastructure, the state must use its ability to provide Medi-Cal managed care plans with financial incentive payments to work with their providers to invest in the necessary delivery and systems infrastructure, build appropriate care management and in lieu of services capacity, and achieve improvements in quality performance and measurement reporting that can inform future policy decisions.

SMI/SED Demonstration Opportunity

With some exceptions, federal Medicaid funding cannot be used to pay for services provided to a Medicaid beneficiary while the beneficiary is residing in an Institution for Mental Disease (IMD). This is referred to as the IMD exclusion. Generally, an IMD is a hospital, nursing home or other institution with more than 16 beds that is primarily

engaged in treating persons with mental diseases. However, the federal government has developed an opportunity for states to receive federal funding for institutional services provided to populations with a Serious Mental Illness or Serious Emotional Disturbance (SMI/SED), similar to the flexibility the state has secured for the Drug Medi-Cal Organized Delivery System (DMC-ODS) pilots. DHCS proposes to assess county interest in pursuing the SMI/SED demonstration opportunity, as long as our systems are positioned to achieve the required goals and outcomes, including building out a full continuum of care to offer beneficiaries community-based care in the least restrictive setting. Counties would voluntarily "opt-in" to participate. The main elements of the proposed SMI/SED demonstration opportunity would include:

- Ensuring high quality of care in psychiatric hospitals and residential settings, including required audits;
- Improving care coordination and transitions to community-based care;
- Increasing access to a full continuum of care including crisis stabilization and other clinically enriched forms of housing in the community with robust support services; and
- Earlier identification and engagement in treatment including through increased integration.

In pursuing this demonstration opportunity, counties that "opt-in" should be prepared to build out a robust continuum so individuals who begin at a higher level of institutional care can be stepped down to a less restrictive, community-based, residential setting.

Mandatory Medi-Cal Application Process upon Release from Jail and County Juvenile Facilities

Justice-involved individuals often receive both medical and behavioral health services while incarcerated. Upon release from jail or county juvenile facilities, proper coordination is needed to ensure the medical and behavioral health needs of an individual continue to be met, and additionally ensure critical non-clinical needs, such as housing, transportation, and overall integration back into the community are met. Studies have shown that these types of care coordination activities reduce unnecessary emergency room and inpatient stays, as well as improve treatment and medication adherence upon release from jail. To ensure all county inmates receive timely access to Medi-Cal services upon release from incarceration, DHCS proposes that California mandate a county inmate Medi-Cal application process by January 2023. Additionally, DHCS is proposing to mandate that jails and county juvenile facilities implement a process for facilitated referral and linkage from county institution release to county specialty mental health, Drug Medi-Cal, DMC-ODS, and Medi-Cal managed care plans when the inmate was receiving behavioral health services while incarcerated, to allow for continuation of behavioral health treatment in the community.

Full Integration Plans

DHCS would like to test the effectiveness of an approach to provide full integration of physical health, behavioral health, and oral health under one contracted entity. Due to the complexity of the policy considerations around this concept, DHCS will need to conduct extensive stakeholder engagement around issues such as eligibility criteria for entities, administrative requirements across delivery systems, provider network requirements, quality and reporting requirements, as well as complex financial considerations due to the current realignment and Proposition 30 structure of behavioral health. Given the complexity of this proposal and time needed for consideration and planning, DHCS expects that the first selected full integration plans would go live no sooner than 2027.

Develop a Long-Term Plan for Foster Care

In June 2020, DHCS launched the Foster Care Model of Care Workgroup to provide an opportunity for stakeholders to weigh in on a long-term plan and strategy for improving health outcomes and the delivery of fully-integrated health care services for foster care children and youth. The workgroup will complete its work in June 2021. Based on input from the workgroup, DHCS and the California Department of Social Services (CDSS) will develop a plan of action, which may involve budget recommendations, waiver amendments, state plan changes or other activities.

1.5 Moving Medi-Cal to a More Consistent and Seamless System by Reducing Complexity and Increasing Flexibility

Medi-Cal provides services to some of California's most vulnerable and medically complex beneficiaries, but many of the services vary depending on the county one lives in. DHCS is proposing to standardize and reduce complexity by implementing administrative and financial efficiencies across the state and aligning delivery systems to provide more predictability and reduce county-to-county differences. These reforms stretch across managed care, behavioral health, dental, and other county-based services.

To achieve such goals, DHCS proposes the following recommendations.

Managed Care

- Standardize managed care enrollment statewide
- Standardize managed care benefits statewide
- Transition to statewide managed long-term services and supports
- Require Medi-Cal managed care plans be National Committee for Quality Assurance (NCQA) accredited
- Implement regional rates for Medi-Cal managed care plans

Behavioral Health

- Behavioral health payment reform
- Medical necessity criteria
- Administrative behavioral health integration statewide
- Regional contracting
- Drug Medi-Cal Organized Delivery System (DMC-ODS) program renewal and policy improvements

Dental

- New benefit: Caries Risk Assessment Bundle for young children (0 to 6 years of age) and Silver Diamine Fluoride for young children (0 to 6 years of age) and specified high-risk and institutional populations, as described in detail below.
- Pay for Performance for two adult and 17 children preventive services codes and continuity of care through a Dental Home

County-Based Services

- Enhance oversight and monitoring of Medi-Cal Eligibility
- Enhance oversight and monitoring of California Children's Services and the Child Health and Disability Prevention program
- Improving beneficiary contact and demographic information

Managed Care

Managed Care Enrollment

DHCS proposes requiring all non-dual eligible Medi-Cal beneficiaries by January 2022 and all full- and partial-benefit dual beneficiaries by January 2023, statewide, to be enrolled mandatorily in a managed care plan. The one exception is for those for whom managed care enrollment is not appropriate due to limited scope of benefits or limited time enrolled. The goal is to align managed care enrollment practices that currently vary by aid code, population, and geographic location.

Standardize Managed Care Benefits

DHCS proposes to standardize managed care plan benefits, so that all Medi-Cal managed care plans provide the same benefit package by 2023. Some of the most significant changes are to carve-in institutional long-term care and major organ transplants into managed care statewide.

Transition to Statewide Managed Long-Term Services and Supports

To achieve a more standardized approach to comprehensive care coordination for all populations, DHCS is proposing to discontinue the Cal MediConnect pilot program at the end of calendar year 2022. DHCS proposes to transition from the pilot approach of the Coordinated Care Initiative (CCI) to standardized mandatory enrollment of dual eligibles into managed care. The goal is to achieve Medi-Cal benefits integration of long-term care into managed care for all Medi-Cal populations statewide, and to transition Cal MediConnect plans to Medicare Dual-Eligible Special Needs Plans (D-SNPs). This will be done in phases:

January 2022: The Coordinated Care Initiative (CCI) proceeds as today, except that the Multipurpose Senior Services Programs benefit would be carved out of managed care. DHCS will also implement voluntary in lieu of services at this time.

January 2023: Full transition to mandatory enrollment of dual eligibles into managed care. Further, all dual and non-dual fee-for-service (FFS) Medi-Cal beneficiaries residing in a long-term care facility will be enrolled in a managed care plan effective January 1, 2023. In addition, Medi-Cal managed care plans operating in CCI counties will be required to operate Medicare D-SNPs to transition the Cal MediConnect demonstration to a permanent, ongoing federal authority and to coordinate members' Medi-Cal and Medicare benefits.

January 2025: Medi-Cal managed care plans in non-CCI counties will be required to operate Medicare D-SNPs.

The purpose of these transitions and phases is to achieve a long-term goal of implementing MLTSS statewide in Medi-Cal managed care beginning in 2027, by providing enough time and incentive to develop the needed infrastructure. This will allow many duals to receive needed MLTSS and home and community-based services statewide through their managed care plan, instead of through a variety of 1915(c) HCBS waivers that currently have capped enrollment and are not statewide.

NCQA Accreditation of Medi-Cal Managed Care Plans

In order to streamline Medi-Cal managed care plan oversight and to increase standardization across plans, DHCS recommends requiring all Medi-Cal managed care plans and their health plan subcontractors to achieve National Committee for Quality Assurance (NCQA) accreditation by 2026. DHCS plans to use NCQA findings to certify or deem that Medi-Cal managed care plans meet certain state and federal Medicaid requirements.

Regional Rates

DHCS proposes to shift the development of Medi-Cal managed care plan rates from a county-based model to a regional rate model. The proposal to move to regional rates has two main benefits. The first benefit is a decrease in the number of distinct actuarial rating cells that are required to be submitted to CMS for review and approval. The reduction in rating cells will simplify the presentation of rates to CMS and allow DHCS to pursue/implement financing advancements and innovations utilizing a more flexible rate model. The second benefit of regional rates is cost averaging across all plans. This will continue to incentivize plan cost efficiencies, as plan rates will be inclusive of the costs within the multi-county region. This shift will produce a larger base for the averaging beyond the experience of plans operating within a single county. This change is fundamental to the ability of DHCS to implement and sustain the other changes proposed in CalAIM.

Behavioral Health

Behavioral Health Payment Reform

The state, in partnership with counties, must take serious steps to continue to invest in and improve access to mental health and substance use disorder (SUD) services for Medi-Cal beneficiaries. Behavioral health transformation is a critical priority for the Governor, the California Health and Human Services Agency, and for DHCS. We recognize that we need to improve quality of and access to care for children and other vulnerable populations. In order to achieve true system transformation, DHCS is committed to first achieving behavioral health payment reform, where DHCS will transition counties from a cost-based reimbursement methodology to a structure more consistent

with incentivizing outcomes and quality over volume and cost. This shift is being designed in conjunction with our county partners and will enable counties to participate in broader delivery system transformation efforts and engage in value-based payment arrangements with their health plan partners to support better coordination and integration between physical and behavioral health. This shift will be done thoughtfully with a key focus on ensuring no disruption of services or financial challenges for our county partners.

Behavioral health payment reform is an essential step to other opportunities for the counties around behavioral health integration, regional contracting and delivery system investments needed to advance a high-quality continuum of care for mental health and SUD services in the community.

Revisions to Behavioral Health Medical Necessity

The medical necessity criteria for specialty mental health services is outdated, lacks clarity, and should be re-evaluated. This issue creates confusion, misinterpretation, and could affect beneficiary access to services as well as result in disallowances of claims for specialty mental health and substance use disorder services. DHCS is proposing to update behavioral health medical necessity criteria to more clearly delineate and standardize requirements and to improve access for beneficiaries to appropriate services statewide.

Administrative Behavioral Health Integration

Approximately half of individuals with a serious mental illness (SMI) have co-occurring substance use and those individuals would benefit from integrated treatment. The state covers Medi-Cal SUD and specialty mental health services through separate county contracts, which makes it difficult for counties and contracted providers to offer integrated treatment to individuals with co-occurring disorders. For example, counties are subject to two separate annual quality assessments, two separate post-payment chart audits, and two separate reimbursement and cost reporting methods. In order to comply with these separate processes, providers offering integrated treatment to a Medi-Cal beneficiary must document SUD treatment services separately from specialty mental health services. The purpose of this proposal is to streamline the administrative functions for SUD and specialty mental health services.

Behavioral Health Regional Contracting

Small counties could optimize resources through regional administration and delivery of specialty mental health and SUD services to Medi-Cal beneficiaries. There are a variety of options available to counties, including a Joint Powers Authority to provide services for a multi-county region (e.g., Sutter/Yuba). Counties could also pool resources to contract with an administrative services organization/third-party administrator or other entity, such

as the local Medi-Cal managed care plan or County Medical Services Program, to create administrative efficiencies across multiple counties. Small counties, rural/frontier counties, and counties with shared population centers or complementary resources should consider opportunities for regional partnership. Furthermore, DHCS encourages counties to join the Drug Medi-Cal Organized Delivery System (DMC-ODS) or provide DMC services through a regional approach. DHCS is committed to working with counties to offer technical assistance to help develop regional contracts and establish innovative partnerships.

Drug Medi-Cal Organized Delivery System (DMC-ODS) Program Renewal and Policy Improvements

DHCS proposes to update the DMC-ODS program, based on experience from the first several years of implementation. Accordingly, DHCS proposes clarifying and/or changing policies to support the goal of improved beneficiary access to care, quality of care, and administrative efficiency.

Dental

The Department set an initial goal to achieve at least a 60 percent dental utilization rate for eligible Medi-Cal children. To continue progress toward achieving this goal, and based on lessons learned from the Dental Transformation Initiative (DTI), DHCS proposes the following statewide reforms for Medi-Cal dental coverage:

- Add new dental benefits based on the outcomes and successes from the DTI that will provide better care and align with national oral health standards. The proposed new benefits include a Caries Risk Assessment Bundle for young children and Silver Diamine Fluoride for young children and specified high-risk and institutional populations; and

- Continue and expand Pay for Performance Initiatives initiated under the DTI that reward increasing the use of preventive services and establishing/maintaining continuity of care through a dental home. These expanded initiatives would be available statewide for children and adult Medi-Cal enrollees.

County Partners

Enhancing County Oversight and Monitoring: Eligibility

This proposal will help to improve DHCS' oversight and monitoring of various aspects of Medi-Cal eligibility and enrollment and the activities of its contracted partners. This includes implementing additional county oversight activities to increase the integrity of the administration of the Medi-Cal program, as well as implementing the recommendations of the California State Auditor's Office. This proposal will also ensure that DHCS remains compliant with federal and state eligibility and enrollment requirements. These enhancements will be developed and implemented in direct collaboration with our county partners.

Enhancing County Oversight and Monitoring: CCS and CHDP

There are several programs – including California Children's Services, the Medical Therapy Program, and the Child Health and Disability Prevention program – that provide services to over 750,000 children in Medi-Cal. The state delegates certain responsibilities for these high-risk children to California's 58 counties and three (3) cities (Berkeley, Pasadena, and Long Beach). The state needs to enhance the oversight of counties to ensure they comply with applicable state and federal requirements. Enhancing monitoring and oversight will eliminate disparities in care and reduce vulnerabilities to the state and counties, thereby preserving and improving the overall health and well-being of California's vulnerable populations.

Improving Beneficiary Contact and Demographic Information

DHCS intends to convene a workgroup of interested stakeholders to provide feedback and recommendations on ways in which beneficiary contact and demographic information can be updated by other entities and the means to accomplish this, while maintaining compliance with all applicable state and federal privacy laws. The goal of the workgroup will be to determine the best pathway for ensuring that reported data is accurate and can be used in eligibility and enrollment systems/databases without creating unintended consequences for other social services programs, Medi-Cal beneficiaries, managed care plans, and the provider community.

1.6 Advancing Key Priorities

As DHCS has assessed the changes proposed under CalAIM, it has become apparent that these proposals are critically dependent upon each other -- without one, the others are neither possible nor powerful.

These reforms are fundamental to achieve the overall goals of improving the system and outcomes for Medi-Cal beneficiaries as well as providing long-term fiscal and programmatic sustainability to the Medi-Cal program and delivery system. In developing these recommendations, DHCS has recognized that individual proposals are significantly less likely to be achievable and successful if other key proposals are not pursued. For example, absent the proposed financing changes with respect to both the regional rate setting for Medi-Cal managed care and the structural changes to Medi-Cal behavioral health financing, the ability of our partnered plan and county entities to institute the changes focused on value-based and integrated delivery of care are significantly harder and potentially impossible to achieve.

These fundamental financing changes would not be possible without the elimination of differences across counties with respect to the delivery systems through which Medi-Cal benefits are delivered. Nearly every other proposal contained within CalAIM (such as enhanced care management, in lieu of services, and incentive payments, as well as the possibility of future full integration pilots) is critically dependent on the success of others.

The Medi-Cal program has evolved over the multiple decades since inception with ever-increasing system and fiscal complexities. CalAIM offers DHCS and the entire State of California an opportunity to take a step back to better assess what Medi-Cal beneficiaries need and alter the delivery systems accordingly, while at the same time working to be more effective and efficient with the finite funding available for the program.

CalAIM aligns with and advances several key priorities of the Administration. At its core, CalAIM recognizes the impact of Medi-Cal on the lives of its beneficiaries well beyond just accessing health services in traditional delivery settings. CalAIM establishes a foundation where investments and programs within Medi-Cal can easily integrate, complement and catalyze the Administration's plan to respond to the state's homelessness crisis; support reforms of our justice systems for youth and adults who have significant health issues; build a platform for vastly more integrated systems of care; and move toward a level of standardization and streamlined administration required as we explore single payer principles through the Healthy California for All Commission.

Furthermore, CalAIM will translate a number of existing Medi-Cal efforts such as Whole Person Care and the Health Homes Program, the prescription drug Executive Order, improving screenings for children, proliferating the use of value-based payments across our system, including in behavioral health and long-term care, into the future of the program. CalAIM will also support the ongoing need to increase oversight and monitoring of all county-based services, including specialty mental health and substance use disorder services, Medi-Cal eligibility administration, and other key children's programs currently administered by our county partners.

Below is an overview of the impact CalAIM could have on certain populations, if approved and funded as proposed:

Health for All: In addition to focusing on preventive and wellness services, CalAIM will identify patients with high and emerging risk/need and improve the entire continuum of care across Medi-Cal. This will ensure the system more appropriately manages patients over time, through a comprehensive array of health and social services spanning all levels of intensity of care, from birth and early childhood to end of life.

High Utilizers (top 5%): It is well documented that the highest utilizers represent a majority of the costs in Medi-Cal and in Medicaid nationally. CalAIM proposes enhanced care management and in lieu of services (such as housing-related services, transitions, respite, and sobering centers) that address the clinical and non-clinical needs of these high-cost Medi-Cal beneficiaries. The initiative envisions a collaborative and interdisciplinary whole person care approach to providing intensive and comprehensive care management services to improve health and mitigate social determinants of health.

Behavioral Health: CalAIM's behavioral health proposals would initiate a fundamental shift in how California organizes and administers specialty mental health and substance use disorder services. It aligns the financing of behavioral health with that of physical health, which provides financial flexibility to innovate, and enter into value-based payment arrangements that improve quality and access to care. Similarly, the reforms in CalAIM simplify administration of, and access to, integrated behavioral health care.

Vulnerable Children: CalAIM is designed to improve and streamline care for medically complex children to ensure they get their physical, behavioral, developmental, and oral health needs met. It aims to identify innovative solutions for providing low-barrier, comprehensive care for children and youth in foster care and furthers the efforts already underway to improve preventive services for children, including identifying the complex impacts of trauma, toxic stress, and adverse childhood experiences through, among other things, a reexamination of the existing behavioral health medical necessity definition.

Homelessness and Housing: The addition of in lieu of services would build capacity to the clinically-linked housing continuum for our homeless population, and would include housing transition navigation services, housing deposits, housing tenancy and sustaining services, short-term post hospitalization housing, recuperative care for inpatient transitions, and day habilitation programs.

Justice-Involved: Under the proposed Medi-Cal pre-release application mandate, enhanced care management and in lieu of services would provide the opportunity to better coordinate medical, behavioral health, and non-clinical social services for justice-involved individuals prior to and upon release from county jails and county juvenile

facilities. These efforts will support scaling of diversion and re-entry efforts aimed at keeping some of the most acute and vulnerable individuals with serious medical or behavioral health conditions out of jail/prison and in their communities, further aligning with other state hospital efforts to better support care for those who are incompetent to stand trial and other forensic state-responsible populations.

Aging Population: In lieu of services, carving in long-term care statewide, mandatory Medi-Cal managed care enrollment, and aligned enrollment for dual eligible beneficiaries in Medi-Cal and D-SNP plans would allow the state to build infrastructure over time to provide MLTSS statewide by 2027. MLTSS will provide appropriate services and infrastructure for integrated care and home and community-based services to meet the needs of aging beneficiaries and individuals at risk of institutionalization and is a critical component of the California's Master Plan for Aging.

1.7 From Medi-Cal 2020 to CalAIM

Through CalAIM, DHCS is undertaking a more targeted approach to consolidating its Medi-Cal benefit package to achieve better alignment across the system. While Medicaid Section 1115 authority has historically been the mechanism of choice for states interested in building and expanding managed care delivery systems, the use of the authority has evolved in recent years. The federal government no longer considers the "savings" generated from the shift from fee-for-service to managed care that occurred 15 years ago in Medicaid as relevant in calculating the required budget neutrality for waivers. CMS in recent guidance has also discontinued approval of traditional financing mechanisms in the Section 1115 context, namely the availability of federal funds for Designated State Health Programs and Safety Net Care Pools.

In addition, given that California has significant learnings from our past Section 1115 demonstrations, DHCS believes a primary shift to the use of other authorities is now appropriate to allow us to expand beyond limited pilots to more statewide initiatives. These factors, combined with federal managed care regulations, has encouraged DHCS to shift its focus away from the Section 1115 waiver authority to instead leverage other available pathways for delivery system transformation in the Medi-Cal program.

This proposal outlines all elements of the Medi-Cal 2020 waiver and how they will, or will not, be incorporated in to CalAIM. DHCS does not believe California is losing any critical funding or ability to improve and advance the delivery systems and ultimately improve the beneficiary experience and outcomes. In fact, the proposed shift will allow programs or pilots that have traditionally lived outside the core managed care system, where nearly 85% of all Medi-Cal beneficiaries receive care, to be brought into the main fold of the managed care delivery system.

In March 2020, as COVID-19 community spread accelerated, the State of California moved quickly to stem the spread by enacting one the nation's earliest stay-at-home orders. This stay-at-home order was accompanied by suspension of non-essential medical procedures, transition to telehealth for many services, transition to telework for administrative staff, and reprioritization of health care resources and training, including infection control measures, to address COVID. While the stay-at-home order and related delivery system changes slowed the spread of the virus, these changes caused significant disruption to the overall health care delivery system, and the economy, in California.

As a result, DHCS received multiple requests from organizations representing the state's health care delivery systems (e.g. counties, provider organizations, hospitals, behavioral health directors, and managed care plans). Stakeholders uniformly requested that, since providers and other partners are not able to properly prepare for CalAIM implementation given the focus and attention needed to respond to the COVID-19 emergency, the state request an extension of the Medi-Cal 2020 Section 1115 waiver.

In recognition, the Governor's revision to the state budget released in May 2020 postponed funding for CalAIM. This confluence of events prevented the state from moving ahead with the negotiation and implementation of CalAIM with a January 1, 2021 start. As such, the state prepared a 12-month extension request for the Medi-Cal 2020 Section 1115 demonstration. The request was posted for public comment in June 2020 and submitted to CMS on September 16, 2020. The 12-month extension is meant to serve as a bridge to a 5-year Section 1115 waiver renewal, primarily to continue key programs that require the authority, including the Global Payment Program (GPP) and the Drug Medi-Cal Organized Delivery System (DMC-ODS). In addition, DHCS is designing a comprehensive Section 1915(b) managed care waiver request for CMS that would also be for a 5-year period.

We look forward to working in close partnership with our federal CMS colleagues and local partners to ensure that the Medi-Cal program continues to change in ways that ultimately further the goals of improved health and outcomes, as well as cost-effectiveness, of the Medi-Cal/Medicaid program.

1.8 CalAIM Stakeholder Engagement

DHCS released the original CalAIM proposal in October 2019 ahead of an intensive four-month stakeholder engagement process. Between November 2019 and February 2020, five topic-specific workgroups comprised of stakeholders across the state participated in a series of robust in-person meetings. During these discussions, Workgroup members provided real-time feedback on the proposals as they evolved and offered helpful considerations with respect to implementation and operations. The public also had the opportunity to provide feedback on the proposals, both during the workgroup sessions and in writing. This iteration of the CalAIM proposal incorporates the broad range of

feedback received during the stakeholder engagement process. It should be noted that this resulting proposal is dependent on the funding availability through the state budget process, and federal approvals.

1.9 Conclusion

CalAIM is an ambitious but necessary proposal to positively affect Medi-Cal beneficiaries' quality of life by improving the entire continuum of care across Medi-Cal, and ensuring the system more appropriately manages patients over time through a comprehensive set of health and social services spanning all levels of intensity of care, from birth to end of life.

CalAIM:

- Keeps all beneficiaries healthy by focusing on preventive and wellness services, while also identifying and assessing member risk and need on an ongoing basis, during transitions in care, and across delivery systems, through effective care coordination.
- Creates a fundamental shift in how California organizes and administers specialty mental health and substance use disorder services, and aligns the financing of behavioral health with physical health, providing financial flexibility to innovate, and enter into value-based payment arrangements that improve quality and access to care.
- Ensures medically complex children and adults get their physical, behavioral, developmental, and oral health needs met.
- Builds capacity in a clinically-linked housing continuum via in lieu of services for California's homeless population, including housing transition navigation services, housing deposits, housing tenancy and sustaining services, short-term post hospitalization housing, recuperative care for inpatient transitions, and day habilitation programs.
- Provides the opportunity to better coordinate clinical and non-clinical services for justice-involved individuals prior to and upon release from jail and county juvenile facilities.
- Allows the state to build infrastructure over time to provide Managed Long-Term Services and Supports (MLTSS) statewide. MLTSS will provide appropriate services and infrastructure for integrated care and home and community-based services to meet the needs of aging beneficiaries and individuals at risk of institutionalization and is a critical component of the State's Master Plan for Aging.

2. Identifying and Managing Member Risk and Need through Whole Person Care Approaches and Addressing Social Determinants of Health

This section will walk through proposals to identify and manage member risk and need:

- Population Health Management Program
- Enhanced Care Management
- In Lieu of Services
- Shared Risk, Shared Savings, and Incentive Payments
- SMI/SED Demonstration Opportunity
- Full Integration Plans
- Long-Term Plan for Foster Care

2.1 Population Health Management Program

2.1.1 Background

DHCS currently does not have a specific requirement for Medi-Cal managed care plans to maintain a population health management (PHM) program, which is a model of care and a plan of action designed to address member health needs at all points along the continuum of care. Many Medi-Cal managed care plans have a population health management program – often in the context of meeting National Committee for Quality Assurance (NCQA) requirements – but some do not. In the absence of a population health management program, beneficiary engagement is often driven by a patchwork of requirements that can lead to gaps in care and a lack of coordination.

The goal of this proposal is to improve health outcomes and efficiency through standardized core population health management requirements for Medi-Cal managed care plans, including NCQA requirements and additional DHCS requirements. The population health management program will be comprehensive and address the full spectrum of care management – including assessing population level and individual member health risks and health-related social needs, creating wellness, prevention, case management, care transitions programs to address identified risks and needs, and using stratification to identify and connect adult and pediatric members to the appropriate programs. Additionally, Medi-Cal managed care plans will develop predictive analytics about which members, communities or populations are emerging as high risk as well as identify and address the needs of outliers with more specific services and supports.

2.1.2 Proposal

All Medi-Cal managed care plans shall develop and maintain a whole system, person-centered population health management program, where the plan will partner with contracted health care providers and community-based partners to identify and address members' health and health-related social needs. Medi-Cal managed care plans shall consult with their local public health department and county behavioral health department during the development of the population health management program.

The population health management program shall meet NCQA standards for population health, regardless of whether the plan is NCQA accredited. In addition to the NCQA accreditation processes, the population health management program description must be filed with the state via the population health management template (forthcoming). After the initial program description submission, the Medi-Cal managed care plan will submit certain portions of the program description, including any changes, to DHCS annually, but significant portions of the program description will only be required to be submitted to DHCS once every three years.

Each Medi-Cal managed care plan shall include, at a minimum, a description of how it will meet the core objectives to:

- Keep all members healthy by focusing on preventive and wellness services;
- Identify and assess member risks and needs on an ongoing basis;
- Manage member safety and outcomes during transitions, across delivery systems or settings, through effective care coordination;
- Identify and mitigate social determinants of health; and
- Reduce health disparities or inequities.

The population health management program shall:

- Include the goal to improve the health outcomes of communities and groups;
- Utilize data to analyze community and population level health and health-related social needs and set measurable goals for improvement;
- Utilize initial and ongoing assessments of data to analyze individual member's needs and identify groups and individuals within groups for targeted interventions;
- Provide assistance for members to navigate health delivery systems, acquire self-care skills to improve functioning and health outcomes, slow the progression of

disease or disability, and support members with serious illness as their disease progresses;

- Coordinate care across the continuum of medical, behavioral health, developmental, oral health, and long-term services and supports, including tracking referrals and outcomes of referrals;
- Deploy strategies to address individual needs and mitigate social determinants of health;
- Deploy strategies to drive improvements in health for specific populations proactively identified as experiencing health disparities;
- Partner with appropriate community-based providers to support individual members, families, and caregivers in managing care.
- Utilize evidence-based practices in screening and intervention;
- Utilize a person-centered and family-centered approach for care planning; and
- Continually evaluate and improve on the population health management program strategy on an ongoing basis through meaningful quality measurement.

Assessment of Risk and Need

1. Initial Data Collection and Population Risk Assessment

As reflected in the NCQA Population Health program requirements and the DHCS Population Needs Assessment All Plan Letter (APL), the Medi-Cal managed care plan shall collect electronically available data sources in order to analyze data that capture the information on member health status and utilization (including physical, behavioral, and oral health), health-related social needs, and linguistic, racial, and cultural characteristics. As part of the population health management requirements, DHCS will continue to apply the existing Population Needs Assessment (PNA) APL requirements to hold the Medi-Cal managed care plans accountable for a PNA, which include requirements for analyzing health disparities and engaging external stakeholders as part of the process. DHCS will consult with NCQA to ensure the PNA APL data requirements meet NCQA data requirements for the population assessment.

The PNA requires that Medi-Cal managed care plans collect and analyze this data across the plan's entire Medi-Cal member population to identify opportunities at a population level to improve health. One example of how this might be done is through a type of analysis commonly known as "hot spotting." As noted in the PNA and NCQA

requirements, key issues Medi-Cal managed care plans must analyze in the assessment include:

- Acute, chronic, and prevention/wellness health needs;
- Areas of clinically inappropriate, over and under-utilization of health care resources;
- Opportunities for better care management and quality improvement;
- Health disparities by race, ethnicity, language, and functional status; and
- Health-related social needs at the community or local level.

The results of the PNA will inform the development of programs and strategies that the Medi-Cal managed care plan will use to address the needs of specific populations. Determining which individuals have access to these specific programs and strategies will be driven by the subsequent member-level risk stratification, population segmentation, and case management activities. Consistent with the PNA APL, Medi-Cal managed care plans must use the assessment to develop and implement an action plan to address community and population needs. DHCS does not currently plan to provide more specific requirements regarding community and population-level program development, but in the population health management template, Medi-Cal managed care plans will be asked indicate what they will be doing in this area, which also may be a focus of future learning collaborative best practice work.

2. Initial Risk Stratification, Segmentation and Tiering

Risk stratification or segmentation will enable Medi-Cal managed care plans to identify specific members who may benefit from wellness, prevention, and disease management activities; members who can benefit from case management; and members who are at risk for developing complex health issues. Consistent with NCQA Population Health program requirements, Medi-Cal managed care plans will be required to risk stratify and segment members into groups that it will use to develop and implement case management, wellness, and health improvement programs and strategies. Medi-Cal managed care plans will also be required to use DHCS-defined criteria to tier its members into four risk tier categories and report that information to DHCS.

Consistent with the NCQA Population Health program requirements, Medi-Cal managed care plans shall conduct the risk stratification and segmentation and DHCS risk tiering using an integrated data and analytics stratification process that considers at least the following sources:

- Previous screening or assessment data;
- Disengaged member reports;
- Claims or encounter data, including all fee-for-service data provided by DHCS;

- And to the extent available:
    - Available social needs data, including housing status ICD-10 data; and
    - Electronic health records.

Risk Stratification or Segmentation: Medi-Cal managed care plans will analyze each individual's data based on the minimum, mandatory list of data sources described above and will then risk stratify and segment members into meaningful sub-populations. The Medi-Cal managed care plan will use risk stratification and segmentation to identify specific members who may benefit from targeted interventions and programs designed to meet identified member needs. Risk stratification and segmentation must occur within 44 days of the effective date of plan enrollment.

The Medi-Cal managed care plan may use its own algorithm to risk stratify or segment its population or it may use the DHCS-defined risk tiers described below as a starting point for further stratification and segmentation. The design of the algorithm, including how the data is stratified and segmented as part of the algorithm, should be informed by the health needs identified through the population assessment and designed so that the Medi-Cal managed care plan can group individual members into meaningful categories and subsequently outreach to individual members within those categories for tailored interventions and programs designed to achieve specific health outcomes. Medi-Cal managed care plans will incorporate enhanced care management into their segmentation in accordance with DHCS enhanced care management target population guidance and Medi-Cal managed care plan flexibility afforded for the enhanced care management benefit. When risk stratifying its member population, Medi-Cal managed care plans must use a validated risk grouper.

Risk stratification or segmentation algorithms shall include past medical and behavioral health service utilization but must also incorporate other data such as health conditions, risk factors, and disease progressions, in order to avoid exacerbating underlying biases in utilization data that may drive health disparities. Medi-Cal managed care plans must analyze the results of its stratification/segmentation algorithm to identify and correct any biases the algorithm may introduce based on race, ethnicity, language, functional status, or other sources of health disparities. In the population health management program description, the Medi-Cal managed care plan will submit to DHCS its list of stratification/segmentation data sources, the risk stratification/segmentation algorithm (or the name of the tool if it is proprietary), and also the method of bias analysis. To promote transparency and best practices, these three pieces of information will be made available for public viewing on DHCS' website and will also be a focus of continuing Medi-Cal managed care plan learning collaborative activities.

Based on the risk stratification/segmentation and the findings from Individual Risk Assessment (IRA) described below, the Medi-Cal managed care plan will link the member with the appropriate services including, but not limited to, wellness and prevention, general case management, complex case management, enhanced care management, in lieu of services (as available) external entity coordination, and transition coordination. Specific minimum requirements for each of these categories are listed in their own sections below.

DHCS Risk Tiering Requirements. This risk tiering process, including the IRA described below, will satisfy federal Medicaid Managed Care Final Rule requirements for initial risk assessment. Medi-Cal managed care plans will use DHCS-defined criteria to assign each member into one of four risk tiers: (1) low risk; (2) medium and rising risk; (3) high risk; and (4) unknown risk. The criteria for these tiers will be developed by DHCS.

The types of criteria used will be similar (but not the same) as the DHCS criteria for risk stratifying seniors and persons with disabilities (SPDs) into low- and high-risk groups. The criteria will align with the questions that DHCS will develop for the IRA survey tool, which is addressed in the next section. “High risk” members are those who are at increased risk of having an adverse health outcome or worsening of their health status. “Medium and rising risk” members are those that are stable at a medium risk level and those whose health status suggest they have the potential to move into the high-risk category.

Members at the medium/rising and high risk levels likely require additional provider-level assessment, care coordination, and/or possibly case management, or other specific services, which will be determined by the Medi-Cal managed care plan’s population segmentation strategy and coordination with providers. “Low risk” members are those who, in general, only require support for wellness and prevention. “Unknown risk” members are those who do not have sufficient data to stratify into a risk tier and for whom the Medi-Cal managed care plan is unable to complete a member-contact screening risk assessment. The IRA survey tool will be designed to have enough information to allow for risk tier assignment on its own if there is insufficient available historical data for the member.

DHCS will develop a process to validate Medi-Cal managed care plans’ implementation of the DHCS risk tier criteria to ensure consistent application and output statewide.

3. Individual Risk Assessment Survey Tool

DHCS will develop a standardized, 10-15 question Individual Risk Assessment (IRA) Survey Tool. There will be two versions, one for children and one for adults. Medi-Cal managed care plans will use the IRA to: (1) confirm or revise the initial DHCS risk tier to which the member was assigned; (2) gather consistent information for members without sufficient data; and (3) add information that will be used as part of its own stratification/segmentation algorithms and population health management strategy.

DHCS' goal in the development of the IRA questions will be to ensure they are validated and can be used with a scoring mechanism so that the IRA information can be integrated into the Medi-Cal managed care plan's risk stratification/segmentation process. DHCS will translate the questions into the threshold languages. Medi-Cal managed care plans will have the flexibility to add questions of their choosing to the IRA and would then also translate those additional questions into all threshold languages. It is expected that Medi-Cal managed care plans will conduct subsequent and separate screenings (or add supplemental questions) to identify specific issues and priorities to address.

The IRA will replace the assessments below:

- Staying Healthy Assessment/Individual Health Education Behavioral Assessment (SHA/IHEBA)
- Health information form/member evaluation tool (HIF/MET)
- Health risk stratification and assessment survey for SPDs
- Whole Child Model Assessment
- The Initial Health Assessment (IHA) provider visit (within 120 days of enrollment) will remain a requirement, but DHCS contracts and policies will not specify provider requirements for that visit.

Medi-Cal managed care plans will continue to be required to ensure the provision of preventive and other services in accordance with contractual requirements and accepted standards of clinical care.

Members assigned to the DHCS medium/rising, high, and unknown risk tiers must be contacted within 90 (medium/rising) and 45 (high and unknown) calendar days respectively to assess their needs. The IRA may be done via multiple modalities, including phone, in-person, electronic, or mail, as long as the screening responses can be transposed into an electronic format that allows for data mining and data exchange of key elements with DHCS. Data exchange of IRA elements with DHCS is not required at this time. Medi-Cal managed care plans should use this modality flexibility to maximize successful contact. Medi-Cal managed care plans shall make at least three (3) attempts to contact a member using available modalities.

If the Medi-Cal managed care plan is unable to obtain a completed IRA from a member, it has the option to create a process for working with the member's assigned primary care provider to: 1) have the member complete the assessment with them; and 2) transfer the resulting information to the Medi-Cal managed care plan.

Medi-Cal managed care plans will use the IRA information to assign or revise the member's DHCS risk tier. Once that process is complete, Medi-Cal managed care plans will be responsible for reporting the member's assigned risk tier to DHCS in an electronic format to enable better tracking and assessment of the impacts of the population health

management program. The Medi-Cal managed care plan will also share information regarding the assigned member's risk tier to the member's assigned PCP in an electronic format. If the member transfers to another Medi-Cal managed care plan, DHCS will provide the member's risk tier to the new Medi-Cal managed care plan.

The IRA questions will align with the DHCS-specified criteria for high, medium/rising, and low risk tiers. It is DHCS's intent that the structure of the IRA will meet NCQA requirements for a Health Appraisal.

- The IRA will include 10-15 questions, which seek to identify preliminary risk information for the following elements: Behavioral, developmental, physical, Long Term Services and Supports, and oral health needs;
- Emergency department visits within the last six months;
- Self-assessment of health status and functional limitations;
- Adherence to medications as prescribed;
- Assessment of health literacy and cultural and linguistic needs;
- Desire or need for case management;
- Ability to function independently and address his/her own health needs;
- Access to basic needs such as education, food, clothing, household goods, etc.;
- Use or need for long-term services and supports;
- Availability of social supports and caregiver;
- Access to private and public transportation;
- Social and geographic isolation; and
- Housing and housing instability assessment;

4. Reassessment

At a minimum, the Medi-Cal managed care plan shall reassess risk and need, including rising risk, of all members annually both the DCHS risk tiering and its own risk stratification/segmentation process. Individual members' risk and need may need to be re-evaluated throughout the year based on a change in condition or level of care, such as an inpatient admission or new diagnosis, the availability of new data, or a case management interaction.

Medi-Cal managed care plans must describe what events or data trigger the re-evaluation process for individual members. In the population health management program description, the Medi-Cal managed care plan must inform DHCS what minimum risk groups would require regular assessment in between the annual risk stratification process. However, this does not limit the Medi-Cal managed care plan from conducting additional assessments beyond what is defined as required by DHCS.

5. Provider Referrals

Medi-Cal managed care plans must establish a process by which providers may make referrals for members to receive case management or services for other emerging needs. Referrals for case management should lead to a re-evaluation of risk stratification and DHCS risk tier assignment. Medi-Cal managed care plans must consider and integrate information received through referrals when determining members' risk stratification.

Actions to Support Wellness and Address Risk and Need

1. General Requirements and Services

The Medi-Cal managed care plan shall integrate required activities with the population health management program as appropriate including, but not limited to member services, utilization management, referrals, transportation, health/plan/benefit education, appointment assistance, warm-handoffs to community-based organizations or other delivery systems, system navigation, primary care provider member assignment, community outreach, preventive services, and screenings for all members.

The Medi-Cal managed care plan shall provide a toll-free line for primary care providers and specialists who seek technical and referral assistance when any physical or behavioral condition requires further evaluation or treatment. Available information shall include assistance in arranging for referrals, including mental health and SUD treatment referrals, developmental services referrals, dental referrals, referrals to home-based medical/social services for people with serious illness, and referrals to long-term services and supports. Communication about the availability of this consultation service shall be found on the front-page of the Medi-Cal managed care plan's website and in materials supplied to providers.

The Medi-Cal managed care plan shall provide a 24-hours-a-day, 7-days-a-week, toll-free nurse advice line for members who seek technical, clinical, and referral assistance for physical, oral, and behavioral health services to address urgent needs.

The Medi-Cal managed care plan shall demonstrate how they support practice change activities, the deployment of evidence-based tools for providers, and models of service delivery that optimize health care and coordinated health care and social services. Finally, the Medi-Cal managed care plan shall develop or provide access to a current and updated community resource directory for case managers and contracted providers.

2. Wellness and Prevention Services

The Medi-Cal managed care plan shall provide wellness and prevention services in accordance with NCQA and contractual requirements. The population health management program shall integrate wellness and prevention services for all members, regardless of risk tier, according to the benefits outlined in the managed care contract including, but not limited to, the following:

- Provide preventive health visits, developmental screenings, and services for:
  - All children (under 21 years of age) in accordance with the American Academy of Pediatrics Bright Futures periodicity schedule.
  - All adults in accordance with US Preventive Services Task Force Grade "A" and "B" recommendations.
- Monitor the provision of wellness and preventive services by primary care providers as part of the Medi-Cal managed care plan Facility Site Review process.
- Provide health educational materials about topics such as disease management, preventive services, Early and Periodic Screening, Diagnostic, and Treatment services, how to access benefits, and other managed care plan health promotion materials.

3. Managing Members with Medium/Rising Risks

The population health management program shall:

- Provide screening for Adverse Childhood Experiences (ACEs) for children and adults, based on the recommended periodicity schedule as specified in the Medi-Cal managed care contract.
- Ensure members receive appropriate follow-up for behavioral, developmental, physical, and oral health needs including preventive care, care for chronic conditions, and referrals to long-term services and supports, as appropriate;

- Refer members identified, through assessment or re-assessment, as needing care coordination or case management to the member's case manager for follow-up care and needed services within 30 calendar days; and

- Assess individual social care needs and deploy appropriate community resources and strategies to mitigate the adverse childhood experiences (ACEs) toxic stress and impacts of social determinants of health in partnership with providers and community organizations.

Additionally, Medi-Cal managed care plans will be required to use predictive analytics to inform them about which patients, communities or populations are emerging as high risk as well as identify and address the needs of outliers with more specific services and supports. To address this focus, Medi-Cal managed care plans shall incorporate the DHCS Population Needs Assessment and NCQA Population Health program requirements on this topic into their population health management strategy. Identifying and addressing the needs of specific high-risk communities and populations – sometimes referred to as "hot spotting" – will be a focus of the population health management learning collaborative and DHCS will continue to assess best practices in this area.

4. Case Management

Case management services actively assist at-risk members in navigating health delivery systems and acquiring self-care skills to improve functioning and health outcomes, slow the progression of disease or disability or prepare for the progression of a serious illness. Case management services are intended for members who are medium- or high-risk or may have rising risks that would benefit from case management services. Members determined to be low risk should continue to receive wellness and prevention services as well as other medically necessary services.

Case management services include the following, as needed and appropriate:

- Screening beyond the IRA to identify and prioritize goals and needs for case management, including both health issues, ACEs and toxic stress, and health-related social needs
- Documentation in an electronic format of the individual care plan and assigned case manager for each member (required for all case management).
- Utilization of evidence-based practices in screening and intervention.
- Ongoing review of the member's goals and care plan as well as identifying and addressing gaps in care.
- Support from an inter-professional team with one primary point of contact for the member.

- Access to person-centered planning, including advanced care planning regarding preferences for medical treatment, and education and training for providers and families.
- Continuous information sharing and communication with the member and their providers.
- Ensuring a person-centered and family-centered approach by identification of member's circle of support or caregiver(s).
- Coordination and access to medically necessary health services and coordination with entities that provide mental health, substance use disorder services, and developmental and oral health services.
- Ensuring coordination and access to community-based services, such as home care, personal care services, and long-term services and supports.
- Developing relationships with local community organizations to implement interventions that address social determinants of health (e.g. housing support services, nutritional classes, etc.).
- Coordinating authorization of services including timely approval of and arranging for durable medical equipment, pharmacy, private duty nursing, palliative care, and medical supplies.
- Promoting recovery using community health workers, peer counselors, and other community supports.
- Requesting modifications to treatment plans to address unmet service needs that limit progress.
- Assisting members in relapse and/or crisis prevention planning that includes development and incorporation of recovery action plans, and advance directives for individuals with a history of frequent mental health readmissions or crisis system utilization.
- Assisting members in care planning related to cognitive impairment, traumatic brain injury, Alzheimer's disease, and dementia.
- Performance measurement and quality improvement using feedback from the member and caregivers.
- Delivery of services in a culturally competent manner that addresses the cultural and linguistic needs by interacting with the member and his or her family in the member's primary language (use of interpreter allowed), with appropriate consideration of literacy and cultural preference.
- If the Medi-Cal managed care plan assigns a case manager outside the plan, written agreements shall define the responsibility of each party in meeting case management requirements to ensure compliance and non-duplication of services. If situations arise where a member may be receiving care coordination from multiple entities, the Medi-Cal managed care plan shall identify a lead care coordinator.

If a member changes enrollment to another Medi-Cal managed care plan, the Medi-Cal managed care plan shall coordinate transition of the member to the new plan's case management system to ensure services do not lapse and are not duplicated in the transition. The Medi-Cal managed care plan must also ensure member confidentiality and member rights are protected.

Members may be assigned to one of three types of case management based on assessment of risk and need.

The three types of case management include:

- **Basic Case Management:** Basic case management would be appropriate for members who require planning and coordination that is not at the highest level of complexity, intensity, or duration. These services are provided by the Medi-Cal managed care plan, clinic-based staff, or community-based staff, and may be provided by non-licensed staff. These services may include assignment to a certified patient-centered medical home, participation in a Medi-Cal managed care plan disease management program or participation in another Medi-Cal managed care plan population health management program.

- **Complex Case Management:** The Medi-Cal managed care plan shall provide complex case management in accordance with NCQA requirements. NCQA defines complex case management as "a program of coordinated care and services for members who have experienced a critical event or diagnosis that requires extensive use of resources." NCQA allows organizations to define "complex." Complex case management generally involves the coordination of services for high-risk members with complex conditions.

- **Enhanced Care Management:** The proposed Enhanced Care Management benefit is designed to provide a whole-person approach to care that addresses the clinical and non-clinical needs of high-cost and/or high-need Medi-Cal beneficiaries enrolled in Medi-Cal managed care plans. Enhanced care management is a collaborative and interdisciplinary approach to providing intensive and comprehensive care management services to targeted individuals. Through collaborative leadership and systematic coordination among public and private entities, the enhanced care management benefit will serve target populations, benefit from data sharing between systems, and coordinate care in real time for beneficiaries. DHCS will evaluate individual and population progress — all with the goal of providing comprehensive care and achieving better health outcomes.

The population health management program description shall describe how and when the services are utilized in conjunction with the risk stratification process, as members with changing risk and needs may require changing levels of case management. If the Medi-Cal managed care plan delegates or contracts with a provider for case management or transition of care services, it must do so in accordance with the NCQA's population health management delegation requirements.

5. In Lieu of Services

"In lieu of services" are flexible wrap-around services that the Medi-Cal managed care plan will integrate into their population health management programs. These services are provided as a substitute or to avoid utilization of other services such as hospital or skilled nursing facility admissions, discharge delays, or emergency department use. In lieu of services should be integrated with case management for members at medium-to-high levels of risk and may fill gaps in Medi-Cal State Plan benefits to address medical or other needs that may arise due to social determinants of health. DHCS is proposing the initial use of in lieu of services to serve as a transition of the work done through existing pilots (e.g. Whole Person Care, the Health Homes Program, the Coordinated Care Initiative, etc.), as well as inform the development of future potential statewide benefits that may be instituted.

Examples of the in lieu of services that DHCS proposes to cover include many of the services currently provided in the Whole Person Care Pilot program that are not covered as Medi-Cal State Plan benefits. Some of these include, but are not limited to, respite, recuperative care, medically tailored meals, supplemental personal care services, housing tenancy navigation and sustaining services, and sobering centers. Medi-Cal managed care plans will develop a network of providers of allowable in lieu of services with consideration for which community providers have expertise and capacity regarding specific types of services. See **Appendix J: In Lieu of Services Options** for more detail.

6. Coordination between Medi-Cal Managed Care Plans and External Entities

The Medi-Cal managed care plan shall describe in the population health management program description how they will coordinate with, and refer members to, health care and social services/programs including, behavioral health services, dental, and home and community-based services. Referrals must be culturally and linguistically appropriate for the member. The Medi-Cal managed care plan must coordinate with competent external entities to provide all necessary services and resources to the member. These entities should be listed as part of the population health management program description identifying specific services each named entity will provide plan members. The Medi-Cal managed care plan's population health management

program description shall include assurance of payment to Indian Health Care Providers.

7. Transitional Services

The Medi-Cal managed care plan shall ensure transitional services are provided to all members who are transferring from one setting, or level of care, to another. The Medi-Cal managed care plan shall work with appropriate staff at any hospital that provides services to its members, whether contracted or non-contracted in the case of emergency services, to implement a safe, comprehensive discharge plan. The plan must provide continued access to medically necessary covered services that will support the member's recovery and prevent readmission.

The Medi-Cal managed care plan shall have in place operational agreements or shall incorporate transitional language into existing network arrangements with the Medi-Cal managed care plan's contracted community physical and behavioral health hospitals, residential treatment facilities and long-term care facilities, as applicable, to ensure smooth transitions. Transition services shall include tribal consultation/outreach for protections involving American Indians and Indian Health Clinic providers. The operational agreements shall define the responsibility of each party in meeting the following requirements:

- Completion of a standardized discharge risk assessment tool. The tool shall assess risk for re-institutionalization, re-hospitalization, and/or substance use disorder treatment recidivism. Each Medi-Cal managed care plan's discharge screening tool must be approved by DHCS;
- Development of a written discharge plan, shared with the beneficiary and all treating providers, to mitigate the risk of readmission and other negative health outcomes;
- Obtain the member's permission to share information with clinical and non-clinical providers to facilitate care transitions;
- Develop discharge planning policies and procedures in collaboration with all hospitals;
- Process all hospital prior authorization requests for clinic services within two business days. Such services shall include authorizations for therapy, home care services, equipment, medical supplies, and pharmaceuticals;
- Educate hospital discharge planning staff on the clinical services that require pre-authorization to facilitate timely discharge from the hospital; and
- Prevent delayed discharges from a hospital due to Medi-Cal managed care plan authorization procedures or transition to a lower level of care.

8. Skilled Nursing Facility Coordination

The Medi-Cal managed care plan shall coordinate with hospital or other acute care facility discharge planners and nursing facility case managers or social workers to ensure a smooth transition to or from a skilled nursing facility or nursing facility. The Medi-Cal managed care plan shall coordinate with the facility to provide case management and transitional care services and ensure coverage of all medically necessary services not included in the negotiated daily rate. This includes, but is not limited to, prescription medications, durable medical equipment, intravenous medications, and any other medically necessary service or product.

- If the Medi-Cal managed care plan, in coordination with the nursing facility or skilled nursing facility, anticipates the member will be in the facility after a member no longer meets criteria for medically necessary skilled nursing care or rehabilitative care, the Medi-Cal managed care plan shall assist the member in exploring all available care options. This includes potential discharge to a home or community residential setting, or to remain in the skilled nursing facility for long-term services and supports.
- If the member is discharged to a home or to a community residential setting, the Medi-Cal managed care plan shall coordinate with the facility to ensure the member is in a safe location. The plan shall ensure medically necessary services are available including, but not limited to, home health services, durable medical equipment and supplies, outpatient rehabilitation services, and any other services necessary to facilitate the member's recovery. The Medi-Cal managed care plan shall also ensure follow-up care is provided consistent with the transitional service requirements listed above.

Population Health Management Oversight

The Medi-Cal managed care plan shall have internal monitoring processes in place to ensure compliance with the population health management program requirements. Quality assurance reviews of documented population health management activities shall include:

- Case identification and assessment according to established risk stratification system;
- Electronically documented treatment plans and care plans with evidence of periodic revision as appropriate to emerging member needs;
- Referral management;
- Effective coordination of care, including coordination of services that the member receives through the fee-for-service system; and

- Identification of appropriate actions for the case manager to take in support of the member, and the case manager's follow-through in performing the identified tasks.

The Medi-Cal managed care plan shall document quality assurance reviews on an annual basis or upon DHCS' request and submit them to DHCS for review. Medi-Cal managed care plans are responsible for ensuring that their delegates comply with all applicable state and federal laws and regulations, contract requirements, and other DHCS guidance, including All Plan Letters, Policy Letters, and Dual Plan Letters. These requirements must be communicated by each Medi-Cal managed care plan to all delegated entities and sub-Medi-Cal managed care plans. The Medi-Cal managed care plan must submit a population health management oversight plan in accordance with NCQA requirements for any entities to which they delegate population health management functions. Such plans would need to be reviewed and approved by the state.

Health Information Technology to Support Integrated Care and Care Coordination

The Medi-Cal managed care plan will work to implement health information technology to support population health principles, integrated care, and care coordination across the delivery system. Examples of health information technology include, but are not limited to, electronic health records, emergency department information exchange, clinical data repositories, registries, decision support and reporting tools that support clinical decision-making, and case management. An overarching goal of the population health management program is to expand interoperable health information technology and health information exchange infrastructure, so that relevant data (including clinical and non-clinical) can be captured, analyzed, and shared to support provider integration of behavioral health and medical services, case management oversight and transitional planning, value-based payment models, and care delivery redesign.

The Medi-Cal managed care plan shall develop data exchange protocols, including member information sharing protocols, before initiating services with any subcontracted entity. Protocols must support integrated behavioral health-physical health coordination including, but not limited to, sharing of claims and pharmacy data, treatment plans or care plans, and advance directives necessary to coordinate service delivery and care management for each member in accordance with applicable privacy laws.

Improved data collection, specifically of encounter data at the provider level, is a critical component of achieving the goals of this proposal, and DHCS will be working with plans and providers to achieve this goal.

Accountability and Oversight of Medi-Cal Managed Care Plans

In order to hold Medi-Cal managed care plans accountable for the activities proposed here, DHCS will increase its oversight and assessment of the plans to include changes

to its audit procedures and the imposition of corrective action plans and financial sanctions, when appropriate. DHCS recognizes that, through this and the other CalAIM proposals, the responsibility of Medi-Cal managed care plans will increase over time, and therefore DHCS' approach to oversight and accountability must also grow and change in conjunction with these proposals. DHCS is committed to providing Medi-Cal managed care plans technical assistance to support the smooth adoption of these changes.

Future Policy Development and Technical Assistance

As technical assistance for Medi-Cal managed care plans in development of their population health management programs, DHCS will provide submission templates and best practice examples of Medi-Cal managed care plan population health management programs from California and other states. DHCS will also create a DHCS-operated learning collaborative for Medi-Cal managed care plans to share information and promising practices. The learning collaborative will foster information sharing and address promising practices in all the DHCS-required population health management activities. The following topics that have been identified by stakeholders:

- Medi-Cal managed care plan coordination and partnerships with external entities that provide carved-out services, such as specialty mental health, Drug Medi-Cal, Regional Centers, schools, public health departments, and community-based organizations that provide social services;
- Engaging with consumers who have health and social needs but are unidentified, unengaged, and are underutilizing services, including methods to engage with these members, build trust, and obtain information from the member about their needs;
- Care transition coordination including sharing discharge risk assessment tools;
- Incorporating social determinants of health and health-related social care needs into case management and community-level population improvement activities;
- Collection of social determinants of health information for risk stratification and segmentation, and for state-level data collection for strategic planning purposes;
- Best practices in how to use population health management programs to support specific populations of interest, such as children and pregnant women, in ways that align with other DHCS initiatives;
- Use of population data for "hot spotting" and other population analysis promising practices;

- Use of general beneficiary medical record release consent to allow Medi-Cal managed care plans and providers to share data broadly for the purposes of care coordination;
- Learning best practices from California Accountable Communities for Health Initiative activities, including opportunities for partnership and elements that may be appropriate to integrate into the population health management strategies;
- Data exchange protocols and the development of health information technology/health information exchange policies; and
- Submission of housing status data to DHCS via ICD-10 coding, in alignment with the current DHCS Value-Based Payment incentive program for these codes.

The best method to advance promising practices in these areas may be to allow them to emerge through a learning collaborative and assessment of Medi-Cal managed care plan outcomes. DHCS may also standardize certain requirements after further research and consultation with stakeholders.

Continuing areas of DHCS policy development will include:

- DHCS Risk Tiering criteria;
- DHCS IRA to gather individual member information for risk tiering and stratification;
- Detailed review of alignment with NCQA Population Health program requirements, in coordination with NCQA and Medi-Cal managed care plans;
- Continued exploration into what guidance DHCS can provide regarding what can be allowed for different types of information sharing between providers and Medi-Cal managed care plans to facilitate care coordination;
- Voluntary guidance from DHCS regarding Medi-Cal managed care plan collection of social determinants of health data from ICD-10 encounter coding. The guidance, and Medi-Cal managed care plan collection of this data in accordance with the guidance, will become mandatory on January 1, 2024; and
- Setting prospective, prioritized goals to improve Medi-Cal managed care population health management over five years from the implementation date. To do this, DHCS will review of population health management program outcomes goals and measures, and their relation to the broader DHCS managed care quality metric strategy, which may be used to assess each Medi-Cal managed care plan's population health management program.

2.1.3 Rationale

The population health management program requirement will ensure that there is a cohesive plan to address beneficiary needs across the continuum of care, from prevention and wellness to complex case management. This proposal will work in conjunction with other CalAIM proposals to meet the overarching CalAIM goals of improving coordination and quality, while reducing unnecessary administrative burden and redundancy. The following CalAIM elements of the population health management program will magnify the positive impact on member outcomes:

- **NCQA Accreditation** will provide a foundation of quality best practices and an oversight structure for the population health management program and other Medi-Cal managed care plan activities;
- The new **enhanced care management** benefit will provide a critical new set of services as well as an effective case management tool to integrate within the population health management program;
- The adoption of a menu of **in lieu of services** – flexible wrap-around services designed to fill medical and social determinants of health gaps – will similarly integrate within the population health management program; and
- Making **shared risk/savings and incentive payments** available to Medi-Cal managed care plans and providers will maximize the effectiveness of the population health management program and new service options.

2.1.4 Proposed Timeline

The population health management program would be implemented as part of the new Medi-Cal managed care plan contracts, with an effective date of January 1, 2023. The date for the first population health management program description submission and other required submissions from Medi-Cal managed care plans to DHCS is to be determined.

2.2 Enhanced Care Management Benefit

2.2.1 Background

Depending on the needs of the beneficiary, some individuals may need to access six or more separate delivery systems (managed care, fee-for-service, mental health, substance use disorder, developmental, dental, In Home Supportive Services, etc.). Given the similarities in target populations across Medi-Cal delivery systems, beneficiaries are likely to be eligible for multiple programs that include some level of care management, depending on the efforts that are underway in their county of residence.

Additionally, as one would expect, the need for care coordination increases with greater system fragmentation, greater clinical complexity, and/or decreased patient capacity for coordinating their own care. The Health Homes Program and many of the Whole Person Care pilots provide such services. DHCS is proposing the implementation of a single, comprehensive enhanced care management benefit within Medi-Cal managed care. Lessons learned from the Whole Person Care pilots and the Health Homes Program will be incorporated to ensure that the new enhanced care management benefit is designed to meet the clinical and non-clinical needs for the highest cost/highest need beneficiaries in Medi-Cal and is available as a statewide benefit.

2.2.2 Proposal

The proposed enhanced care management benefit will replace the current Health Homes Program and elements of the Whole Person Care pilots, building on positive outcomes from those programs over the past several years. Based on extensive stakeholder engagement, DHCS will require that beneficiaries receiving Health Homes or Whole Person Care services are seamlessly transitioned to continue receiving care coordination services by way of the new enhanced care management benefit. Medi-Cal managed care plans will be mandated to contract with all existing local providers offering Health Homes and Whole Person Care services, with a few contractual exceptions. Medi-Cal managed care plans will be required to contract with community-based providers that have experience serving the enhanced care management target populations, and who have expertise providing the core enhanced care management services. Further, to allow non-Whole Person Care or Health Homes Program counties additional time to develop an adequate local infrastructure, a phased-in approach for implementing enhanced care management will be adopted.

It is the state's intention to implement this new initiative in a complementary, rather than duplicative manner that will build upon the strengths and foundations of these existing programs. DHCS recognizes the significant investment the Whole Person Care entities made over the past five years in building the capacity for these services. The intention is to build on those investments and infrastructure to continue the positive outcomes achieved by the Whole Person Care pilots. Additionally, as a result of extensive stakeholder feedback, DHCS has determined that Medi-Cal managed care plans will be required to coordinate enhanced care management services with county Targeted Case Management programs to ensure non-duplication of services and provide a holistic approach to care for Medi-Cal's most vulnerable beneficiaries.

The proposed enhanced care management benefit is designed to provide a whole-person approach to care that addresses the clinical and non-clinical needs of high-cost and/or high-need Medi-Cal beneficiaries enrolled in Medi-Cal managed care plans. Enhanced care management is a collaborative and interdisciplinary approach to

providing intensive and comprehensive care management services to targeted individuals.

Medi-Cal managed care plans will proactively identify members who meet the target population criteria and can benefit from enhanced care management services. The enhanced care management providers will be taking on the responsibility for coordinating services across all delivery systems. They are the primary responsible entity for coordinating across multiple medical and social service domains of care. Authorized members will be assigned a lead care manager that will have responsibility for interacting directly with the member and coordinating all primary, behavioral, developmental, oral health, and long-term services and supports, any in lieu of services, and services that address social determinants of health needs, regardless of setting.

Through collaborative leadership and systematic coordination among public and private entities, the enhanced care management benefit will serve target populations, benefit from data sharing between systems, and coordinate care in real time for beneficiaries. DHCS will evaluate individual and population progress — all with the goal of providing comprehensive care and achieving better health outcomes.

The overarching goals for enhanced care management are:

- Improving care coordination;
- Integrating services;
- Facilitating community resources;
- Improving health outcomes;
- Addressing social determinants of health; and
- Decreasing inappropriate utilization.

The enhanced care management target populations include: (see **Appendix I: Enhanced Care Management Target Population Descriptions** for more detailed definitions):

- Children or youth with complex physical, behavioral, developmental, and/or oral health needs (e.g. California Children Services, foster care, youth with Clinical High-Risk syndrome or first episode of psychosis).
- Individuals experiencing homelessness, chronic homelessness or who are at risk of becoming homeless.
- High utilizers with frequent hospital admissions, short-term skilled nursing facility stays, or emergency room visits.

- Individuals at risk for institutionalization who are eligible for long-term care services.
- Nursing facility residents who want to transition to the community.
- Individuals at risk for institutionalization with Serious Mental Illness (SMI), children with Serious Emotional Disturbance (SED) or Substance Use Disorder (SUD) with co-occurring chronic health conditions.
- Individuals transitioning from incarceration who have significant complex physical or behavioral health needs requiring immediate transition of services to the community.

Enhanced Care Management Design and Services

The enhanced care management benefit, which will be delivered by community-based providers (”ECM Providers”) contracting with Medi-Cal managed care plans, will provide multiple opportunities to engage beneficiaries by stratifying risk and need, developing care plans and strategic interventions to mitigate risk and help clients achieve improved health and well-being. Enhanced care management services extend beyond standard care coordination and disease management activities and are concentrated on the coordination and monitoring of cost-effective, quality direct care services for the individual, as well as connections to needed community supports for indirect care needs.

The enhanced care management benefit is fundamentally person-centered, goal-oriented, and culturally relevant to assure that, as a primary goal of the program, members receive needed services in a supportive, effective, efficient, timely, and cost-effective manner. Enhanced care management will emphasize prevention, health promotion, continuity and coordination of care to link members to services as necessary across providers and settings and with emphasis on identifying the least restrictive and most integrated setting that will meet the needs of the beneficiary.

The role of enhanced care management is, through face-to-face visits, to coordinate all primary, acute, behavioral, developmental, oral, and long-term services and supports for the member, including participating in the care planning process, regardless of setting. Enhanced care management activities shall become integrated with other care coordination processes and functions and shall assume primary responsibility for coordination of the member’s physical health, behavioral health, oral health, developmental, and long-term care needs.

Enhanced care management will be provided at a level dictated by the complexity of the health and social needs of the member. The approach to enhanced care management will be high-touch, on-the-ground, and face-to-face, with frequent contacts for persons residing in community settings and nursing facilities. Enhanced care management care managers are expected to develop relationships with members and their families, engage

members and families in needs assessment and care planning processes, and work with the primary care provider to address the member's needs in coordinating physical and behavioral health care.

The enhanced care management care managers will operate within the member's community, serve as the members' primary point of contact and are responsible for ensuring that applicable physical, behavioral, long-term care, developmental, oral, social, and psychosocial needs are met in the safest, least restrictive way possible while considering the most cost-effective way to address those needs. Care managers meet members where they are, both literally, and from a medical management and plan of care perspective. Community health workers can also be used to improve outreach and provide care coordination services for beneficiaries.

Required programmatic elements to be implemented include, but are not limited to, care coordination, health promotion, comprehensive transitional care, member and family supports and referral to community and social services. These elements include helping beneficiaries navigate, connect to and communicate with providers and social service systems; coaching beneficiaries on how to monitor their health and identify and access helpful resources; identifying and coordinating available in lieu of services such as housing services; helping beneficiaries move safely and easily between different care settings and reducing avoidable hospital admissions and readmissions; educating beneficiaries and their family/support system about their conditions to improve treatment adherence and medication management; providing referrals to community and social services; and follow-up to help ensure that beneficiaries are connected to the services they need.

Program Administration

Enhanced care management will be administered by the Medi-Cal managed care plans, who will have direct responsibility for establishing the enhanced care management benefit and criteria for their members, subject to contractual requirements and programmatic guidance provided by DHCS. DHCS intends for Medi-Cal managed care plans to build upon the expertise and infrastructure of the existing Whole Person Care pilots and Health Homes Program to achieve these outcomes and, with some exceptions, to contract directly with existing Whole Person Care providers and Health Homes Program community-based care management entities, as well as other necessary contracting with public and private providers to deliver such services.

In addition, DHCS expects that plans will work in coordination and collaboration, and even contract when appropriate, with county behavioral health systems who often are the primary providers of services to a subset of Medi-Cal beneficiaries. This proposal requests that managed care plans determine the service design and intensity based on the parameters established by DHCS. DHCS will build enhanced funding into the

capitation rates to enable Medi-Cal managed care plans to successfully provide enhanced care management benefit. The Medi-Cal managed care plans will have strong oversight and will perform regular auditing and monitoring activities to ensure that all requirements are met. If a plan proposes to keep some level of enhanced care management in-house instead of contracting with direct providers, the plan will need to demonstrate to the state that their enhanced care management benefit is appropriately community-based and provide a rationale for not contracting with existing WPC and HHP providers (per the exceptions outlined in the enhanced care management and in lieu of services Model of Care Template and managed care plan contract language.)

For individuals with a primary SMI diagnosis, SUD, children with SED, or children involved in child welfare, county behavioral health staff should be considered to serve as the enhanced care management provider through a contractual relationship, provided they agree to coordinate all the services (physical, developmental, oral health, long-term care and social needs) needed by those target populations, not just their behavioral health needs. These staff will focus on the behavioral health needs and interventions for the Medi-Cal beneficiary, act as a resource for the Medi-Cal managed care plan in managing the needs of this population and ensuring that beneficiaries are linked to appropriate county resources; as well as other resources that have more experience and documented success in working with those living with these conditions.

Targeted Case Management

Furthermore, Medi-Cal managed care plans will be expected to work with Local Governmental Agencies to ensure that members receiving enhanced care management services do not receive duplicative Targeted Case Management services; this approach will also help support the Department's goal of strengthening the connections across California's delivery systems. The Targeted Case Management program is an optional Medi-Cal Program funded by federal and local funds. See **Appendix B: Targeted Case Management** for which counties currently participate in the Targeted Case Management program.

DHCS may need to review and discuss other potential county funding interactions with this benefit to ensure there is no duplication of services or funding.

Transition and Coordination Plan

Medi-Cal managed care plans currently operating a Health Homes Program or operating in a county with a Whole Person Care pilot or Targeted Case Management program, will be required to submit a transition and coordination plan to DHCS by July 1, 2021. Through the transition and coordination plan, managed care plans will demonstrate how they will translate the existing programs into the enhanced care management benefit and in lieu of services and coordinate with existing Targeted Case Management programs. The

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plans must also demonstrate a good faith effort to contract for enhanced care management and in lieu of services with existing Health Homes providers and Whole Person Care entities already providing such services. If the Medi-Cal managed care plan and existing provider cannot come to agreement, the Medi-Cal managed care plans will need to provide DHCS information as to why such entities were not able to come to a contractual agreement.

Medi-Cal managed care plans in counties with Targeted Case Management programs will be required to submit information in the transition and coordination plan describing how they will work with the Local Government Agency to ensure that members receiving enhanced care management services do not receive duplicative Targeted Case Management services.

A transition and coordination plan will not be required for Medi-Cal managed care plans in counties that do not have Whole Person Care pilots, Health Homes Programs, or Targeted Case Management.

Implementation

January 1, 2022: All Medi-Cal managed care plans in counties with Whole Person Care pilots and/or Health Homes Programs will begin implementation of the enhanced care management benefit, for those target populations currently receiving Health Homes Program and/or Whole Person Care services.

July 1, 2022:

- Medi-Cal managed care plans in counties with Whole Person Care pilots and/or Health Homes Programs will implement additional mandatory enhanced care management target populations.
- All Medi-Cal managed care plans in counties without Whole Person Care pilots and/or Health Homes Programs must begin implementation of select enhanced care management target populations.

January 1, 2023: All Medi-Cal managed care plans in all counties must implement enhanced care management for all target populations.

Medi-Cal managed care plans that begin implementing on January 1, 2022 will submit an enhanced care management Model of Care proposal to DHCS for review by July 1, 2021. Draft contract provisions will be shared with plans in February 2021. Medi-Cal managed care plans that will implement enhanced care management on July 1, 2022, will submit an enhanced care management Model of Care by January 1, 2022. All plans must complete readiness activities for the mandatory target populations. Medi-Cal managed

care plans can submit to DHCS additional optional target populations, in addition to the mandatory target populations.

Federal regulations require that Medi-Cal managed care plan implementation activities shall include tribal consultation/outreach for protections involving American Indians and Indian Health Clinic providers. Through the enhanced care management Model of Care, managed care plans must demonstrate that there are sufficient Indian Health Clinics participating in their provider network to ensure timely access to services available under the contract from such providers for American Indian enrollees who are eligible to receive services. Medi-Cal managed care plans will provide a description of their coordination with tribal partners within the enhanced care management transition and coordination plan.

By July 1, 2022, all Medi-Cal managed care plans will need to submit to DHCS an enhanced care management Model of Care proposal for serving individuals transitioning from incarceration for implementation on January 1, 2023 in all counties. Re-entry transitions involve working closely with corrections departments, including probation, courts and the local county jail system to ensure connections to care once individuals are released from jail. While there is some infrastructure in place for this enhanced care management target population due to Whole Person Care Pilots, these types of arrangements require significant planning and coordination between the managed care plan, counties, sheriff, probation, and other key stakeholders.

DHCS is also looking to leverage the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment (SUPPORT) for Patients and Communities Act provisions that may make it possible to begin providing enhanced care management for individuals exiting from incarceration with known medical and behavioral health needs 30 days prior to release.

This aspect of enhanced care management will support the scaling of diversion efforts aimed at keeping some of the most acute and vulnerable individuals with serious medical or behavioral health conditions out of jail/prison and in their communities. In this case, Medi-Cal managed care plans can contract with county and non-profit entities that work to meet the health care needs of those who are involved in pre- or post-booking diversion behavioral health and criminogenic treatment programs and, thus, are at risk for incarceration and could, through care coordination and service placement, have a treatment plan built to avoid incarceration and get into community-based care and services.

Furthermore, to complement this enhanced care management benefit, DHCS is proposing to mandate that all counties implement a county inmate pre-release Medi-Cal application process by January 1, 2023.

Mandated County Inmate Pre-Release Application Process

In 2004, the Centers for Medicare & Medicaid Services (CMS) issued a State Medicaid Director letter, entitled "Ending Chronic Homelessness," that encouraged states to ensure that applications for Medicaid are processed in a timely manner so that individuals can receive Medicaid-covered services immediately upon release from a public institution.

On May 6, 2014, DHCS provided guidance in All-County Welfare Directors Letter #14-24, on the pre-release application process for state inmates who apply for Medi-Cal coverage. Subsequently, on June 25, 2014, DHCS clarified in All County Welfare Directors Letter #14-24E, that the guidance issued in the May 2014 letter is also applicable to county inmates. However, a specific pre-release process to facilitate the applications for county inmates was not defined and implementation of such process was voluntary.

The current pre-release application process varies from county to county. From a survey of some counties, DHCS learned that relatively larger counties with pre-release programs, such as Orange County and Stanislaus County, have agreements with third-party entities (e.g., community-based organizations or vendors) to streamline the pre-release application process and to provide dedicated application intake staff that visit individuals at the county jail while still in custody. Of the smaller counties surveyed, Yolo County has an agreement with the Sheriff's Department to establish communication channels and set up physical stations at the correctional facility, as well as security clearances for designated county staff to speak with the county inmate applicant directly. **Appendix C: County Inmate Pre-Release Application Process sample contracting Models** includes the three main models currently being used for various county inmate pre-release application programs.

DHCS is proposing to mandate that all counties implement a county inmate pre-release Medi-Cal application process by January 1, 2023, which would include juvenile facilities. The goal of the proposal is to ensure the majority of county inmates/juveniles that are eligible for Medi-Cal and are in need of ongoing physical or behavioral health treatment receive timely access to Medi-Cal services upon release from incarceration.

Additionally, DHCS is proposing to mandate that all county jails and juvenile facilities implement a process for facilitated referral and linkage from county release to county specialty mental health, Drug Medi-Cal, Drug Medi-Cal Organized Delivery Systems, and Medi-Cal managed care providers when the inmate was receiving behavioral health services while incarcerated to allow for continuation of behavioral health treatment in the community. DHCS will look to counties to implement medical record release processes that would allow medical records to be shared with the county behavioral health and Medi-Cal managed care providers, prior to or upon release from jail or county juvenile facility.

The mandated county inmate pre-release application process will standardize policy, procedures, and collaboration between California's county jails, county sheriff's departments, juvenile facilities, county behavioral health and other health and human services entities. This collaboration will ensure that eligible individuals are enrolled in Medi-Cal prior to release and will establish a continuum of care and ongoing support that may ultimately help to reduce the demand for costly and inappropriate services.

2.2.3 Rationale

DHCS continues to strengthen integration within the state's health care delivery system and is working with health promotion partners to achieve better care and better health outcomes at lower cost to the Medi-Cal program. Creating a statewide enhanced care management benefit with required target populations is consistent with the CalAIM objective of reducing variation and complexity across the delivery system, as well as identifying and managing member risk and need. The benefit will comprise an intensive set of services for Medi-Cal members who require coordination at the highest levels. Targeted individuals are beneficiaries who may be challenged with medical and behavioral conditions, access to care issues, chronic illnesses, disabilities, multiple social determinants of health, and require multidisciplinary care to regain health and function.

The enhanced care management benefit will provide Medi-Cal managed care plans with opportunities to help beneficiaries achieve improved health and well-being through stratifying risk and need and developing care plans and strategic interventions. Enhanced care management services will extend beyond standard care coordination and disease management activities. They will be concentrated on the coordination and monitoring of cost-effective, high quality, direct care services, as well as connections to needed community supports for non-direct care needs.

2.2.4 Proposed Timeline

DHCS is proposing a phased statewide implementation of the enhanced care management benefit and inclusion in Medi-Cal managed care contracts. Medi-Cal managed care plans in counties with Whole Person Care Pilots and/or Health Homes Programs will implement enhanced care management on January 1, 2022 for those target populations currently receiving Health Homes and/or Whole Person Care services. On July 1, 2022, Medi-Cal managed care plans in those counties will implement additional required target populations and counties without Whole Person Care pilots and/or Health Homes Programs will begin implementing select populations on July 1, 2022. The benefit must be implemented for in all counties all target populations, including individuals transitioning from incarceration, by January 1, 2023.

DHCS is proposing an effective date of January 1, 2023 for counties to implement a county inmate/juvenile pre-release application process. To ensure the necessary data

sharing agreements and communication plans are in place, below is detailed timeline for planning and implementation of this proposal:

- **March 1, 2021:** Establish workgroup with County Welfare Director's Association and counties to develop and vet implementation plan
- **May 1, 2021:** All county guidance development
- **November 1, 2021:** County and stakeholder feedback process
- **January 1, 2022:** Publish All County Welfare Director Letter
- **January – December 2022:** County implementation planning and technical assistance
- **January 1, 2023:** Implementation of county inmate pre-release application process

2.3 In Lieu of Services

2.3.1 Background

The Whole Person Care pilots and Health Homes Program built a foundation for an integrated approach to coordinating medical care, behavioral health, and social services to improve beneficiary health outcomes. The implementation of these programs, however, has varied across California and did not provide a statewide platform to comprehensively address the needs of beneficiaries with the most complex health challenges.

According to federal Medicaid program rules, "in lieu of services" are medically appropriate and cost-effective alternatives to services that can be covered under the State Plan. They are typically delivered by a different provider or in a different setting than traditional State Plan services. An in lieu of service can only be covered if:

- The state determines that the service is a medically appropriate and cost-effective substitute or setting for the State Plan service;
- The services are optional for the managed care plan to provide;
- The services are optional for beneficiaries and they are not required to use the in lieu of service; and
- The in lieu of services are authorized and identified in the state's Medi-Cal managed care plan contracts.

Once adopted, Medi-Cal managed care plans will integrate in lieu of services into their population health management plans – often in combination with the new enhanced care

management benefit – to address gaps in State Plan benefit services. In lieu of services may be focused on addressing combined medical and social determinants of health needs to avoid higher levels of care. For example, in lieu of services might be provided as a substitute for, or to avoid, hospital or nursing facility admissions, discharge delays, and emergency department use. Based on extensive stakeholder feedback, DHCS has updated the in lieu of services menu of services. The feedback enhanced the overall design of in lieu of services, allowing beneficiaries receiving Health Homes or Whole Person Care services to continue receiving optional plan services. Furthermore, the additional feedback optimized the depth and capacity for serving eligible beneficiaries.

2.3.2 Proposal

DHCS is proposing to include the following fourteen (14) distinct services as in lieu of services under Medi-Cal managed care. Details regarding each proposed set of services are provided in **Appendix J: In Lieu of Services Options**:

- Housing Transition/Navigation Services
- Housing Deposits
- Housing Tenancy and Sustaining Services
- Short-Term Post-Hospitalization Housing
- Recuperative Care (Medical Respite)
- Respite Services
- Day Habilitation Programs
- Nursing Facility Transition/Diversion to Assisted Living Facilities, such as Residential Care Facilities for Elderly and Adult Residential Facilities
- Community Transition Services/Nursing Facility Transition to a Home
- Personal Care and Homemaker Services
- Environmental Accessibility Adaptations (Home Modifications)
- Meals/Medically Tailored Meals
- Sobering Centers
- Asthma Remediation

The provision of in lieu of services is voluntary for Medi-Cal managed care plans and beneficiaries have the option to accept the in lieu of services or receive the State Plan services instead. Each service will have defined eligible populations, code sets, potential providers, restrictions, and limitations. However, individual in lieu of services may be used

together with other complementary in lieu of services based on individual needs and may be combined with enhanced care management services for high-risk, complex-need individuals. ILOS can be offered as an appropriate EPSDT service. Other appropriate EPSDT services should be offered in conjunction with any ILOS.

Transition and Coordination Plan

Since DHCS is building on the infrastructure developed for the Health Homes Program and parts of the Whole Person Care pilots, Medi-Cal managed care plans in counties with these programs will be required to submit a Transition and Coordination Plan to the state by July 1, 2021 demonstrating how they will transition existing programs into their enhanced care management benefit and in lieu of services. The plans must also demonstrate a good faith effort to come into agreement with and contract for enhanced care management and in lieu of services with Health Homes providers and Whole Person Care entities providing such services. DHCS recognizes the significant investment in infrastructure, as well as the existing expertise in providing these types of services, by our local county and other public/private partners and expects Medi-Cal managed care plans to partner with these entities to continue providing these critical services. If the Medi-Cal managed care plan and existing provider cannot come to agreement, the Medi-Cal managed care plans will need to provide DHCS a justification as to why the plan has not contracted with such entities.

2.3.3 Rationale

Adoption of this set of in lieu of services will provide additional support to beneficiaries with complex medical and behavioral health needs who experience socio-economic conditions that impede their ability to achieve their health goals. These circumstances put them at risk of hospitalization, institutionalization, and/or in need of other higher cost services.

Currently, Medi-Cal strategies to address beneficiaries' social determinants of health vary across the state, depending on the initiatives underway in different regions. Consistent with the CalAIM objective of reducing variation and complexity across the delivery system, as well as identifying and managing member risk and need, establishing coverage of a set of in lieu of services will make a statewide offering of these critical interventions for Medi-Cal beneficiaries.

The in lieu of services framework allows for regions that do not currently have a sufficient infrastructure to provide the full array of services to build network capacity in a way that meets the unique needs of their residents. This may include partnerships to develop physical infrastructure, as well as collaborations with new provider types who have not historically worked with Medi-Cal. This will also set the stage for Medi-Cal managed care

plans to be prepared to have long-term services and supports integrated into their care program by 2027.

The stakeholder feedback was critical to ensuring that the identified services will adequately address the critical needs of beneficiaries. The final policy incorporates feedback received regarding strategies for building the necessary service infrastructure in a cost-effective manner, finalizing the eligible populations, potential restrictions and limitations, and appropriate provider types to deliver this new set of services.

2.3.4 Proposed Timeline

January 1, 2022: DHCS is proposing statewide implementation and inclusion of in lieu of services in Medi-Cal managed care plan contracts. DHCS will provide technical assistance to plans as they prepare to implement this new set of services.

2.4 Shared Risk, Shared Savings, and Incentive Payments

2.4.1 Background

The combination of carving in long-term care statewide, enhanced care management and in lieu of services provides a number of opportunities, including an incentive for building an integrated, managed long-term services and supports program by 2027 and building the necessary clinically-linked housing continuum for our homeless population.

In order for the state to be equipped with the needed MLTSS and clinically linked housing continuum infrastructure, it is important to consider potential incentives and shared savings/risk models that could be established to encourage Medi-Cal managed care plans and providers to fully engage. Incentive funding will be focused on building a pathway for Medi-Cal managed care plans to invest in the necessary delivery and systems infrastructure, build appropriate and sustainable enhanced care management and in lieu of services capacity, and achieve improvements in quality performance that can inform future policy.

2.4.2 Proposal

DHCS proposes to create a series of incentives through a multi-pronged risk strategy. Potential approaches include:

- A blended capitation rate to account for the addition of seniors and persons with disabilities and long-term care beneficiaries into managed care. The rate will be subject to a blend true-up, which will provide financial protections in case of significant differences between actual long-term care beneficiary enrollment and assumptions used during capitation rate development.

- A time-limited, tiered, and retrospective shared savings/risk financial calculation performed by DHCS. This tiered model would be available for three calendar years – 2023, 2024 and 2025.

- A prospective model of shared savings/risk incorporated via capitation rate development. DHCS proposes to implement this approach beginning in calendar year 2026, once historical cost and utilization experience is available that would reflect the implementation of in lieu of services, long-term care services, and enhanced care management benefits statewide in managed care.

DHCS will establish plan incentives linked to delivery system reform through an investment in enhanced care management and in lieu of services infrastructure. The incentive payments will also be based on quality and performance improvements and reporting in areas such as LTSS and other cross-delivery system metrics. The target of incentive payments is to drive change at the managed care plan and provider levels. DHCS anticipates managed care plans will partner and share the incentive dollars with on-the-ground providers, including our critical partners that operate Federally Qualified Health Centers, Rural Health Centers, Indian Health Service clinics, public hospital safety net systems, and county behavioral health systems and providers to work collaboratively to meet the defined targets of incentive program.

2.4.3 Rationale

In recognition of the financial uncertainties that accompany the implementation of enhanced care management, in lieu of services, and MLTSS statewide, DHCS is committed to implementing strategies that will limit excessive financial risk (losses) for Medi-Cal managed care plans, as well as for the state and federal governments. At the same time, DHCS supports the use of strategies that will result in financial gains that can be shared between Medi-Cal managed care plans and the state and federal governments. DHCS' goal is to establish financial mechanisms that will ensure a mutual commitment to the success of the proposed short- and long-term reforms and innovations within the Medi-Cal managed care program.

DHCS' proposed risk approaches are intended to strengthen financial incentives for Medi-Cal managed care plans to:

- Divert or transition beneficiaries from long-term institutional care to appropriate home and community-based alternatives, supported by the availability of in lieu of services and enhanced care management;

- Make the necessary infrastructure investments to support the goal of transitioning to an integrated long-term services and supports program; and

- Improve quality, performance measurement, and data reporting as a pathway toward realizing better health outcomes for Medi-Cal beneficiaries.

2.4.4 Proposed Timeline

Rate setting, including associated risk strategies, is a dynamic process. Therefore, DHCS will engage and collaborate with Medi-Cal managed care plans and make future refinements as determined appropriate.

- **January – December 2021:** Develop shared savings/risk and plan incentive methodologies and approaches with appropriate stakeholder input.
- **January 1, 2022:** Begin implementation of managed care plan incentives.
- **No sooner than January 1, 2023:** Begin implementation of a seniors and persons with disabilities/long-term care blended rate.

2.5 Serious Mental Illness/Serious Emotional Disturbance Demonstration Opportunity

2.5.1 Background

On November 13, 2018, CMS issued a State Medicaid Director letter that outlines opportunities for states to design innovative service delivery systems to improve care for adults with serious mental illness (SMI) and children with serious emotional disturbance (SED) who are enrolled in Medicaid.

This SMI/SED demonstration opportunity allows states to receive federal matching funds for services provided to Medicaid beneficiaries during short-term stays for acute care in psychiatric hospitals or residential treatment settings that qualify as an institution for mental disease (IMD) (e.g., psychiatric hospitals or psychiatric health facilities that have more than 16 beds), as long as it is part of a broader effort to build a robust continuum of care allowing care in the least restrictive, community-based settings. Due to the long-standing federal exclusion of Medicaid matching funds for services provided in these settings, California's counties have historically paid the full cost of inpatient mental health services provided to Medi-Cal beneficiaries in these settings.

2.5.2 Proposal

DHCS proposes that California pursue this SMI/SED demonstration opportunity to receive federal financial participation for services provided to Medi-Cal beneficiaries in an IMD. DHCS heard from stakeholders both positive and negative feedback regarding this proposal. Stakeholders in favor of the demonstration opportunity stated the additional federal funds could provide opportunities to improve service delivery and outcomes

across the continuum of care from inpatient to community-based settings, and the availability of additional matching funds would free up other local resources that counties could reinvest in strengthening other mental health services and further build the continuum of care in the community.

Proponents suggested that the demonstration opportunity is a critical component of solutions for the state hospital crisis (with long wait lists for people found incompetent to stand trial, as the state hospitals are full) and for achieving health equity, since increasing the number of short-term, crisis stabilization resources can divert people with mental illness to treatment instead of entering the justice system. People of color are disproportionately placed in justice settings instead of in mental health treatment, and lack of bed availability is a contributing factor. Stakeholders also expressed opposition based on concerns that the presence of the existing IMD exclusion is the primary safeguard in inhibiting county mental health departments from expanding the use of institutional settings and an important incentive to develop alternatives to those settings, and that using federal dollars to fund IMDs could divert resources from community-based services, undermining progress toward increased community integration and a community-based continuum of care.

On balance, DHCS believes the benefits outweigh the risks, and proposes that California submit an application to CMS using the usual process for submitting a Section 1115 waiver demonstration application. Similar to the state's existing 1115 demonstration to provide residential and other SUD treatment services under Medi-Cal, county participation would be voluntary.

2.5.3 Rationale

If California is approved to participate in the SMI/SED demonstration opportunity, federal financial participation would become available for mental health services provided to Medi-Cal beneficiaries in an IMD if all requirements are met. This additional funding would provide opportunities to improve service delivery and outcomes across a well-developed and robust continuum of care from inpatient to community-based settings, which is a requirement of this waiver. Availability of additional federal matching funds would free up other local resources, such as realignment funds, that counties may then reinvest in strengthening other mental health services and further build the continuum of care in the community.

The SMI/SED demonstration opportunity comes with many federal milestones and requirements. As of October 2020, Washington DC, Vermont, Indiana, and Idaho have approved applications, and Massachusetts, Oklahoma and Utah have pending 1115 waiver application to CMS. Below is a summary of key requirements, some of which may pose feasibility challenges:

- **Average Length of Stay:** The state would be required to achieve a statewide average length of stay of no more than 30 days for beneficiaries residing in IMDs. CMS developed guidance regarding calculations of average length of stay, clarifying that a short-term stay for acute care is limited to no more than 60 consecutive days, as long as the state continues to meet the statewide average length of stay of 30 days or less, and that states may not claim for *any* part of a stay (days 0 to 60) that exceeds 60 days.

- **Improving Community-based Services**: States participating in the SMI/SED demonstration opportunity will be expected to commit to taking several actions to improve community-based mental health care. These actions are linked to a set of goals for the SMI/SED demonstration opportunity and will milestones for ensuring quality of care in IMDs, to improve connections to community-based care following stays in acute care settings, to ensure a continuum of care is available to address more chronic, on-going mental health care needs of beneficiaries, to provide a full array of crisis stabilization services, and to engage beneficiaries with SMI/SED in treatment as soon as possible.

- **Maintenance of Effort:** According to the guidance, CMS will be examining the commitment to ongoing maintenance-of-effort on funding outpatient community-based mental health services and states must provide an assessment of current availability of mental health services. The purpose of the maintenance-of-effort requirement is to ensure that resources are not disproportionately drawn into increasing access to treatment in inpatient and residential settings at the expense of community-based services.

- **Data Collection & Required Measures:** The state would need to report on a common set of measures and agree to additional measures and concepts specific to the state's demonstration parameters.

- **Health Information Technology:** The state would be required to develop and submit a health information technology plan that describes the ability to leverage technology, advance health information exchange(s), and ensure interoperability in support of the demonstration's goals. The health information technology plan would address electronic care plan sharing, care coordination, and behavioral and physical health integration.

- **Staffing and Resource Considerations:** Since DHCS does not currently pay for IMD services for this target population, pursuing the demonstration and ensuring compliance with requirements would require additional staffing and resources. Similarly, counties would likely need additional resources to implement and comply with elements required by the demonstration.

For additional information about the demonstration goals and milestones, federal application requirements, and other relevant requirements, please refer to the **Appendix E: CalAIM Benefit Changes Chart** of this proposal.

2.5.4 Proposed Timeline

The SMI/SED demonstration proposal would be developed no sooner than July 1, 2022. If the waiver proposal is approved by CMS, DHCS would work with interested counties to develop a formal implementation plan, with expected launch of the demonstration in 2023-24.

2.6 Full Integration Plans

2.6.1 Background

Currently, Medi-Cal beneficiaries must navigate multiple complex managed care and fee-for-service delivery systems to meet all of their health care needs. Beneficiaries enrolled in Medi-Cal managed care plans receive physical health care and treatment for mild-to-moderate mental health conditions from their Medi-Cal managed care plan, care for SMI/SED and SUD from the county delivery system, and dental care from a separate fee-for-service delivery system or a dental managed care plan. This fragmentation can lead to gaps in care and disruptions in treatment, cost inefficiencies, and generally fails to be patient-centered and convenient for most beneficiaries. The longevity gap among individuals with serious and persistent mental illness, and the fact that this group suffers and dies from un-or under-treated chronic physical health conditions, demonstrates the need to pilot the concept of a fully integration delivery system.

2.6.2 Proposal

DHCS would like to test the effectiveness of full integration of physical health, behavioral health, and oral health under one contracted entity. Multiple Medi-Cal delivery systems (Medi-Cal managed care, county mental health plans, county Drug Medi-Cal and DMC-ODS programs) would be consolidated under one contract with DHCS. To further develop this concept, DHCS will be engaging in stakeholder conversations to inform the development of the various components associated with fully integrating health care services. Topics will include contractor selection criteria, strategies for consolidating contract requirements, subcontracting and network requirements, and delivery system administration issues such as care coordination, utilization management, quality monitoring, and external quality review organization functions.

2.6.3 Rationale

In alignment with CalAIM, fully integrating all or most of the Medi-Cal health care delivery systems under one contract would improve the beneficiary experience as well as health outcomes by eliminating fragmentation, duplication, and the need to navigate multiple systems. In addition, integration will improve access to health data/data sharing among providers and between the plan and DHCS. Full integration would also result in overall administrative simplification by consolidating and streamlining system infrastructure. An integrated delivery system would allow for more efficient coordination of care and create opportunities to identify and manage the risks and needs of the beneficiaries in a more holistic way.

As part of the CalAIM workgroup process, DHCS sought stakeholder feedback to understand the benefits, risks and considerations for plans and counties interested in participating in a full integration model. Discussion included realignment (county behavioral health participation would need to be voluntary), how non-Medi-Cal funding streams would be managed (such as MHSA), criteria for participation, the need for adequate planning and preparation, the importance of clearly defined outcome measures, and other considerations.

2.6.4 Proposed Timeline

DHCS acknowledges the complexity of this proposal, and for this reason, is proposing a go-live of no sooner than January 2027, to allow sufficient time for planning and preparation, in partnership with counties, plans and other stakeholders.

2.7 Long-Term Plan for Foster Care

2.7.1 Background

Children and youth in foster care often present with complex medical, behavioral, oral and developmental health problems rooted in their history of childhood trauma and adverse childhood experiences (ACEs) Navigating multiple systems of care can create inherent challenges. Under the Medi-Cal program, beneficiaries receive services through various delivery systems, including Medi-Cal managed care, fee-for-service, California Children's Services, regional centers, dental county mental health plans, Drug Medi-Cal, and DMC-ODS programs. While children and youth in foster care typically have a comprehensive team to help facilitate and oversee their care including social workers, public health nurses, and the judicial system; many challenges remain in navigating Medi-Cal delivery systems, especially if there are multiple placements that may result in the child moving from one county to another or between homes in a single county.

In recent years, California has placed a greater emphasis on the behavioral health care needs of child welfare-involved children and families through major reforms such as the

Continuum of Care Reform, Family Urgent Response System, development of short-term residential treatment providers and coordinated efforts to implement the new federal Family First Prevention Services Act in California.

2.7.2 Proposal

In assessing the challenges foster care children and youth face, in June 2020 DHCS launched a workgroup of interested stakeholders to consider whether DHCS should develop a different model of care for children and youth in foster care, including the former foster youth and youth transitioning out of foster programs and services. To facilitate this discussion and develop meaningful recommendations, DHCS invited participation from key partners including but not limited to: the Department of Social Services, the Department of Education, child welfare county representatives and state-level associations, Medi-Cal managed care plans, behavioral health managed care plans, juvenile justice and probation, foster care consumer advocates, regional centers, and judicial entities involved with matters pertaining to children who are placed into the foster care system. DHCS also commissioned focus groups with foster youth and foster parents, to hear directly from those most affected by the challenges in the current system.

2.7.3 Proposed Timeline

DHCS launched the workgroup in June 2020, and will meet every other month through June 2021. DHCS and CDSS then will take lessons learned from the workgroup and the input from stakeholders and develop a comprehensive set of recommendations and plan of action, which may involve budget recommendations, waiver amendments, State Plan changes or other activities.

3. Moving Medi-Cal to a More Consistent and Seamless System by Reducing Complexity and Increasing Flexibility

This section will walk through the proposals aimed at standardizing and reducing complexity across all delivery systems.

Managed Care

- Managed Care Benefit Standardization
- Mandatory Managed Care Enrollment
- Transition to Statewide Long-Term Services and Supports, Long-Term Care & Duals-Special Needs Plans
- NCQA Accreditation of Medi-Cal Managed Care Plans
- Regional Managed Care Capitation Rates

Behavioral Health

- Behavioral Health Payment Reform
- Medical Necessity Criteria and Other Related Changes
- Administrative Integration of Specialty Mental Health and Substance Use Disorder Services
- Behavioral Health Regional Contracting
- DMC-ODS Renewal and Policy Improvements

Dental

- New Dental Benefits and Pay for Performance

County Partners

- Enhancing County Eligibility Oversight and Monitoring
- Enhancing County Monitoring and Oversight: California Children's Services and Child Health and Disability Prevention
- Improving Beneficiary Contact and Demographic Information

Managed Care

3.1 Managed Care Benefit Standardization

3.1.1 Background

Medi-Cal delivers services through a variety of delivery systems today including fee-for-service, managed care, county mental health, Drug Medi-Cal Organized Delivery System, and Drug Medi-Cal. Most full-scope Medi-Cal beneficiaries receive their physical health

services through a Medi-Cal managed care plan. While Medi-Cal managed care exists statewide, it is operated under six different model types that currently differ based on whether certain benefits are part of the Medi-Cal managed care plan's responsibility or provided through a different delivery system.

3.1.2 Proposal

Under CalAIM, DHCS is proposing to standardize the benefits that are provided through Medi-Cal managed care plans statewide. Regardless of the beneficiary's county of residence or the plan they are enrolled in, they will have the same set of benefits delivered through their Medi-Cal managed care plan as they would in another county or plan.

DHCS is proposing the following changes:

Carved Out Benefits

- Effective April 1, 2021, all pharmacy benefits or services by a pharmacy billed on a pharmacy claim will be carved out from Medi-Cal managed care plans (pursuant to the Governor's Executive Order N-01-19 from January 7, 2019). This applies to all Medi-Cal managed care plans, including AIDS Healthcare Foundation, but does not apply to SCAN Health Plan, Programs of All-Inclusive Care for the Elderly (PACE) organizations, Cal MediConnect health plans, and Major Risk Medical Insurance Program (MRMIP).

- Effective January 1, 2022, the following benefits that are currently within the scope of some or all the Medi-Cal managed care plans will be carved out:

    - Specialty mental health services that are currently carved in for Medi-Cal members enrolled in Kaiser in Solano and Sacramento counties; and

    - The Multipurpose Senior Services Program which is currently included in the Medi-Cal managed care plans in the seven Coordinated Care Initiative counties.

Carved In Benefits

- Effective January 1, 2022, all major organ transplants, currently not within the scope of many Medi-Cal managed care plans, will be carved into all plans statewide for all Medi-Cal members enrolled in a plan.

- Effective January 1, 2023, institutional long-term care services (i.e. skilled nursing facilities, pediatric/adult subacute care, intermediate care facilities for individuals with developmental disabilities, disabled/habilitative/nursing services, specialized rehabilitation in a skilled nursing facility or intermediate care facilities), currently

not within the scope of many Medi-Cal managed care plans will be carved into all plans statewide for all Medi-Cal members enrolled in a plan.

In order to provide a smooth transition from fee-for-service to managed care, promote access and maintain affordability, DHCS proposes to require that long-term care and transplant providers accept as payment in full and require the Medi-Cal managed care plan to pay the applicable Medi-Cal fee-for-service rate, unless the provider and plan mutually agree upon an alternative payment. This is consistent with how these transitions to managed care have occurred in the past, such as with the Coordinated Care Initiative and the Whole Child Model.

3.1.3 Rationale

The standardization of benefits delivered through Medi-Cal managed care plans statewide has two main purposes and benefits:

- Beneficiaries will no longer have to deal with the confusion that may arise when moving counties/plans and to find that different benefits are covered by their new plan or that they need to access another delivery system; and
- DHCS will be able to implement a change to Medi-Cal managed care plan rate setting. Currently, the capitation payment rates are developed on a county-by-county and plan-by-plan basis, resulting in excessive administrative work and challenges. With the standardization of the benefits and populations, DHCS will be able to move to a regional rate setting process that will reduce the number of rates being developed and allow DHCS to work with the managed care plans to explore different rate setting methodologies and adjustments to reward improved quality and outcomes.

3.1.4 Proposed Timeline

The benefit standardization will be effective and included in Medi-Cal managed care plan contracts by January 2023, according to **Appendix F: Managed Care Enrollment Proposed Aid Code Group Coverage**.

3.2 Mandatory Managed Care Enrollment

3.2.1 Background

Currently, the Medi-Cal program provides benefits through both a fee-for-service and managed care delivery system. Enrollment into the fee-for-service delivery system or the managed care delivery system is based upon specific geographic areas, the health plan model, and/or the aid code that the beneficiary is determined to qualify for. In some cases, enrolling in managed care is optional for beneficiaries. However, more than 80 percent of Medi-Cal beneficiaries are currently served through the managed care delivery system.

3.2.2 Proposal

In an effort to enhance coordination of care, increase standardization, and reduce complexity across the Medi-Cal program, DHCS is proposing to standardize which aid code groups will require mandatory managed care enrollment versus mandatory fee-for-service enrollment, across all models of care and aid code groups, statewide. Under this proposal, beneficiaries in a voluntary or excluded from managed care enrollment aid code that are currently accessing the fee-for-service delivery system, would be required to choose a Medi-Cal managed care plan and will not be permitted to remain in fee-for-service. DHCS completed extensive data analytics to inform this proposal, for example, 73% of beneficiaries with other health coverage are already enrolled in managed care today and of non-long-term care share of cost beneficiaries, on average only 5.4% of beneficiaries meet their monthly share of cost.

DHCS is proposing implementation of this change in two phases, transitioning non-dual eligible populations in 2022 and dual eligible populations in 2023. A non-dual member is defined as a Medi-Cal member without any Medicare coverage. A dual beneficiary is defined as a Medi-Cal member with any Medicare coverage. This would include Medi-Cal members with Medicare A only or Part B only (partial duals) and members with Medicare Part A and B (full duals) regardless of enrollment in Medicare Part C or Part D. See below for a summary of changes and **Appendix F: Managed Care Enrollment Proposed Aid Code Group Coverage** for more details.

Given the ability and directive of Medi-Cal managed care plans to provide case and care management not available in a fee-for-service environment, DHCS firmly believes that Medi-Cal managed care is a delivery system we should continue to invest in and rely upon. In conjunction with these new and increased responsibilities, DHCS plans to increase oversight of the plans and their delegated entities to ensure that current requirements being met but also that the additional benefits and requirements contained in CalAIM are truly being provided statewide.

Mandatory Managed Care Enrollment

Below are the populations that currently receive benefits through the fee-for-service delivery system that would transition to Medi-Cal managed care upon implementation of this proposal in 2022:

- Trafficking and Crime Victims Assistance Program (except share of cost)
- Individuals participating in accelerated enrollment
- Child Health and Disability Prevention infant deeming
- Pregnancy-related Medi-Cal (Pregnant Women only, 138-213% citizen/lawfully present)
- American Indians
- Beneficiaries with other health care coverage

- Beneficiaries living in rural zip codes

Below are the populations that currently receive benefits through the fee-for-service delivery system except in COHS and CCI counties that would transition to the Medi-Cal managed care system upon implementation of this proposal in 2023:

- All dual and non-dual individuals eligible for long-term care services (includes long-term care share of cost populations)
- All partial and full dual aid code groups, except share of cost or restricted scope, will be mandatory Medi-Cal managed care, in all models of care starting in 2023

Mandatory Fee-for-Service Enrollment

This proposal would also move the following populations from mandatory managed care enrollment into mandatory fee-for-service enrollment upon implementation of this proposal in 2022:

- Omnibus Budget Reconciliation Act (OBRA): This population was previously mandatory managed care in Napa, Solano, and Yolo counties.
- Share of Cost: beneficiaries in county organized health systems (COHS) and Coordinated Care Initiative counties excluding long-term care share of cost.

Therefore, beneficiaries in the following aid code groups will have mandatory fee-for-service enrollment:

- Restricted scope
- Share of cost (including Trafficking and Crime Victims Assistance Program share of cost, excluding long-term care share of cost)
- Presumptive eligibility
- State medical parole, county compassionate release, and incarcerated individuals
- Non-citizen pregnancy-related aid codes enrolled in Medi-Cal (not including Medi-Cal Access Infant Program enrollees)

DHCS recommends keeping enrollment requirements for foster care children and youth in place until the Foster Care Workgroup makes recommendations on the future delivery system for foster care children and youth.

3.2.3 Rationale

Moving to mandatory managed care enrollment will standardize and reduce the complexity of the varying models of care delivery in California. Populations moving between counties will have the same experience when it comes to receiving services through a managed care plan. Transitioning current populations to mandatory managed care enrollment will also allow for Medi-Cal managed care plans to provide more

coordinated and integrated care and provide beneficiaries with a network of primary care providers and specialists.

Additionally, DHCS will be able to implement a change to Medi-Cal managed care plan rate setting. Currently, the capitation payment rates are developed on a county-by-county and plan-by-plan basis, resulting in excessive administrative work and challenges. With the standardization of the benefits and populations, DHCS will be able to move to a regional rate setting process that will reduce the number of rates being developed and allow DHCS to work with the managed care plans to explore different rate setting methodologies and adjustments to reward improved quality and outcomes.

3.2.4 Proposed Timeline

- **January 1, 2022:** Non-Dual and pregnancy related aid code group, and population-based transitions, except for LTC aid codes.
- **January 1, 2023:** Dual aid code group transition, including LTC aid codes for both non-dual and dual beneficiaries.

3.3 Transition to Statewide Long-Term Services and Supports, Long-Term Care, & Dual Eligible Special Needs Plans

3.3.1 Background

Under CalAIM, DHCS is proposing to transition CMC and the CCI to a statewide MLTSS and dual eligible special needs plan (D-SNP) structure. This policy is intended to help meet the statewide goals of improved care integration and person-centered care, under both CalAIM and the California Master Plan for Aging.

The Coordinated Care Initiative has been underway in seven California counties and is comprised of two parts: 1) Cal MediConnect, a demonstration project that combined acute, primary, institutional, and home and community-based services into a single benefit package for individuals who are fully or partially eligible for Medicare and Medicaid; 2) mandatory Medi-Cal managed care enrollment for dual eligibles for all Medi-Cal benefits, including managed long-term services and supports.

The Governor's 2017-2018 budget determined that the Coordinated Care Initiative was not cost-effective due to the financing of the In-Home Supportive Services benefit, which was carved out to fee-for-service effective January 1, 2018. DHCS will carve out Multipurpose Senior Services Program services to fee-for-service effective January 1, 2022 for all Medi-Cal members. CMS approved an extension for the remaining program elements – Cal MediConnect and mandatory managed long-term services and supports enrollment – until December 31, 2022.

While the Coordinated Care Initiative and Cal MediConnect offer the promise of better integrated care for California's dual eligibles, the program is only available in seven out of 58 counties. Additionally, Cal MediConnect has been a complex program to administer.

DHCS is implementing a new approach to take the key lessons learned and innovative strategies from these programs and make them more broadly available across the State.

3.3.2 Proposal

Aligned Enrollment

DHCS will use selective contracting to move toward aligned enrollment in D-SNPs; beneficiaries will enroll in a Medi-Cal managed care plan and D-SNP operated by the same parent company to allow for greater integration and coordination of care.

- In CCI counties, aligned enrollment will begin in 2023. Cal MediConnect members will transition to aligned D-SNPs and managed care plans operated by the same organization as their Cal MediConnect product.
- Aligned enrollment will phase-in in non-CCI counties as plans are ready. DHCS will require managed care plans to apply for aligned D-SNPs to be effective no later than contract year 2025.
- Dual eligible beneficiaries already enrolled in a non-aligned D-SNP (a D-SNP that is not affiliated with their managed care plan) when aligned enrollment takes effect in their county will be in that D-SNP (allowing the beneficiary to stay in the non-aligned D-SNP). New enrollment in those non-aligned D-SNPs will be closed.

In conjunction with the aligned enrollment approach, starting in 2022 CMS will limit enrollment into Medicare Advantage (MA) plans that are D-SNP “look-alikes.” These are MA plans that offer the same cost sharing as D-SNPs, but do not offer integration and coordination with Medi-Cal or other benefits targeted to the dual eligible population, such as risk assessments or care plans.

As outlined in the CMS Contract Year 2021 Medicare Advantage and Part D Final Rule:

- CMS will not enter into contracts with new MA plans that project 80 percent or more of the plan's enrollment will be entitled to Medicaid starting in 2022; and
- CMS will not renew contracts with MA plans (except SNPs) that have enrollment of 80 percent or more enrollees who are entitled to Medicaid (unless the MA plan has been active for less than one year and has enrollment of 200 or fewer individuals).

DHCS will also allow plans in CCI counties with managed care plan contracts, existing D-SNPs, and existing MA D-SNP look-alike plans to transition their dual eligible populations enrolled in the MA look-alike into an existing D-SNP in 2022, prior to the end of CCI. This will provide better coordination of care, without reducing enrollment in Cal MediConnect plans, and is in alignment and preparation for the CMC transition to D-SNP aligned enrollment in 2023.

D-SNP Integration Requirements

DHCS will require that all D-SNPs use a model of care addressing both Medicare and Medi-Cal services to support coordinated care, high-quality care transitions, and information sharing. DHCS will work with CMS to incorporate new CalAIM model of care requirements into the D-SNP model of care, as appropriate.

As DHCS implements aligned enrollment, DHCS will require D-SNPs to:

- Develop and use integrated member materials.
- Include consumers in their existing advisory boards.
- Work with CMS to establish quarterly joint contract management team meetings for aligned D-SNP and managed care plans.
- Include dementia specialists in their care coordination efforts.
- Coordinate carved-out LTSS benefits including IHSS, MSSP, and other HCBS waiver programs.

Additionally, DHCS will work with CMS to coordinate audit timing, to avoid a D-SNP/managed care plan being audited by both agencies at the same time.

Long-Term Care Carve In

In conjunction with mandatory Medi-Cal managed care enrollment, DHCS will require statewide integration of LTC into managed care for Medi-Cal populations by 2023. This means that full- and partial-benefit duals in LTC facilities in counties or plans that do not already include LTC will be enrolled in Medi-Cal managed care by 2023.

D-SNP Transitions and Enrollment Policies

DHCS will encourage aligned enrollment of dual eligibles into matching managed care plans and D-SNPs to promote more integrated care. During all transitions, DHCS will work with CMS to ensure beneficiaries receive continuity of care protections.

Mandatory Enrollment into Medi-Cal Managed Care Plans

DHCS is committed to providing beneficiary and provider education, as well as technical assistance around Medi-Cal managed care plan requirements, for mandatory enrollment of dual eligibles into Medi-Cal managed care. As part of this work, DHCS will:

- Review and make any needed updates to education and enrollment materials used to assist dual eligibles in enrolling into a managed care plan or PACE for their Medi-Cal benefits.

- Help educate providers about necessary billing practices as well as the processes that will not change, building on materials and best practices previously developed under CCI.

3.3.3 Rationale

Individuals dually eligible for Medicare and Medi-Cal are among the highest need populations. However, lack of coordination between Medicare and Medi-Cal can make it difficult for individuals enrolled in both programs to navigate these separate systems of care. California has made significant progress in building integrated systems through the implementation of CCI and CMC in seven counties (Los Angeles, Orange, San Diego, San Mateo, Riverside, San Bernardino and Santa Clara). As part of the CalAIM initiative, DHCS is leveraging the lessons and success of CCI to develop policies to promote integrated care through D-SNPs and MLTSS across California. This includes mandatory enrollment for dual eligibles into managed care plans for their Medi-Cal benefit and increasing the availability of aligned D-SNPs. This will allow duals to voluntarily enroll for their Medicare benefits into the D-SNP that is aligned with their managed care plan.

In addition, to promote integrated, person-centered care, the D-SNP and MLTSS policies will rely on California's robust and diverse array of HCBS providers across the state who serve older Californians and people with disabilities. In support of this effort, DHCS plans to submit a request for supplemental funding through the federal Money Follows the Person grant to accelerate LTSS system transformation design and implementation, and to expand HCBS capacity. The one-time supplemental funding would be used to develop a multi-year roadmap for implementing strategies and solutions for strengthening HCBS and MLTSS programs and provider networks. DHCS' intent is that the roadmap will provide a unified vision to integrate CalAIM MLTSS, D-SNP policy and the related in lieu of services policy, other components of the Master Plan on Aging, and all of HCBS, to expand and better link those HCBS to Medi-Cal managed care and D-SNP plans.

3.3.4 Proposed Timeline

- **January 1, 2021:** All existing D-SNPs must meet new regulatory integration standards effective 2021.

- **January 1, 2022**: Voluntary in lieu of services in all Medi-Cal managed care plans and CMC plans. Multipurpose Senior Services Program (MSSP) carved out of managed care in CCI counties. Plans in CCI counties with existing managed care plan contracts, existing D-SNPs, and existing MA D-SNP look-alike plans may transition their dual eligible populations enrolled in the MA look-alike into an existing D-SNP.

- **December 31, 2022**: Discontinue CMC and CCI.

- **January 1, 2023**: Statewide mandatory enrollment of full- and partial- benefit dual eligible beneficiaries into managed care plans for Medi-Cal benefits, including dual and non-dual eligible LTC residents and statewide integration of LTC into Medi-Cal managed care. Aligned enrollment begins in CCI counties and managed care plans in those counties must stand up D-SNPs. All CMC members cross-walked to matching D-SNP and managed care plans, subject to CMS and state requirements.

- **January 1, 2025**: Aligned enrollment begins in non-CCI counties; All managed care plans required to begin operating D-SNPs (voluntary enrollment for dual eligibles' Medicare benefit).

- **January 1, 2027**: Implement MLTSS statewide in Medi-Cal managed care.

3.4 NCQA Accreditation of Medi-Cal Managed Care Plans

3.4.1 Background

The National Committee for Quality Assurance (NCQA) is a private, not-for-profit organization that offers accreditation to health plans and other health care-related entities (e.g., accountable care organizations) in the areas of quality improvement, population health management, network management, utilization management, credentialing and re-credentialing, and member experience. NCQA also develops quality performance measures known as the Healthcare Effectiveness Data and Information Set (HEDIS) measures, which provide a standardized method for comparing health plan performance. Currently, 26 states require NCQA accreditation for their contracted Medicaid managed care plans.

DHCS conducts annual medical audits of all Medi-Cal managed care plans, but does not currently "deem," or use information obtained from a national accreditation review, to satisfy mandatory external quality review activities, with the exception of the credentialing requirement of the annual medical audit. Federal regulations permit the state to deem this information for credentialing purposes.

DHCS does not currently require Medi-Cal managed care plans to be accredited by NCQA. Out of 24 full scope Medi-Cal managed care plans in the state, 17 health plans currently have NCQA accreditation. Medi-Cal managed care plans that provide private coverage through Covered California are required to be accredited by either NCQA, the Utilization Review Accreditation Commission (URAC), or the Accreditation Association for Ambulatory Health Care (AAAHC).

3.4.2 Proposal

To streamline Medi-Cal managed care plan oversight and to increase standardization across plans, DHCS recommends requiring all Medi-Cal managed care plans and their

health plan subcontractors to be NCQA accredited by 2026. DHCS may use NCQA findings to certify or deem that Medi-Cal managed care plans meet particular state and federal Medicaid requirements. However, numerous stakeholders have shared with DHCS their concerns around DHCS deeming any elements of its current oversight of the managed care plans. Before DHCS recommends deeming of elements of its annual medical audits of the plans, DHCS will solicit feedback on the proposed deemable elements. If deeming does occur, DHCS will post information on the deeming elements and the corrective action plan for NCQA oversight findings on its website. DHCS will not accept accreditation from entities other than NCQA (e.g. URAC). Additional information on proposed deeming is below.

DHCS will also require Medi-Cal managed care plan NCQA accreditation to include the LTSS Distinction Survey subsequent to all health plans operating a D-SNP by 2027; the exact effective date for the LTSS Distinction Survey will be determined at a later date. Requiring the LTSS Survey will align with the state's effort to carve-in long-term care services and expand in lieu of services to make MLTSS a statewide benefit.

While DHCS is interested in the potential future addition of the Medicaid (MED) module to routine NCQA health plan accreditation, as it could potentially maximize the opportunity for streamlining state compliance and deeming, DHCS has determined that it is premature to require the MED module at this point, given how new it is for NCQA.

Finally, DHCS had considered requiring Medi-Cal managed care plans to ensure any non-health plan subcontractors to whom certain contractual elements are delegated are NCQA accredited for that function. DHCS will not require this in its contracts with the Medi-Cal managed care plans at this time; Medi-Cal managed care plans will need to determine if they will require any accreditation of their non-health plan subcontractors. If DHCS decides to deem particular elements of NCQA health plan accreditation standards, and any Medi-Cal managed care plans elect to require NCQA accreditation of their subcontractors, the Medi-Cal managed care plans will have the option to offer deeming on those same elements, if applicable, with their subcontractors.

3.4.3 Rationale

One of the three objectives of CalAIM is to reduce variation and complexity across Medi-Cal delivery systems, including standardization of the Medi-Cal managed care benefit. requiring NCQA accreditation of its managed care plans and following the NCQA framework, DHCS can potentially increase standardization throughout the state and reduce redundancies in various processes and assessments, in areas such as care coordination, which DHCS currently requires. Further, NCQA accreditation can assist in streamlining DHCS monitoring and oversight of managed care plans, particularly with regard to the annual medical audits, by increasing the number of elements in which DHCS may consider deeming Medi-Cal managed care plans. This would allow the annual medical audits to focus on other DHCS priority areas not reviewed by NCQA.

The addition of the LTSS Distinction Survey aligns with DHCS' goal of making LTSS a statewide benefit. DHCS recognizes that the addition of this survey to routine NCQA accreditation may be difficult for Medi-Cal managed care plans that are not already NCQA accredited, so DHCS will determine a timeframe for requiring the LTSS Distinction Survey that falls after all managed care plans have achieved routine NCQA plan accreditation.

3.4.4 Proposed Timeline

DHCS will require all Medi-Cal managed care plans and their health plan subcontractors to be NCQA accredited by 2026.

- DHCS will review and consider elements of NCQA health plan accreditation standards for deeming in relation to the annual A&I compliance audits.
    - DHCS will ensure that a complete crosswalk of federal and state Medicaid requirements and NCQA health plan accreditation standards is available online for comment prior to finalizing any deeming decisions.
    - DHCS will ensure that any NCQA health plan accreditation elements selected for potential deeming are vetted with stakeholders prior to finalizing any deeming decisions.
- DHCS may consider implementing deeming of the select elements sooner than 2026 for Medi-Cal managed care plans that already have NCQA accreditation. DHCS will align all applicable processes in its Medi-Cal managed care plan contract and All Plan Letters with the following six NCQA health plan accreditation categories to correspond with the requirement for accreditation by 2026:
    - Quality Improvement;
    - Population Health Management;
    - Network Management;
    - Utilization Management;
    - Credentialing; and
    - Member Experience.

3.5 Regional Managed Care Capitation Rates

3.5.1 Background

DHCS currently develops, certifies, and implements managed care capitation rates on an annual basis for contracted Medi-Cal managed care plans. DHCS develops distinct rates for each contracted managed care plan by county/region and population group. Due to the complexities of the Medi-Cal managed care program, which includes varied and intricate financing mechanisms, DHCS calculates multiple rating components for each capitation rate for a total of more than 4,000 rating components on an annual basis as of

state fiscal year 2018-19. The excessively large number of rating components DHCS must develop on an annual basis is administratively burdensome and contributes to lengthy annual federal review and approval timeframes. It also limits DHCS' ability to advance value-based and outcomes-focused rate setting methodologies. With the changes contemplated in CalAIM, DHCS views the need for simplified methodologies with a reduced number of components as necessary to achieving our broader goals of improving care delivery, access, quality and outcomes for our Medi-Cal beneficiaries.

3.5.2 Proposal

A regional rate-setting methodology provides a pathway toward simplification of the rate-setting process for the Medi-Cal managed care program. The proposed simplification will afford DHCS the flexibility to continue to pursue strategies that support advancements and innovations within the program.

To ensure a successful transition, DHCS proposes a two-phased approach:

Implement Regional Rates in Targeted Counties (Phase I)

- DHCS would implement Phase I for calendar years 2022 and 2023 (at a minimum) for targeted counties and Medi-Cal managed care plans;
- DHCS would advance new regional rate-setting approaches and streamline rate processes and methodologies;
- DHCS would utilize Phase I as a means of identifying strategies and further improvements that will support a seamless transition to regional rate setting statewide; and
- DHCS would engage and collaborate with contracted Medi-Cal managed care plans and industry associations as part of this process.

Fully Implement Regional Rates Statewide

- DHCS proposes to fully implement regional rates statewide no sooner than calendar year 2024, to align with the end of Phase I; and
- DHCS will consider health care market dynamics, including but not limited to health care cost and utilization data, across counties when determining regional boundaries.

3.5.3 Rationale

The proposed transition to regional rates statewide offers four main benefits:

- Regional rates would reduce the number of distinct rating components that DHCS must develop on an annual basis, and thereby permit DHCS to utilize a more flexible rate structure model. This flexibility is essential to DHCS' ability to pursue

advancements and innovations in the Medi-Cal managed care program, including CalAIM, and to explore new, innovative ideas.

- Regional rates would simplify the presentation of rates to CMS, which may expedite federal review and approval of the Medi-Cal managed care capitation rates. DHCS could implement rate-setting approaches that promote efficiency, including cost-averaging processes, across Medi-Cal managed care plans.
- These approaches would continue to incentivize Medi-Cal managed care plans to operate efficiently as rates will be based upon costs across the multi-county region. In effect, each Medi-Cal managed care plan will be incentivized to compete to be more efficient than other plans in their region.
- Regional rates would provide a larger, multi-county base for averaging, and thereby alleviate some of the criticisms regarding the process currently used by DHCS.

3.5.4 Proposed Timeline

Rate setting is a dynamic process. Therefore, DHCS will proceed methodically, engage and collaborate with Medi-Cal managed care plans, and make future refinements as determined actuarially appropriate.

- **Calendar Year 2020 and 2021:** Develop regional rate-setting methodologies and approaches with appropriate stakeholder input.
- **January 1, 2022:** Implement Phase I for targeted counties and Medi-Cal managed care plans.
- **Calendar Year 2023:** Evaluate and continue to refine the rate-setting process prior to the implementation of regional rates statewide.
- **No sooner than January 1, 2024:** Fully implement regional rates statewide.
- **Post-implementation:** Continue to evaluate and refine the rate-setting process and regions.

Behavioral Health

3.6 Behavioral Health Payment Reform

3.6.1 Background

Through realignment efforts in 1991 and 2011, funding for the majority of the non-federal share of costs associated with the specialty mental health and substance use disorder (SUD) services became the responsibility of the counties. Currently, counties are reimbursed for the federal and state portion of costs for services and administration of these programs via Medicaid Certified Public Expenditure (CPE) methodologies. Under

CPE methodologies, reimbursements to counties are limited to costs incurred by the counties and are subject to a lengthy and labor-intensive cost reconciliation process.

For specialty mental health services, counties pay with non-federal funds at the time of service and when incurring costs to administer the programs. The counties then submit CPEs to DHCS so that the state can draw down eligible federal Medicaid matching funds. In accordance with the CMS-approved CPE protocol, mental health plans receive interim reimbursement of federal financial participation on a fee-for-service basis, pursuant to interim rates approved by the state on an annual basis for approved units of service for allowable procedure codes. The state completes the interim reconciliation of interim Medicaid payments no later than 24 months after the close of each state fiscal year. The final cost reconciliation of mental health plan interim Medicaid payments occurs within 36 months after the certified, reconciled, state-developed cost reports are submitted.

The Drug Medi-Cal portions of the State Plan establishes the interim payment methodology for both Narcotic Treatment Program and non-Narcotic Treatment Program services. Generally, this methodology requires an interim reimbursement at the statewide maximum allowable or uniform statewide daily dosing rate. DHCS also provides an interim reimbursement to counties for costs incurred to administer DMC-ODS or DMC programs. After the fiscal year ends, DHCS performs a settlement with counties for the cost of administering the SUD services (either through DMC State Plan or through DMC-ODS). These cost reconciliations occur years after the close of the state fiscal year to allow time for claims run out as well as for DHCS to complete its cost reconciliation audits.

To incentivize additional investment in the delivery systems and reduce overall burden on counties and the state, DHCS is proposing to reform behavioral health payment methodologies for counties. Under the current CPE methodology, counties are not able to retain revenue when implementing cost-reduction efforts, thereby limiting the ability to fully invest in the delivery system to improve access and quality. These reforms will allow not only for more timely review and final payment, but will enable the county behavioral health system, for the first time, to participate in and design true outcomes and value-based reimbursement structures that reward better overall results and quality of life for Medi-Cal beneficiaries.

3.6.2 Proposal

The state is proposing to reform its behavioral health payment methodologies via a multi-phased approach with the goal of increasing available reimbursement to counties for services provided and to incentivize quality objectives. This proposal would move reimbursement for all inpatient and outpatient specialty mental health and substance use disorder services from CPE-based methodologies to other rate-based/value-based structures that instead utilize intergovernmental transfers to fund the county-supplied non-federal share. DHCS proposes to implement the shift in methodology in two initial phases:

- In order to establish appropriate payment rates, DHCS proposes to transition specialty mental health and SUD services from existing Healthcare Common Procedure Coding System (HCPCS) Level II coding to Level I coding, known as Current Procedural Terminology (CPT) coding, when possible; and
- DHCS will establish reimbursement rates, as well as an ongoing methodology for updating rates, for the updated codes with non-federal share being provided by counties via intergovernmental transfer instead of CPEs, eliminating the need for reconciliation to actual costs.

Transition from HCPCS Level II Coding to CPT Coding

DHCS is proposing to transition from existing HCPCS Level II coding to CPT coding in all cases where a suitable CPT code exists. If a suitable CPT code does not exist, DHCS would identify an appropriate HCPCS Level II code.

For specialty mental health services, DHCS would identify a mix of HCPCS Level II codes and CPT codes for the following service functions: therapy, assessments, treatment planning, rehabilitation, prescribing medication, administering medication, patient education, and crisis intervention. DHCS would establish a rate for each of the HCPCS Level II codes and CPT codes identified within each service function. Counties would receive payment for each service rendered based upon the rate established for the specific HCPCS Level II code or CPT code. Services that currently receive a bundled rate, such as psychiatric inpatient hospital services, adult residential treatment, crisis residential treatment, psychiatric health facility services, crisis stabilization, day treatment, and day rehabilitation, would continue to be reimbursed using a bundled rate.

For SUD services, DHCS would identify a mix of HCPCS Level II codes and CPT codes for the following service functions: assessment, case management, crisis intervention, discharge planning, group counseling, individual counseling, medical psychotherapy, prescribing medication, administering medication, recovery services, and treatment planning. DHCS would establish a rate for each of the HCPCS Level II codes and CPT codes identified within each service function. Counties would receive payment for each service rendered based upon the rate established for the specific HCPCS Level II code or CPT code. Narcotic Treatment Programs would continue to be reimbursed a daily rate for each encounter.

Rate Setting Methodology

For the establishment of reimbursement rates, DHCS is proposing to set rates by peer grouping. Each peer group would be made up of counties with similar costs of doing business to best reflect local needs. Rates would include a service component as well as an administrative component and a utilization management/quality assurance component, which would be percentages on top of the service component. Additionally,

DHCS is proposing to establish a methodology to provide, at a minimum, an annual update to established rates to ensure that reimbursement continues to reflect the cost of providing services, administration, and required utilization management/quality assurance activities.

To start, DHCS is proposing to process intergovernmental transfers and make payments to counties on a monthly basis. Eventually, DHCS plans to transition to quarterly intergovernmental transfers and payments to reduce the administrative burden tied to processing intergovernmental transfers and payments for 58 counties on a monthly basis. The state will discuss with the counties the appropriate time to transition from monthly to quarterly payments.

3.6.3 Rationale

Under CPE-based methodologies, all reimbursement is limited to the actual cost of providing services, which does not allow for value-based arrangements or incentives to reduce costs and share in the savings. The shift from CPE to intergovernmental transfer-based methodologies will allow DHCS, in collaboration with county partners, to:

- Establish rates for reimbursement that are not limited to cost and instead focus on the quality and value of services;
- Provide more flexibility to counties to explore provider reimbursement arrangements that incentivize quality and value;
- Create opportunities for improved coordination of care by simplifying options for contracts and payments between Medi-Cal managed care plans and counties, without limiting financial benefits for the county; and
- Reduce state and county administrative burden and allow counties to close their accounting records closer to the end of a fiscal year by eliminating the lengthy and labor-intensive cost-reconciliation process.

Finally, the shift from HCPCS Level II coding to HCPCS Level I coding will allow for more granular claiming and reporting of services provided, creating the opportunity for more accurate reimbursement to counties/providers. The shift in coding will also allow counties and DHCS to better report performance outcomes and measures. In turn, the increased reporting will provide counties and DHCS with more accurate, useful information on health care quality to inform policy decisions.

3.7.4 Proposed Timeline

Given the need to ensure county readiness for this change in approach, DHCS is looking forward to working with counties and stakeholders to establish the timeline for adoption of the HCPCS Level I. DHCS proposes to work with counties and stakeholders to evaluate county readiness and develop a strategy to support them in making this transition. However, the earliest date the shift would occur would be July 1, 2022.

The transition from cost-based reimbursement to an established rate schedule would take place concurrently with the adoption of the HCPCS Level I coding. DHCS would, initially, establish separate rate schedules for specialty mental health and substance use disorder services, with the goal of aligning rate schedules when these services are administratively integrated into a single behavioral health managed care program. DHCS would begin the intergovernmental transfer-based reimbursement at the start of a state-county fiscal year to ease the transition.

3.7 Medical Necessity Criteria

3.7.1 Background

Current medical necessity criteria for specialty mental health services are outdated and confusing and can lead to challenges for beneficiaries in accessing appropriate care. Current diagnosis requirements can prevent beneficiaries from receiving urgently needed care, especially for children, who are entitled to care before developing a mental health condition, or for people with a co-occurring substance use disorder whose diagnosis may not be immediately clear. DHCS requirements for provider documentation are confusing and may lead to provider burden and risk of payment disallowance during audits.

Currently, DHCS does not standardize screening practices to determine where a beneficiary should initially seek mental health care. As a result, counties and plans have a variety of approaches to determine where beneficiaries should initially access care, whether with county Mental Health Plans (for specialty mental health services) or with Medi-Cal Managed Care or Fee for Service delivery systems (for beneficiaries not meeting criteria for specialty mental health services). DHCS does not currently standardize how beneficiaries transition across these delivery systems when their status changes, leading to inconsistent practices. In addition, the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) protection for beneficiaries under age 21 is inconsistently interpreted and leads to confusion and variation in practice.

3.7.2 Proposal

With the CalAIM initiative, DHCS aims to design a coherent plan to address beneficiaries' needs across the continuum of care, ensure that all Medi-Cal beneficiaries receive coordinated services, and improve health outcomes. The goal is to ensure beneficiary access to the right care in the right place at the right time.

In CalAIM, DHCS proposes to update and clarify medical necessity criteria for specialty mental health services for both adults and children, including allowing reimbursement of treatment before diagnosis and clarifying that treatment in the presence of a co-occurring SUD is appropriate and reimbursable when medical necessity is met.

DHCS proposes to clarify EPSDT protections for beneficiaries under age 21, and create criteria for children to access specialty mental health services based on experience of trauma and risk of developing future mental health conditions, such as involvement in child welfare or experience of homelessness.

DHCS proposes to develop a standardized screening tool to facilitate accurate determinations of when care would be better delivered in the specialty mental health delivery system or in the Medi-Cal managed are or fee for service system. In addition, DHCS proposes to develop a standardized transition tool, for when a beneficiary's condition changes, and they would be better served in the other delivery system.

DHCS proposes to implement a "no wrong door" policy to ensure beneficiaries receive medically necessary treatment regardless of the delivery system where they seek care. This policy would allow beneficiaries who directly access a treatment provider to receive an assessment and mental health services, and to have that provider reimbursed for those services, even if the beneficiary is ultimately transferred to the other delivery system due to their level of impairment and mental health needs. In certain situations, beneficiaries may receive non-duplicative services in multiple delivery systems, such as when a beneficiary has an ongoing therapeutic relationship with a therapist or psychiatrist in one delivery system while requiring medically necessary services in the other.

DHCS also proposes to simplify and streamline mental health documentation requirements, to align with medical provider requirements, improve efficiency, and decrease provider burnout.

With respect to inpatient specialty mental health services, DHCS proposes to update the criteria for psychiatric inpatient medical necessity currently provided in Title 9 of the California Code of Regulations. To facilitate improved communication between mental health plans and hospitals, and to decrease variation in clinical documentation requests across counties, DHCS will develop, in consultation with hospital and county stakeholders, documentation standards and concurrent review protocols to allow efficient and streamlined communication of clinical information during concurrent review.

Division of Services Between Mental Health Plans and Medi-Cal Managed Care Plans

To ensure beneficiaries with behavioral health needs are guided to the most appropriate delivery system to address their needs, DHCS is proposing to update its medical necessity criteria and processes, which would be organized as described below:

California provides Medi-Cal mental health services through Managed Care Plans, Fee for Service (FFS), and county mental health plans. The delivery system responsible to provide the mental health service depends on the degree of a beneficiary's impairment from the mental health condition and other criteria described below. Beneficiaries may receive mental health services prior to diagnosis in any of these delivery systems under certain conditions, even if ultimately the beneficiary is determined not to have a mental disorder. Beneficiaries may initiate medically necessary mental health services in one delivery system and receive ongoing services in another system. Beneficiaries whose degree of impairment changes may transition between the delivery systems, or under some circumstances may receive medically necessary mental health services in more than one delivery system. Care shall be coordinated between the delivery systems and services shall not be duplicated.

Medi-Cal Managed Care Plan responsibilities:

The following nonspecialty mental health services are covered by managed care plans:

a) Individual and group mental health evaluation and treatment (including psychotherapy and family therapy);
b) Psychological 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 (note: the pharmacy benefit will be carved out of managed care plans contracts and transitioned to fee for service delivery under Medi-Cal Rx as of 4/1/2021).

Medi-Cal managed care plans are responsible to provide the above nonspecialty mental health services to adult beneficiaries 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. Managed care plans are also required to provide non-specialty mental health services to children under the age of 21. Managed care plans are also responsible to provide mental health services to beneficiaries with potential mental health disorders

These services are also available in the FFS mental health delivery system for beneficiaries not enrolled in Medi-Cal managed care.

County Mental Health Plan responsibilities:

For beneficiaries 21 years and over, Mental health plans are responsible to provide specialty mental health services for beneficiaries who meet (A) and (B) below:

(A): The beneficiary must have one of the following:

(i) Significant impairment ("impairment" is defined as distress, disability or dysfunction in social, occupational, or other important activities), OR
(ii) A reasonable probability of significant deterioration in an important area of life functioning.

(B): The beneficiary's condition in (A) is due to:

(i) A diagnosed mental health disorder (according to the current Diagnostic and Statistical Manual of Mental Disorders and International Statistical Classification of Diseases and Related Health Problems criteria), OR

(ii) A suspected mental disorder that has not yet been diagnosed.

For beneficiaries under age 21[1],
Mental health plans are responsible to provide specialty mental health services to beneficiaries who meet either Criteria 1 **or** Criteria 2:

Criteria 1: The beneficiary is at high risk for a future mental health disorder due to experience of trauma, evidenced by: scoring in the high-risk range on a DHCS-approved trauma screening tool, or involvement in the child welfare system, or experience of homelessness.

Criteria 2: The beneficiary must meet both (A) and (B), below:

(A): The beneficiary must have at least one of the following:

I. Significant impairment, or
II. A reasonable probability of significant deterioration in an important area of life functioning, or
III. iii. A reasonable probability a child will not progress developmentally as appropriate, or
IV. Less than significant impairment, but requires mental health services that are not included within the mental health benefits that managed care plans are required to provide.

(B): The beneficiary's condition in (A) is due to:
I. A diagnosed mental health disorder (according to the current Diagnostic and Statistical Manual of Mental Disorders and International Statistical Classification of Diseases and Related Health Problems criteria), or
II. A suspected mental disorder that has not yet been diagnosed.

Mental health plans provide the following specialty mental health services

1. Crisis Residential Treatment Services
2. Adult Residential Treatment Services
3. Crisis Interventions
4. Crisis Stabilization
5. Day Rehabilitation
6. Day Treatment Intensive
7. Medication Support Services
8. Psychiatric Health Facility Services

[1] The Early and Periodic Screening, Prevention and Treatment protection entitles beneficiaries under age 21 to services necessary to correct or ameliorate a mental illness and condition recommended by a qualified provider operating within his or her scope of practice, whether or not the service is in the state plan.

9. Psychiatric Inpatient Hospital Services
10. Targeted Case Management/Intensive Care Coordination
11. Mental Health Services and Intensive Home-Based Services (including the following service interventions: Assessment, Plan Development, Therapy, Rehabilitation, and Collateral)
12. Therapeutic Behavioral Services
13. Therapeutic Foster Care Services

Substance Use Disorder Services

As with the current SMHS medical necessity criteria, the current Section 1115 waiver for SUD services requires beneficiaries to be diagnosed with a SUD to meet criteria for reimbursement, preventing the provision of treatment services prior to a definitive diagnosis.

As for mental health, DHCS proposes that substance use disorder treatment services may be provided and reimbursed prior to the determination of a diagnosis, including providing services to beneficiaries with co-occurring mental health disorders.

In addition, DHCS heard many comments from stakeholders about how to improve the Drug Medi-Cal Organized Delivery System, which are reflected in the "DMC-ODS Program Renewal and Policy Improvements" section of this proposal.

Documentation Requirements for Specialty Mental Health and Substance Use Disorder Services

Documentation requirements for SUD and SMHS are currently stringent. Stakeholders report that concern about disallowances result in providers spending an excessive amount of time "treating the chart instead of treating the patient." With the goal of aligning standards across physical and behavioral health programs, DHCS is proposing to update documentation requirements for specialty mental health and substance use disorder treatment to simplify and streamline requirements. For example, DHCS proposes to eliminate the requirement for a point-in-time treatment plan signed by the client, with progress notes tying to the treatment plan. Evidence does not show that shared decision-making is achieved through signature requirements, and the requirement that every note and every intervention must tie to a treatment plan is inefficient and inconsistent with documentation requirements in the medical (physical health) system. DHCS proposes to align behavioral health and medical documentation requirements in Medi-Cal by requiring problem lists and progress notes to reflect the care given and to align with the appropriate billing codes. DHCS also proposes to revise the clinical auditing protocol, to use disallowances when there is evidence of fraud, waste, and abuse, and to use quality improvement methodologies (such as oversight from the External Quality Review Organization) for minor clinical documentation concerns. These documentation changes will align with behavioral health payment reform, as the use of Level 1 HCPCS codes comes with national documentation standards and expectations.

Technical Corrections

DHCS proposes to make other technical corrections to address outdated references to the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV), rather than the more current DSM-V, and reflect federal diagnostic coding requirements related to use of International Classification of Diseases (ICD) code sets.

3.7.3 Rationale

Updates to medical necessity criteria for specialty mental health and SUD services, and related policy proposals, are required to achieve more up-to-date clinical practices and better clarity for oversight.

3.7.4 Proposed Timeline

DHCS recommends making changes to the specialty mental health and substance use disorder medical necessity criteria and related processes, as applicable, effective January 1, 2022 with the approval of the Section 1115 and 1915(b) waivers.

3.8 Administrative Integration of Specialty Mental Health and Substance Use Disorder Services

3.8.1 Background

California's mental health plans operate under the authority of a Section 1915(b) waiver, while DMC-ODS plans operate under the authority of a Section 1115 demonstration, and Drug Medi-Cal fee-for-service programs are authorized through California's Medicaid State Plan.

For mental health plans and DMC-ODS plans, DHCS contracts with counties to act as prepaid inpatient health plans to provide, or arrange for the provision of, specialty mental health services and DMC-ODS treatment services to beneficiaries. While the specialty mental health services program is a statewide benefit, the DMC-ODS managed care program is only covered in counties that have "opted-in" and are approved to participate by DHCS and CMS.

Fifty-six mental health plans administer the SMHS program, including two joint arrangements in Sutter/Yuba and Placer/Sierra. For SUD services, 37 counties administer the DMC-ODS program, covering more than 90 percent of the Medi-Cal population. Seven of these counties contract with a local Medi-Cal managed care plan to provide an alternative regional model for DMC-ODS. The remaining 21 counties provide SUD treatment services through Drug Medi-Cal.

Medi-Cal specialty mental health and SUD treatment services are currently administered through separate, unique structures at the county level. Beneficiaries with co-occurring mental health and SUD treatment needs must navigate multiple systems to access care.

Beneficiaries must review multiple handbooks and provider directories, navigate separate intake and assessment processes, and often travel to multiple locations to receive care. Counties and providers face challenging documentation and coding requirements, especially for beneficiaries with both SUDs and mental health conditions.

At the system level, counties must demonstrate compliance with two sets of requirements and are subject to multiple reviews. For DMC-ODS counties, administering two distinct prepaid inpatient health plans must demonstrate compliance with federal managed care requirements twice, essentially running two almost entirely separate managed care programs with duplicative processes for quality improvement and performance measurement, beneficiary appeals, and program integrity.

3.8.2 Proposal

DHCS is proposing administrative integration of specialty mental health and SUD services into one behavioral health managed care program. This proposal is distinct from the Full Integration Plan which will integrate physical, behavioral and oral health care into comprehensive managed care plans. The goal is to improve outcomes for beneficiaries through coordinated treatment across the continuum of care. An additional goal and benefit would be to reduce administrative and fiscal burdens for counties, providers, and the state.

For counties participating in DMC-ODS managed care, DHCS is interested in working toward integrating the two behavioral health programs/prepaid inpatient health plans into a single behavioral health plan structure. The result would be a single prepaid inpatient health structure in each county or region responsible for providing, or arranging for the provision of, specialty mental health and SUD treatment services for all Medi-Cal beneficiaries in that county or region. Participating counties would benefit from streamlined state requirements and the elimination of redundancy. Consolidating operations and resources into one behavioral health managed care plan would allow counties to successfully meet state and federal requirements and significantly decrease their administrative burden.

Additionally, Drug Medi-Cal fee-for-service counties will also be able to integrate such services; however, slight variations may apply due to the differences of federal requirements for fee-for-service verses prepaid inpatient health plans.

Clinical Integration

1. Access Line

Counties are required to have a 24-hour access line for mental health plans and for DMC-ODS. Some Drug Medi-Cal counties may also have 24-hour access lines, although it is not a requirement. Many counties already use their access lines in an integrated manner to triage, screen, and refer beneficiaries for both specialty mental

health and SUD treatment services; however, some counties maintain separate lines. Under an integrated model, the goal would be for all counties to have an integrated, 24-hour access line for beneficiaries seeking either specialty mental health and/or SUD services.

2. Intake/Screening/ Referrals

Processes for intake, screening, and referral vary by county. Optimally, counties would have standardized and streamlined intake processes that are timely, emphasize a positive beneficiary experience, and use a "no wrong door" approach to help beneficiaries access mental health and substance use disorder services. While assessments are performed by clinicians and tailored to the needs of the client, and may vary based on setting, DHCS proposes to move forward with a standardized statewide screening tool for beneficiaries 21 and over, and one for beneficiaries under 21, to ensure beneficiaries receive prompt care in the right delivery system.

3. Assessment

Assessment processes and tools for specialty mental health and SUD services also vary by county. For example, the American Society of Addiction Medicine placement tool is used to make level of care determinations DMC-ODS. However, an assessment tool is not required in Drug Medi-Cal counties. For SMHS, the Child and Adolescent Needs and Strengths tool is required for children and youth; however, there is not a required tool for adults. More research will be needed to determine which aspects, authorities, or requirements need to be addressed to integrate clinical assessments for mental health and SUDs.

4. Treatment Planning

Currently, treatment planning for specialty mental health and SUD treatment services is conducted separately and is not integrated. Beneficiaries receiving both types of services can have multiple treatment plans that include different documentation requirements. To improve efficiency, counties would integrate treatment planning for both specialty mental health and substance use disorder services with simplified and aligned documentation requirements. The goal would be to develop a new, simplified, more client-centered and strength-based approach to behavioral health treatment planning and to align treatment planning and documentation standards with physical health care. Additionally, DHCS will provide counties with relevant Medi-Cal services data, which may include managed care encounter and pharmacy claims data, to allow for better coordination of care and treatment planning.

5. Beneficiary Informing Materials

Currently, beneficiaries who receive services through mental health plans and DMC-ODS receive two beneficiary handbooks. The handbooks are not the same, but both

address elements that are required by federal managed care regulations, such as language regarding the grievance, appeals and state fair hearing processes. The goal is to consolidate beneficiary information materials to streamline them into one user-friendly handbook, reduce confusion, increase access, and achieve administrative efficiencies.

Consideration would need to be given to implementing this element in Drug Medi-Cal counties, since they are not currently required to have a beneficiary handbook.

Administrative Integration

1. Contracts

Currently, there are three separate contract types between DHCS and counties: mental health plans, DMC-ODS and Drug Medi-Cal counties. Under an integrated system, the goal would be to have only one contract in every county that would cover both all Medi-Cal specialty mental health and SUD treatment services.

2. Data Sharing / Privacy Concerns

Counties are responsible for managing data-sharing at two levels: within and across county plans, and at the provider level. Data sharing and privacy concerns need to be explored to determine what areas can be addressed, since there are different considerations and regulations pertaining to data sharing for SMHS and SUD services. Addressing these concerns will be critical in determining whether and when counties can integrate assessments, treatment plans, and electronic health records, among other processes. A thorough assessment of the various barriers and solutions to stringent patient privacy protections will be required. There will need to be a thorough assessment by the state and counties to identify the various barriers and solutions to stringent patient privacy protections built into federal regulations.

3. Electronic Health Record Integration and Re-Design

Many counties currently operate separate electronic health records (EHRs) or maintain differently configured and separate records for specialty mental health and substance use disorder services. This is largely in response to federal regulations, but also due to historical bifurcation of the two programs and different documentation and data-reporting requirements for the specialty mental health and substance use disorder programs. Timelines for integrating different components of administrative integration will depend on counties' ability to arrive at a record design that is compliant and then collaborate with their vendors to make multiple, timely modifications to their electronic health records.

4. Cultural Competence Plans

Mental health plans are required to have a plan for culturally responsive care for specialty mental health services. DMC-ODS plans are also required to have a culturally responsive care plan. Under an integrated system, counties would have only one integrated plan for culturally responsive care instead of two, separate plans.

Considerations would need to be given to how this element would be implemented in Drug Medi-Cal counties since they are currently not subject to these same requirements.

Integration of DHCS Oversight Functions

1. Quality Improvement

Some counties have integrated quality improvement and performance measurement programs for specialty mental health and substance use disorder services. However, most programs – or components of them – are still separate. Under an integrated system, counties would develop and operationalize a consolidated quality improvement plan, have a single quality improvement committee, and develop a comprehensive list of performance measures for specialty mental health services and substance use disorder services.

2. External Quality Review Organizations

Pursuant to federal Medicaid managed care requirements, an external quality review is required for both mental health plans and DMC-ODS. Currently, Behavioral Health Concepts is the contractor that acts as the External Quality Review Organization for both programs. However, there are separate contracts, review processes, timelines, and protocols. In addition, counties must develop separate performance improvement plans for each program. The goal is to implement a combined external quality review process, which would result in one external review and integrated performance improvement plans, and ultimately having one single External Quality Review Organization (EQRO) report for each county. Since an external quality review is not required for Drug Medi-Cal counties, further exploration will be needed to determine the extent to which these elements would play a role under an integrated model.

3. Compliance Reviews

Current compliance reviews conducted by DHCS for mental health plans, DMC-ODS, and Drug Medi-Cal counties are separate. Under an integrated model, the goal would be to consolidate compliance reviews into a single review with an integrated protocol. A particular focus of this effort will be on streamlining documentation requirements for behavioral health providers to allow integrated behavioral health care.

4. Network Adequacy

Network adequacy certification processes are separate for specialty mental health plans and DMC-ODS. Under an integrated model, DHCS would certify one network for specialty mental health and substance use disorder managed care services for each county, instead of certifying two networks as currently required.

5. Licensing & Certification

Existing requirements and processes for licensing and certification are different and separate for specialty mental health and substance use disorder providers. The goal is to streamline licensing and certification requirements, processes, and timeframes across the behavioral health managed care system, where appropriate. Successful implementation of integrated care models would also necessitate a discussion on non-administrative changes that may be needed, such as workforce development, cross-training of existing providers, and adoption of new evidence-based practices.

3.8.3 Rationale

About half of individuals with a SMI have a co-occurring substance use and those individuals benefit from integrated treatment. Since the state provides Medi-Cal-covered substance use disorder and specialty mental health services through two separate county-operated delivery systems, it is difficult for counties to provide integrated treatment to individuals who have co-occurring disorders. For example, counties with both DMC-ODS and mental health plans are subject to two separate annual quality assessments, two separate post-payment chart audits, and two separate reimbursement and cost reporting methods. The purpose of this proposal is to make changes to streamline the administrative functions for SUD and SMHS.

3.8.4 Proposed Timeline

The goal would be to submit for a single, integrated behavioral health plan in each county or region responsible for providing, or arranging for the provision of, specialty mental health and SUD services under the next 1915(b) waiver in 2027. Both state-level and county-level activities will be required to achieve this goal. Successful implementation will require careful sequencing and planning and a phased-in approach where cohorts are considered.

3.9 Behavioral Health Regional Contracting

3.9.1 Background

State law allows two or more counties acting jointly to deliver or subcontract for the delivery of specialty mental health services. Furthermore, participating DMC-ODS counties are permitted to develop regional delivery systems for required modalities or to act jointly to deliver covered services, with approval from DHCS and CMS, as applicable.

3.9.2 Proposal

DHCS encourages counties to develop regional approaches to administer and deliver specialty mental health and substance use disorder services to Medi-Cal beneficiaries. There are a variety of options available to counties, including a Joint Powers Authority to operate such services for a multi-county region (e.g., Sutter/Yuba). Counties could also pool resources to contract with an administrative services organization/third-party administrator or other entity, such as the County Medical Services Program or the local Medi-Cal managed care plan, to create administrative efficiencies across multiple counties.

Small counties, rural/frontier counties, and counties with shared population centers or complementary resources should consider opportunities for regional partnership. DHCS is interested in discussing how counties not currently seeking DMC-ODS participation may be more interested in doing so through a regional approach and/or how services provided under Drug Medi-Cal might also be provided through a regional approach. DHCS is committed to working with counties to offer technical assistance to help develop regional contracts and establish innovative partnerships.

3.9.3 Rationale

Acting jointly through regional contracts would allow counties to pool their resources, which can improve access and availability of services for Medi-Cal beneficiaries in their region and allow for increased county administrative efficiencies. Although regional contracting is currently allowed under state law, only a few counties have taken advantage of this opportunity. Regional contracting would give counties opportunities to share workforce and jointly invest in administrative infrastructure such as electron health records, billing and claiming systems, and oversight/quality assurance and improvement.

Regional contracts offer numerous potential advantages. For example, network adequacy certification requires significant administrative infrastructure to develop and maintain policies and procedures for tracking network resources, and counties must identify and contract with additional qualified providers when network gaps are identified. Both functions (tracking and finding new providers) can prove challenging in some counties that may have fewer local providers. Through regional contracts, counties could reduce duplication and standardize administrative processes, such as beneficiary handbooks, provider directories, and grievance and appeal processes.

For Drug Medi-Cal counties, regionalization could potentially enable smaller counties to participate in DMC-ODS, providing a broader set of services to their residents when it would not be otherwise feasible. By participating in DMC-ODS, these counties could then create a single, integrated behavioral health plan, as described in the CalAIM Administrative Integration of Specialty Mental Health and Substance Use Disorder Services proposal.

In addition, Medi-Cal managed care plans, mental health plans, and DMC-ODS plans must meet the full array of state and federal requirements applicable to prepaid inpatient health plans under the federal Medicaid managed care regulations. Among these are network adequacy, quality assessment and performance improvement, beneficiary rights and protections, and program integrity. For individual counties, entering into regional contracting agreements would reduce the administrative burden of meeting Medicaid managed care requirements. Counties could better utilize resources to focus on improving access, quality of care, and beneficiary outcomes, while mitigating the risk of audit exceptions and administrative and financial sanctions.

3.9.4 Proposed Timeline

DHCS seeks input from county partners and other stakeholders regarding an estimated timeframe for establishing regional contracting agreements.

3.10 Drug Medi-Cal Organized Delivery System Renewal and Policy Improvements

3.10.1 Background

One of the key goals of the Drug Medi-Cal Organized Delivery System (DMC-ODS) was to treat more people more effectively by reorganizing the delivery system for substance use disorder (SUD) treatment through Medi-Cal. California's Drug Medi-Cal Organized Delivery System (DMC-ODS) was the nation's first SUD treatment demonstration project under Section 1115, approved by CMS in 2015. Since then, more than 20 other states have received approval for similar substance use disorder treatment demonstrations. The program has established a continuum of care modeled after the American Society for Addiction Medicine (ASAM) criteria. These criteria are the most widely used and comprehensive set of guidelines for placement, continued stay, and transfer/discharge of patients with addiction.

The benefits under the DMC-ODS, which counties administer as pre-paid inpatient health plans (PIHPs), include all of the standard SUD treatment services covered in California's Medicaid State Plan (outpatient, intensive outpatient, perinatal residential, narcotic treatment programs and naltrexone), plus case management, multiple ASAM levels of residential substance use disorder treatment, withdrawal management services, recovery services, physician consultation and if the county chooses, additional medication assisted treatment, and partial hospitalization.

Also included in the current program is the expenditure authority to allow federal Medicaid reimbursement for short-term residential SUD treatment stays in an Institution for Mental Disease (IMD). The IMD exclusion has historically prohibited federal reimbursement for residential and inpatient mental health and SUD treatment for Medicaid enrollees age 21-64, in facilities with more than 16 beds. This exclusion deterred most providers in the State who found it financially unviable to operate facilities with so few beds. Allowing for reimbursement of residential SUD treatment services through the Medi-Cal program, with

no limitation on the number of beds, means that counties can receive federal matching funds for services that were previously unavailable.

Currently, DMC-ODS is not a statewide benefit since the program operates only in counties that "opt in" to participate and are approved to do so by both DHCS and CMS. There are currently 37 counties participating in the DMC-ODS demonstration, providing access to SUD treatment services for 96 percent of the Medi-Cal population. Seven of these counties are working with a local managed care organization to implement a regional model. Medi-Cal beneficiaries in the 21 counties not participating in the program provide their SUD treatment services through fee-for-service as authorized through the Drug Medi-Cal State Plan. The fee-for-service benefit is more limited than the DMC-ODS benefit in terms of covered services and that it is not a managed care program.

3.10.2 Proposal

DHCS proposes to update and improve the DMC-ODS, based on experience from the first several years of implementation. Accordingly, DHCS proposes to clarify or change policies to support the goal of improved beneficiary care and administrative efficiency.

DHCS aims to design a cohesive plan to address beneficiaries' SUD treatment needs across the continuum of care, ensure that all Medi-Cal beneficiaries receive coordinated services, and to promote long-term recovery. This requires developing new approaches to care delivery and system administration that will improve the beneficiary experience, increase efficiency, ensure cost-effectiveness, and achieve positive health outcomes.

The 37 counties that have implemented the DMC-ODS have made tremendous strides in improving the continuum of care for Medi-Cal beneficiaries with SUD treatment needs. Implementation across 37 California counties has also yielded lessons learned and opportunities to clarify or change policies to support the goal of improved beneficiary care and administrative efficiency. DHCS also acknowledges that for many counties, the DMC-ODS model of care is still very new since implementation was phased in over several years.

Accordingly, DHCS solicited input from stakeholders on the following proposed policy clarifications and changes, which have been thoughtfully constructed to balance system improvements while minimizing disruptions at the local level.

DHCS also intends to provide counties with another opportunity to opt-in to participate in the DMC-ODS in hopes of promoting DMC-ODS participation across the state. While participation in DMC-ODS will not be mandatory for counties, DHCS would like to work with counties not currently participating in the DMC-ODS to explore ways to encourage the remaining counties to opt-in.

Residential Treatment Length-of-Stay Requirements

Currently, within a 365-day period, adult residential SUD treatment services may be authorized for two non-continuous stays, for up to 90 days for each stay, with one 30-day extension permitted for one of the stays. Similarly, within a 365-day period, adolescent residential treatment services may be authorized for two non-continuous stays; however, stays for adolescents are limited to 30 days each stay, with one up to 30-day extension allowed for one of the stays.

Residential length-of-stay should be determined based on the individual's condition, medical necessity, and treatment needs. Given that the two-episode limit is inconsistent with the clinical understanding of relapse and recovery from SUDs, DHCS proposed in the 12-month extension request to remove this limitation and base treatment on medical necessity.[2] DHCS will further propose that there be no distinction between adults and adolescents for these particular requirements.

Note: DHCS must obtain approval from CMS regarding all components of the Section 1115 extension and renewal. CMS is currently only approving SUD 1115 demonstrations with a residential benefit average length-of-stay of 30 days. While some states may show average lengths of stay that are close to the 30-day target, these are likely to include numerous treatment episodes that may have terminated prematurely, before the client achieved positive clinical outcomes. Including these shorter stays in the calculation may lower the average and give the impression that shorter lengths of stay are universally feasible and appropriate.

As such, DHCS will examine the possibility of tracking and documenting the average length-of-stay for only those DMC-ODS enrollees that achieve positive treatment outcomes. Furthermore, with the substantial rise in methamphetamine usage and overdose deaths in California, DHCS will work closely with CMS to negotiate a residential treatment benefit that accounts for the increased clinical needs of individuals utilizing stimulants.

[2] Proposed changes to the DMC-ODS program included in the Medi-Cal 2020 12-month extension request: 1) Remove the limitation on the number of residential treatment episodes that can be reimbursed in a one-year period, 2) Clarify that reimbursement is available for SUD assessment and appropriate treatment even before a definitive diagnosis, 3) Clarify that recovery services benefit, 4) Expand access to MAT, and 5) Increase access to SUD treatment for American Indians and Alaska Natives.

Residential Treatment Definition

The current definition of residential treatment in California does not clearly define the amount, duration, and scope of covered services, and there are different treatment standards and limitations for adults and adolescents.

DHCS proposes that the definition of residential treatment be updated to remove the adolescent length-of-stay limitations, and to add mandatory provisions for referral to medication assisted treatment. DHCS would also propose to remove the distinction between adults and adolescents for these requirements, with the exception of Early and Periodic Screening, Diagnostic, and Treatment services.

Recovery Services

As part of Dimension 6 (Recovery Environment) of the ASAM criteria, during the transfer/transition planning process, beneficiaries shall be linked to applicable recovery services. Beneficiaries may access recovery services after completing their course of treatment whether they are triggered, have relapsed, or as a preventive measure to avoid relapse.

DHCS proposed in the 12-month extension to clarify the following policies related to recovery services:

- Specify the services included in the benefit (e.g., group, education sessions, and assessment);
- Establish when and how beneficiaries may access these services, including language to encourage the use of recovery services for justice-involved individuals: and
- Define the term “after completing their course of treatment,” to not inadvertently prohibit beneficiaries receiving long-term medication assisted treatment from having access to recovery services.

If these proposed changes are not ultimately approved in the 12-month extension, they will be included in the demonstration renewal request that DHCS will submit in 2021, for a five year renewal from January 1, 2022-December 31, 2026.

Additional Medication Assisted Treatment

Counties are required to cover opioid treatment program services, also called Narcotic Treatment Programs. Currently counties may elect to cover additional medication assisted treatment, which includes the ordering, prescribing, administering, and monitoring of all medications for SUD treatment.

DHCS proposed in the 12-month extension request to keep the additional medication assisted treatment (MAT) services as an optional benefit but clarified the coverage provisions to require that all substance use disorder managed care providers demonstrate that they either directly offer, or have referral mechanisms to medication assisted treatment. The goal is to have a county-wide multi-delivery system of coverage.

Clinician Consultation Services

Currently, physician consultation services cover time spent by the DMC-ODS physicians consulting with addiction medicine physicians, addiction psychiatrists, or clinical pharmacists. The name of the benefit will change to Clinician Consultation Services and be expanded to include consultation services for, and by, licensed clinicians including Nurse Practitioners and Physician Assistants. Coverage of consultation services is designed to help clinicians seek expert advice on designing treatment plans for beneficiaries. Clinician consultation services can only be billed and reimbursed by providers in DMC-ODS provider sites.

DHCS proposes to clarify the terms of clinician consultation, particularly with regard to how and who can claim this activity. DHCS proposes to remove the limitation that clinician consultation services can only be billed by certified Drug Medi-Cal providers. Counties may contract with SUD clinicians not certified by Drug Medi-Cal. DHCS' telehealth policy will be used to guide this effort.

Evidence-Based Practice Requirements

Currently, providers are required to implement at least two of the following evidence-based treatment practices based on a timeline established in the county implementation plan: Motivational Interviewing, Cognitive Behavioral Therapy, Relapse Prevention, Trauma-Informed Treatment, and Psycho Education. The two evidence-based practices are a per-provider per-service modality.

DHCS proposes to retain the five (5) current evidence-based practices and add Contingency Management to the renewal proposal. Providers are not limited to providing only the six evidence-based practices.

DHCS Provider Appeals Process

Following a county's protest procedure, a provider may currently appeal to DHCS if it believes that the county erroneously rejected the provider's solicitation for a contract.

DHCS proposes removing this process from as it is convoluted, has rarely been used, and it is already addressed by the network adequacy requirements. All providers have a right to appeal under the federal 438 requirements.

Tribal Services

DHCS proposed in the 12-month extension to take several actions to increase access to SUD treatment for American Indians and Alaska Natives, including:

- Providing an allowance for specific cultural practices for Tribal 638 and Urban clinics, reimbursement, and definitions of scope of practice for the workforce of traditional healers and natural helpers, and culturally specific evidence-based practices.

- Requiring Indian health care providers to use at least two evidence-based practices as defined in the DMC-ODS and/or from a list developed by DHCS in consultation with Tribal and Urban partners.

These changes are requested to ensure American Indians and Alaska Natives have access to culturally appropriate and evidence-based substance use disorder treatment.

Treatment after Incarceration

The current language requiring the ASAM criteria, may be underestimating the level of care necessary to serve individuals being released from incarceration, since their substance use was either not possible during incarceration or because individuals under parole/probation supervision are likely hesitant to admit to substance use.

Because inmates are at a high risk of relapse and overdose upon release from incarceration, whether or not there was active use in the last 12 months, DHCS plans to clarify access language for individuals leaving incarceration who have a known substance use disorder.

Billing for Services Prior to Diagnosis

Currently, counties may not begin billing for SUD services until a beneficiary has been diagnosed (i.e., counties may not bill for time spent conducting substance use disorder assessments). Since it takes time for clinicians to evaluate a beneficiary for a substance use disorder, and sometimes presenting symptoms are due to a combination of mental illness, substance use disorder, or both, DHCS proposed in the Medi-Cal 2020 extension to clarify the waiver Special Terms and Conditions to allow reimbursement for SUD assessments (even if it takes multiple visits) before a final diagnosis is determined, which aligns with requirements around assessments for specialty mental health services.

Medical Necessity for Narcotic Treatment Programs (NTPs)

DHCS proposes to update and align the STCs with best practices to allow a physician's history and physical to determine medical necessity for NTP services as required by

federal licensing laws. In addition, DHCS would clarify requirements for the initial assessment and medical necessity determinations in other settings.

Early Intervention (Level 0.5)

DHCS proposes to add ASAM 0.5 level of care for beneficiaries under 21, to allow early intervention as an organized service that may be delivered in a wide variety of settings. This service is designed to explore and address problems or risk factors related to substance use, and to help the individual recognize the harmful consequences of high-risk substance use. This includes engagement activities (including screening, assessment, brief interventions such as motivational interviewing and counseling) for beneficiaries at high-risk for developing substance-related or addictive behavior problems, or those for whom there is not yet sufficient information to document a substance use disorder.

3.10.3 Proposed Timeline

The following changes would go into effect on January 1, 2021, subject to federal approval of the Medi-Cal 2020 12-month extension request:

- Remove the limitation on the number of residential treatment episodes that can be reimbursed in a one-year period
- Clarify that reimbursement is available for SUD assessment and appropriate treatment even before a definitive diagnosis
- Clarify that recovery services benefit
- Expand access to MAT
- Increase access to SUD treatment for American Indians and Alaska Natives.

The remaining changes outlined above would go into effect January 1, 2022, subject to federal approval.

Dental

3.11 New Dental Benefits and Pay for Performance

3.11.1 Background

DHCS is committed to improving the accessibility of Medi-Cal dental services and improving oral health outcomes for Medi-Cal members. To demonstrate that commitment, three initiatives and policy changes have been implemented in recent years:

- The Dental Transformation Initiative under the current Medi-Cal 2020 Section 1115 demonstration;
- Proposition 56 supplemental provider payments; and

- Restoration of the optional adult dental benefit under Medi-Cal.

These efforts have been successful in increasing preventive dental service utilization for children, as well as increasing adult utilization of dental care. While two of the initiatives share a common theme – financial incentives for positive outcomes – they are time-limited. DHCS has included a chart (see **Appendix H: Dental in Proposition 56 vs. CalAIM**) that reflects the dental codes with financial incentives available under CalAIM and Proposition 56.

3.11.2 Proposal

The Department set a goal to achieve at least a 60 percent dental utilization rate for Medi-Cal eligible children. In order to progress toward achieving that goal and based on lessons learned from the Dental Transformation Initiative, DHCS proposes the following reforms for Medi-Cal dental be made statewide provide better care and align with national dental care standards. The proposed new benefits include:

- Caries Risk Assessment Bundle for young children; and
- Silver Diamine Fluoride for young children; and specified high-risk and institutional populations; and
- Expanded pay-for-performance initiatives that a) reward increasing the use of preventive services and b) reward establishing/maintaining continuity of care through a dental home. These expanded initiatives would be available statewide for children and adult enrollees.

These expanded initiatives would be available statewide for children and adult enrollees.

New Dental Benefits

DHCS proposes adding coverage of a Caries Risk Assessment Bundle for children ages 0 to 6 years. The Caries Risk Assessment bundle would include nutritional counseling (D1310) to educate and influence behavior change. Based on risk level associated with each individual Medi-Cal beneficiary ages 0 to 6, the benefit would allow the following frequency of services:

- Low – comprehensive preventive services 2x/year (D0601)
- Moderate – comprehensive preventive services 3x/year (D0602)
- High – comprehensive preventive services 4x/year (D0603)

Additionally, DHCS proposes to add coverage of Silver Diamine Fluoride for children ages 0 to 6 years and persons with underlying conditions such that nonrestorative caries treatment may be optimal, which may include adults living in a Skilled Nursing Facility/ Intermediate Care Facility (SNF/ICF) or part of the Department of Developmental Services (DDS) population. The Silver Diamine Fluoride benefit would provide two visits per member per year, for up to ten teeth per visit, at a per tooth rate and a maximum of four treatments per tooth.

Pay for Performance

To increase statewide preventive service utilization for children and adults, DHCS is proposing to provide a flat rate performance payment for each paid preventive service rendered by a service office location.

Additionally, the state proposes to provide an annual flat rate performance payment to a dental service office location that maintains dental continuity of care by establishing a dental home for each patient and perform at least one annual dental exam/evaluation (D0120/D0150/D0145) for two or more years in a row.

3.11.3 Rationale

These policy proposals align with the legislature's charge to achieve at least a 60 percent dental utilization rate for Medi-Cal eligible children, CMS Oral Health Initiative goals for Medicaid (increase by ten percentage points the proportion of Medicaid and CHIP children ages one to 20 who receive a preventive dental service), and our lessons learned from the Dental Transformation Initiative (DTI).

For example, in the DTI - Domain 1, incentive payments were made to service office locations that increased the utilization of the top eleven preventive services available to children. As a result, not only has utilization of preventive services continued to increase year after year, but since the baseline year of 2014, the number of services has increased eight percent and the number of services per member has also increased by seven percent.

Furthermore, data comparing a control group of children in Dental Transformation Initiative counties who did not receive Caries Risk Assessment with children who did receive Caries Risk Assessment over two calendar years yielded staggering results. The Medi-Cal children who had a Caries Risk Assessment received over 300 percent more preventive services compared to 189 percent for non-Caries Risk Assessment children. Additionally, in this same period, the number of restorative services was almost half that of the control group. Medi-Cal children receiving Caries Risk Assessment had a 263 percent increase in restorative services while the control group with no Caries Risk Assessment had a 475 percent increase in restorative services.

3.11.4 Proposed Timeline

DHCS is currently evaluating a timeline for implementation as funding for Designated State Health Programs (DSHP) is not approved in extension of the Medi-Cal 2020 demonstration.

County Partners

3.12 Enhancing County Eligibility Oversight and Monitoring

3.12.1 Background

The implementation of the Affordable Care Act (ACA) marked a monumental overhaul of the Medi-Cal program by financing a coverage expansion to populations that previously did not qualify, in addition to streamlining eligibility requirements for some populations. County social service agencies strived to acclimate to the vast changes in regulations while managing an unprecedented surge in Medi-Cal applications submitted statewide. To afford counties the opportunity to modify business processes to effectively administer the Medi-Cal program post Affordable Care Act, counties were held harmless by DHCS for performance standards.

Federal, state, and DHCS audits of Medi-Cal eligibility determinations conducted since the implementation of the Affordable Care Act in 2014 have identified several issues that must be addressed and resolved. Audit findings include performance issues related to timeliness of application processing and timeliness of annual eligibility renewal processing. Discrepancies between the Medi-Cal Eligibility Data System (MEDS), and the county Statewide Automated Welfare System (SAWS) also resulted in audit findings, which in part were caused by system-related issues connected to the implementation of the California Healthcare, Eligibility, Enrollment and Retention System (CalHEERS).

Audit findings, recommendations, and corrective action plans imposed upon DHCS require the State to implement additional oversight activities needed to increase the administrative integrity of the Medi-Cal program. Federal audit findings have also levied fiscal penalties upon DHCS, requiring the state to repay the federal matching funds that were claimed because of erroneous Medi-Cal eligibility determinations.

3.12.2 Proposal

DHCS recommends a phased-in approach to working with the counties to increase program integrity with respect to eligibility and enrollment.

- **Reinstate County Performance Standards**: In response to audit findings, DHCS will reinstate the county performance standards required under state law as a means of addressing and correcting error rates and issues which may have a future impact on the timeliness and accuracy of Medi-Cal eligibility determinations. DHCS plans to implement a series of oversight programs throughout the course of the next 24 months. This includes the implementation of a statewide MEDS alerts monitoring program.

- **Develop an Updated Process for the Monitoring and Reporting of County Performance Standards**: In collaboration with CWDA, SAWS and the counties, DHCS will define roles, responsibilities, and develop an updated written process for the monitoring and reporting of the existing county eligibility performance standards. This process will clearly outline DHCS' performance expectations, taking into consideration the issues that are beyond the counties' control, but including potential consequences if standards are not met.

- **Ensure DHCS/County Partnership through Regular Meetings and Open Lines of Communication:** DHCS will work collaboratively with CWDA, counties, and SAWS to develop a communications plan that articulates a process for receiving and responding to county requests for technical guidance and assistance as necessary and appropriate to support counties through this transition. DHCS will look at leveraging existing meetings, and/or developing dedicated meetings to further open lines of communication related to county oversight and monitoring. DHCS will continue to encourage county feedback in identifying gaps or needed clarifications in policy guidance and automation issues. DHCS will also work closely with counties, SAWS and CalHEERS to identify and pursue needed automation changes to support counties in the effective administration of the Medi-Cal program.

- **Develop a Tiered Corrective Action Approach**: DHCS will work with county partners to establish a tiered corrective action approach that would require the submission of a Corrective Action Plan for counties that do not meet established performance expectations. DHCS remains committed to supporting counties and providing timely policy guidance, along with technical assistance, as needed, in addressing and correcting error trends.

- **Incorporate Fiscal Penalties as Part of the Tiered Corrective Action Approach**: For counties that do not demonstrate sufficient improvement in performance, DHCS will take disciplinary action that could range from technical assistance to requiring corrective action plans to imposing financial penalties on counties that fail to show significant improvement and/or are unresponsive to CAPs.

- **Incorporate Findings/Actions in Public Facing Report Cards**: DHCS will work with CWDA, counties and the SAWS to further develop county performance reports that are publicly posted on the California Health and Human Services (CHHS) Open Data Portal and increase accountability by issuing annual public-facing report cards to all 58 counties.

3.12.3 Rationale

This proposal is envisioned to be a crucial step toward achieving DHCS' larger vision for CalAIM by ensuring Medi-Cal enrollment processes are applied in a standardized and consistent manner statewide. This proposal will help to improve DHCS' oversight and monitoring of various aspects of Medi-Cal eligibility and enrollment and the activities of its contracted partners. This includes implementing additional county oversight activities to increase the integrity of the administration of the Medi-Cal program, as well as implementing the recommendations of the California State Auditor's Office. This proposal will also ensure that DHCS is compliant with federal and state requirements.

3.12.4 Proposed Timeline

Given the Executive Order to halt all county renewal processes and negative actions through the duration of the Public Health Emergency (PHE), the implementation timeline reflected for this initiative will shift if the PHE is extended. The dates noted are based on the PHE ending and normal county business processes resuming January 2021, allowing 12 months from the end of the PHE for counties to process and clean-up the resulting backlog. Dates are subject to change once the end of the PHE is established.

- **June 1 – August 31, 2021**: DHCS will reinstate County Performance Standards, including incorporation of MEDS alert monitoring statewide.

- **September 1 – December 30, 2021:** DHCS will develop and publish an updated process for the monitoring and reporting of County Performance Standards, incorporating an outline of the tiered Corrective Action steps which will include disciplinary action ranging from CAPs for counties that do not meet performance expectations, to potential fiscal penalties for unresponsive counties.

- **January 1 – March 31, 2022:** DHCS will begin assessing County Performance Standards, in keeping with the aforementioned updated process.

- **April 1 – June 30, 2022:** DHCS will implement the county performance monitoring dashboard (a public facing report card). The dashboard is envisioned to represent county performance in application processing, renewal processing, and MEDS alert processing, and could potentially include other measures to be mutually agreed upon in the future.

- **July 1 – September 30, 2022:** DHCS will begin publishing the county performance monitoring dashboard on the CHHS Open Data Portal.
- **July 1 – December 31, 2023:** DHCS will begin taking steps toward fiscal sanctions for counties who do not demonstrate sufficient improvement in meeting performance expectations or are unresponsive.

3.13 Enhancing County Oversight and Monitoring: CCS and CHDP

3.13.1 Background

The California Children's Services program serves as a proxy of Medi-Cal for case management services and provides diagnostic and treatment services, physical and occupational therapy services to children and youth with eligible medical conditions. The Child Health and Disability Prevention program delivers periodic health assessments and services to low-income children and youth; and provides care coordination to assist families with medical appointment scheduling, transportation, and access to diagnostic and treatment services.

California Children's Services and Child Health and Disability Prevention beneficiaries are best served when their care is delivered in a standardized and consistent manner. It is the State's responsibility to ensure that the same high-quality standard of care is compliant with federal and State guidelines for all beneficiaries. To remain proactive with emerging trends, technology, medical advances, and interventions, it is essential the State continue to evolve its efforts accordingly.

3.14.2 Proposal

DHCS intends to provide enhanced monitoring and oversight of all 58 counties and three (3) cities (Berkeley, Pasadena, and Long Beach) to ensure continuous, and unwavering optimal care for children. To implement the enhanced monitoring and oversight of California Children's Services and Child Health and Disability Prevention in all counties, DHCS will develop a robust strategic compliance program. Effective compliance programs begin with ascertainable goals, performance measures, and metrics capturing all federal and State requirements. Ongoing quality assurance and data reviews are fundamental to ensuring compliance and continued improvements in program operations and beneficiary care.

Initial efforts will entail a review of all current standards and guidelines for both programs. Once the internal policy review is complete, DHCS will develop initial auditing tools to assess current county/city operations and compliance. DHCS will then evaluate and analyze the findings gathered during audits to identify gaps and vulnerabilities across the State within the programs. The information gathered will be the cornerstone for future efforts, and the basis for the development of the strategic compliance program.

County/City variances in program operations and compliance with federal and State laws are also identified by tracking trends. DHCS will refine and update oversight policies and procedures and implement best practices. DHCS, along with input from our county partners and other stakeholders, will establish goals, metrics, performance measures, and milestones to ensure counties/cities are providing the necessary provider oversight and medical/ dental care for beneficiaries. DHCS will provide training and technical assistance with internal and external partners to achieve statewide consistency of the compliance requirements and goals. In addition, DHCS will conduct ongoing quality assurance reviews, develop, and create county/city program specific dashboards, as necessary to meet internal and external reporting needs.

In alignment with technology trends, the State plans to shift counties/cities from annual hardcopy submission of Plan and Fiscal Guidelines budgets to a more efficient and streamlined automated electronic submission process. Training and overview of the electronic submission process conducted for the counties ensures understanding prior to implementation of the automated system. More rigorous annual review of all county budgets will further efficiencies, contain costs, and improve outcomes.

To better manage this population's health care and ensure targeted interventions are implemented, each county/city and state will enter into a Memorandum of Understanding (MOU) with DHCS. The MOU, in conjunction with other supportive policies (information notices, numbered letters, etc.), will detail how the state will monitor county/city activities, policies and procedures, conduct audits, and implement corrective action plans. This MOU will be developed utilizing information obtained during the audits with the intent of having signed agreements with all counties/cities.

After initial deployment of the enhanced monitoring and oversight, DHCS will continue to conduct ongoing audits, stay proactive with emerging developments, and monitor trends to ensure high-quality consistent care. DHCS will allow sufficient time for counties to implement and adjust to this new structure prior to engaging in any sort of progressive action. DHCS will continue compliance oversight to preserve and improve the overall health and well-being of these vulnerable populations.

3.13.3 Rationale

Enhancing monitoring and oversight will eliminate disparities in care to beneficiaries and reduce vulnerabilities to the state, thereby preserving and improving the overall health and well-being of California's vulnerable populations.

3.13.4 Proposed Timeline

- **Phase I: August 2020 – June 2021**
    - Review of current standards, policies, and guidelines

  - Development of goals, performance measures, and metrics
  - Revision of current Plan and Fiscal Guidelines guidance document
  - Continuation of the establishment of an electronic submission portal for the annual county/city budgets.

- **Phase II: July - September 2021**
  - Development of auditing tools
- **Phase III: October 2021 – September 2022**
  - Shift to an electronic automated PFG submission by the counties/cities
  - Develop training documents
  - Evaluate and analyze findings and trends
  - Identify gaps and vulnerabilities
- **Phase IV: October 2022- Ongoing**
  - Initiate Memorandum of Understanding between State and counties
  - Continuous monitoring and oversight
  - Continuous updates to standards, policies, and guidelines

3.14 Improving Beneficiary Contact and Demographic Information

3.14.1 Background

Medi-Cal has approximately 13 million enrolled beneficiaries; approximately 80 percent are enrolled in the managed care delivery system and 20 percent are enrolled in the fee-for-service delivery system. County social services departments are delegated by DHCS to process Medi-Cal applications and renewals, as well as to generally provide case management services. Counties use Statewide Automated Welfare Systems (SAWS_ to support and maintain Medi-Cal enrollment processes. The SAWS, of which there are currently three, contain contact and demographic information on enrolled individuals. The systems maintain electronic interfaces with the state-level eligibility and enrollment system (California Healthcare Eligibility, Enrollment, and Retention System) and the state-level eligibility database, the Medi-Cal Eligibility Data System. The Medi-Cal Eligibility Data System is the system of record for purposes of Medi-Cal eligibility information, claims payment, and health plan assignment, among other things.

When a beneficiary has a change in circumstances that affects their eligibility, the beneficiary is required to report changes to their county eligibility worker within ten calendar days of the change. Such changes include but are not limited to address and contact information updates, family size (increases or decreases), access to other health insurance, changes in income, and death. County eligibility workers are then responsible

for ensuring the data maintained in the local county eligibility system is accurate and up to date. Under current state law, Medi-Cal managed care plans have the ability to report updated contact information to the county when they have obtained consent from the beneficiary for such reporting.

Accurate contact and demographic information is critical for purposes of ongoing program enrollment and care management for beneficiaries. This information is used by Medi-Cal fee-for-service providers and Medi-Cal managed care plans, as well as other providers of care, for purposes of effective communication and interaction with Medi-Cal beneficiaries, including deploying care management strategies based on individual needs.

Given the substantial volume of individuals in the process of enrolling in or renewing Medi-Cal coverage, it is critical that DHCS, counties and plan and provider partners have accurate contact and demographic information. A more effective and efficient process for keeping this information up to date in California's systems is needed.

3.14.2 Proposal

DHCS intends to convene a workgroup of interested stakeholders to provide feedback and recommendations on ways in which contact and demographic information can be updated by other entities and the means to accomplish this while maintaining compliance with all applicable state and federal privacy laws. The goal of the workgroup will be to determine the best pathway for ensuring that reported updated data is accurate and can be used in eligibility and enrollment systems/databases without creating unintended consequences for other social services program, Medi-Cal beneficiaries, managed care plans, and the provider community.

3.14.3 Rationale

As DHCS seeks to make improvements in its approach to population-based health care and drive innovation in health care delivery, it is critical that our Medi-Cal providers, managed care plans, county partners, and others have access to accurate, up-to-date contact and demographic information for beneficiaries. County eligibility workers play a key role in ensuring contact information is current; however, there are other entities that interact with Medi-Cal beneficiaries on a regular basis who may have access to more current information. As a result, DHCS would like to leverage and explore the possibility of other entities having the opportunity to also update contact and demographic information about Medi-Cal beneficiaries.

3.14.4 Proposed Timeline

DHCS proposes to engage with key partners during 2022-23 to develop thoughtful and realistic recommendations for implementing improvements in how contact and demographic information can be updated by other entities in addition to county eligibility

workers. Such changes may be effectuated through updates to the Medi-Cal application, use of eligibility online portals and/or other means. As part of the workgroup effort, DHCS will also seek input in terms of timing of implementation, taking into consideration current system migrations, consolidations and/or modernization efforts.

4. Conclusion

DHCS developed these CalAIM proposals with a view toward the future and what will be necessary to more effectively and positively impact Medi-Cal beneficiaries' quality of life. These proposals were drawn from more than a year-long effort by DHCS leadership and staff, as well as engagement with critical partners and experts across the State and the nation. These ambitious proposals represent a long-term vision for advancing and improving the Medi-Cal program in fundamental ways that build upon the foundations established in prior waivers and expansion efforts. The success of the thinking behind CalAIM will fundamentally rest on the collaboration and coordination of DHCS, our plan, provider, county, and legislative partners, and the entire stakeholder community. DHCS recognizes that these proposals will likely require significant time and fiscal investment and look forward to working with our partners and through the budget process to most effectively implement the concepts proposed in this initiative. These efforts are not limited to a single year, but represent DHCS' current vision for what Medi-Cal might be able to achieve over the next five to ten years, and beyond.

5. From Medi-Cal 2020 to CalAIM: A Crosswalk

California is embarking on a new and system-wide initiative to transform how beneficiaries' access Medi-Cal services. As the Medi-Cal program has expanded under the Affordable Care Act and through other state-led initiatives, and with over 80% of beneficiaries now being served through managed care plans, it is an opportune time to consider the patient experience from an even more global perspective. Currently, beneficiaries may need to access six or more separate delivery systems (managed care, fee-for-service, specialty mental health, substance use disorder, dental, In Home Supportive Services, etc.) in order to receive the care they need. This combination of system fragmentation and clinical complexity, and the likelihood of decreased beneficiary capacity, makes access to effective care coordination even more critical.

As such, the state is undertaking a more targeted approach to consolidating its Medi-Cal benefit package to achieve better alignment across the system. While Section 1115 waiver authority has historically been the mechanism of choice for states interested in building and expanding managed care delivery systems, the use of the authority has evolved in recent years. The federal government no longer considers the "savings" generated from the shift from fee-for-service to managed care that occurred 15 years ago in Medicaid as relevant in calculating budget neutrality for waivers. CMS, in recent

guidance, has also discontinued approval of traditional financing mechanisms in the Section 1115 context, namely the availability of federal funds for Designated State Health Programs and Safety Net Care Pools. These factors, combined with new federal managed care regulations, have encouraged DHCS to shift its focus away from the Section 1115 waiver authority to instead leverage other available pathways for innovation in the Medi-Cal program.

In the spring of 2020, in response to the COVID-19 public health emergency, DHCS determined that additional time would be needed to prepare Medi-Cal managed care plans, counties, and a wide array of stakeholders for the transition from the Section 1115 waiver to the CalAIM structure. As such, the state prepared a 12-month extension request for the Medi-Cal 2020 Section 1115 demonstration. The request was posted for public comment in June 2020 and submitted to CMS on September 16, 2020. The 12-month extension is meant to serve as a bridge to a 5-year Section 1115 waiver renewal, primarily to continue key programs that require the authority, including the Global Payment Program (GPP) and the Drug Medi-Cal Organized Delivery System (DMC-ODS). In addition, DHCS is designing a comprehensive Section 1915(b) managed care waiver request for CMS that would also be for a 5-year period.

The following table outlines the proposed approach under CalAIM for each of the key Medi-Cal 2020 waiver elements:

Crosswalk of Medi-Cal 2020 Waiver Components to CalAIM Proposals

Medi-Cal 2020 Waiver Component	Included in Waiver Extension Through 12/31/21	Planned for CalAIM	Description	Timeline
Medi-Cal Managed Care	X	Transition to new 1915(b) waiver.	The general authority for various Medi-Cal managed care will be shifted from 1115 to 1915(b). This would include PACE models needing waiver approval and Whole Child Model.	January 1, 2022
Whole Person Care Pilots	X	Transition to new 1915(b) waiver and managed care plan contract authority.	Medi-Cal managed care plans would provide a new enhanced care management benefit. Additionally, Medi-Cal managed care plans will have the option to provide a menu of approved in lieu of services. The majority of Whole Person Care services will continue to be available as both enhanced care management and in lieu of services via Medi-Cal managed care plans, and ultimately will be expanded to Medi-Cal managed care plans in non-Whole Person Care counties.	January 1, 2022
PRIME		Transition to managed care directed payment under the Quality Incentive Pool (QIP) Program.	The existing PRIME funding structure was transitioned into QIP directed payments effective July 1, 2020. Network Designated Public Hospital (DPH) systems and the District/Municipal Public Hospitals (DMPHs) will have the opportunity to participate in and receive directed QIP payments from their contracted Medi-Cal managed care plans for reporting on a set of quality improvement measures through the QIP program.	Phase I: July 1 – December 31, 2020 Phase II: January 1, 2021
Health Homes Program	X	Transition to new 1915(b) waiver as Enhanced Care Management.	Medi-Cal managed care plans would provide a new enhanced care management benefit similar to the benefits included in the Health Homes Program. Medi-Cal managed care plans will have the option of providing a menu of approved in lieu of services. Services currently provided to populations with complex health needs under the HHP will become available under the managed care delivery system structure.	January 1, 2022

Crosswalk of Medi-Cal 2020 Waiver Components to CalAIM Proposals

Medi-Cal 2020 Waiver Component	Included in Waiver Extension Through 12/31/21	Planned for CalAIM	Description	Timeline
Coordinated Care Initiative and Cal MediConnect	X	Managed care authority to new 1915(b) waiver; Extension of 1115A demonstration for Cal MediConnect through 2022; eventual Medicare-Duals Special Needs Plans (D-SNPs).	Transition to standardized mandatory enrollment of dual eligibles into Medi-Cal managed care plans. Multipurpose Senior Services Programs will be carved out; long-term care will be carved in statewide. All Medi-Cal managed care plans will be required to offer coverage through D-SNPs for care coordination and integration of benefits.	CCI program with end date of December 31, 2022
Drug Medi-Cal Organized Delivery System (DMC-ODS)	X	Expenditure authority for residential SUD treatment remains in 1115 waiver; Services and delivery system move to new 1915(b) waiver.	The Drug Medi-Cal Organized Delivery System (DMC-ODS) provides a continuum of care for substance use disorder treatment.	Implementation continues January 1, 2022
Global Payment Program	X	1115 waiver renewal.	Continuation of existing program, with discontinuation of Safety Net Care Pool funds, using only Medicaid Disproportionate Share Hospital (DSH) allotment funds.	January 1, 2022.

Crosswalk of Medi-Cal 2020 Waiver Components to CalAIM Proposals

Medi-Cal 2020 Waiver Component	Included in Waiver Extension Through 12/31/21	Planned for CalAIM	Description	Timeline
Dental Transformation Initiative	X	Transition authority to Medi-Cal State Plan.	New dental benefits and provider payments: • Caries Risk Assessment Bundle for ages 0-6; • Silver Diamine Fluoride for ages 0-6, and specified high-risk and institutional populations Pay for Performance incentives for preventive services and establishing continuity of care through dental homes	January 1, 2022
Community-Based Adult Services (CBAS)	X	1115 waiver renewal.	Services for eligible older adults and those with disabilities to restore or maintain their optimal capacity for self-care. The goal is to delay or prevent inappropriate or personally undesirable institutionalization.	January 1, 2022
Eligibility Authorities	X	1115 waiver renewal.	Full Scope Benefit for Pregnancy Related Beneficiaries with FPL 109-138% and Out of State Former Foster Care Youth.	January 1, 2022
Rady CCS Pilot	X	Not included.	The demonstration project tested two healthcare delivery models for children enrolled in the California Children's Services (CCS) Program.	Expires December 31, 2021
Designated State Health Programs (DSHP)	X	Not included.	Financing mechanism under 1115 waiver which has permitted federal funding for certain State health programs not traditionally allowed for federal funding	Expires December 31, 2020
Tribal Uncompensated Care	X	Not included.	The state makes supplemental payments to Indian Health Service (IHS) and tribal 638 facilities to take into account their responsibility to provide uncompensated care. DHCS will work to implement Tribal FQHCs by January 1, 2021, which will account for the remaining services being billed for under Tribal Uncompensated Care.	Expires December 31, 2021

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5.1 Transition of PRIME to Quality Incentive Program

5.1.1 Background

The California Public Hospital Redesign and Incentives in Medi-Cal (PRIME) program built on other delivery system transformation efforts focused on strengthening patient-centered primary and specialty outpatient care, improving care coordination, and providing the right care in the most appropriate settings. A total of 17 Designated Public Hospitals and 34 District and Municipal Public Hospitals participated in PRIME. PRIME was designed to accelerate efforts by participating entities to change care delivery, maximize health care value, and strengthen their ability to successfully perform under risk-based alternative payment models. PRIME was intentionally designed to be ambitious in scope and time limited. Using evidence-based quality improvement methods, the initial work required the establishment of performance baselines followed by target-setting, and the implementation and ongoing evaluation of quality improvement interventions.

In 2017, California created a Quality Incentive Program (QIP) – a managed care directed payment program – for the state's Designated Public Hospitals. The state directs Medi-Cal managed care plans to make QIP payments tied to designated performance metrics in four strategic categories: primary care, specialty care, inpatient care, and resource utilization. The QIP measures do not directly overlap with any of the quality measures being used in PRIME, rather they are designed to be complementary. The QIP promote access to care, value-based purchasing, and to tie funding to quality outcomes, while at the same time further aligning state, Medi-Cal managed care plan, and hospital system goals. The QIP also creates incentives to build data and quality infrastructure and ties funding directly to these goals, allowing the state to pay for quality and build capacity.

5.1.2 Proposal

DHCS is in the process of transitioning the quality improvement work and funding that has been available through PRIME into the QIP and permitting the District and Municipal Public Hospitals to begin participating in the program, which has enabled hospitals to continue quality improvement efforts underway at all 51 PRIME entities after PRIME expired on June 30, 2020. This transition promotes value-based purchasing, ties funding to quality outcomes, and aligns PRIME entities' transition to the QIP with California's transition to the calendar year rating period for Medi-Cal managed care plans.

There are two key phases in the PRIME-to- QIP transition:

- **Phase I:** Alignment with the calendar year health plan rating period, July 1, 2020 through December 31, 2020

- **Phase II:** Merge to QIP, January 1, 2021 through December 2021, and beyond.

Phase I: Alignment with Calendar Year Rating Period

All 51 PRIME entities transitioned into a six-month transitional program on July 1, 2020 to calibrates the new program to end on the same date as Bridge Period 2019-20, an 18-month rate year for Medi-Cal managed care plans that ended on December 31, 2020. For performance on both the original QIP quality metrics (for Designated Public Hospitals) and the PRIME transition metrics (for Designated Public Hospitals and 34 District and Municipal Public Hospitals) during this period, the 51 entities will be paid through Medi-Cal managed care plans, via state-directed Medi-Cal managed care plan payments. CMS approval for this six-month program was obtained on September 14, 2020.

To earn funds for PRIME transition metrics, all 51 PRIME entities will continue to report to DHCS on quality improvement projects and measures from PRIME. The six-month transition will use a twelve-month measurement period to ensure that performance can be fairly compared to benchmarks set by DHCS. Due to the COVID-19 public health emergency, entities will use the March 1, 2019 to February 29, 2020 measurement period and be held to achieving the minimum performance benchmark established by DHCS from PRIME Demonstration Year 15. The Designated Public Hospitals will also continue activities on the original QIP quality metrics during this six-month period, utilizing the same modifications due to the COVID-19 public health emergency outlined for PRIME above.

Phase II: Merge to QIP

Subject to obtaining the necessary federal approvals, January 1, 2021 will be the start of QIP Year 4 and will include the Designated Public Hospitals and 34 District and Municipal Public Hospitals, totaling 51 QIP entities. Similar to Phase I, payments to the 51 QIP entities will be directed payments through the Medi-Cal managed care plans. Program Year 4 will align with Rate Year 2021, corresponding to calendar year 2021.

PRIME Policy Letters and associated PRIME reporting guidance will no longer apply to QIP. DHCS will review all prior PRIME Policy Letters and QIP Policy Letters for relevance and issue updated Policy Letters and reporting guidance to Designated Public Hospitals and District and Municipal Public Hospitals.

DHCS worked with stakeholders to develop a revised metric set for Program Year 4 that prioritizes CMS Adult and Child Core Set measures, HEDIS measures, other nationally vetted and endorsed measures, and measures in wide use across Medicaid quality initiatives. The measures align with well-established benchmarks and State, Medi-Cal managed care plan, and hospital system goals. The Program Year 4 metric set meaningfully reflects the goals and priorities of CalAIM.

5.1.3 Rationale

The QIP Program is intended to promote access to care, value-based payments, and tie funding to quality outcomes, while at the same time further aligning state, Medi-Cal managed care plan, and hospital system goals. The PRIME to QIP transition will engage both Designated Public Hospitals and 34 District and Municipal Public Hospitals to continue quality improvement work for select priority metrics in QIP As such, this proposal will help achieve the following goals of CalAIM:

- Enhance coverage expansion to address health disparities among vulnerable populations;
- Drive delivery transformation across Designated Public Hospitals and District and Municipal Public Hospitals toward value-based care and away from volume-based care, and
- Reduce variation and complexity across hospital systems through alignment of quality measures with those required of health plans.

5.1.4 Proposed Timeline

January 1, 2021: Complete transition from PRIME to QIP for Designated Public Hospitals and District and Municipal Public Hospitals using new CMS Adult and Child Core Set measures, HEDIS measures, and other nationally-vetted and endorsed measures

5.2 Global Payment Program Extension

5.2.1 Background

The Global Payment Program is a five-year pilot program included in California's Medi-Cal 2020 Section 1115 demonstration waiver. The Global Payment Program establishes a statewide pool of funding by combining a portion of California's federal Disproportionate Share Hospital (DSH) allotment with available uncompensated care funding. These funds support public health care system efforts to provide health care for California's uninsured population and promotes the delivery of more cost-effective and higher-value care to the uninsured.

Global budgets are allocated to public health care systems based on available funding and service point thresholds to be achieved. Public health care systems can achieve their hospital specific global budget by meeting a service point threshold that incentivizes movement from high cost, avoidable services to providing higher value and preventive services in the most appropriate setting.

The Global Payment Program's requirements are established in the Special Terms and Conditions for California's Medi-Cal 2020 Section 1115 demonstration and the program

funding is authorized December 31, 2021 under the one year Medi-Cal 2020 extension proposal, submitted to CMS on September 16, 2020.

5.2.2 Proposal

DHCS proposes to extend the Global Payment Program under CalAIM through a renewal of the Medi-Cal Section 1115 waiver demonstration. The Global Payment Program will operate under the following assumptions:

- The start date of Program Year 7 will begin on January 1, 2022, and end on December 31, 2022. The Global Payment Program was originally approved through June 30, 2020. On August 3, 2020, the Centers for Medicare and Medicaid Services (CMS) approved a waiver amendment extending the program and authorizing Program Year 6A for the period of July 1, 2020 through December 31, 2020. The Medi-Cal 2020 one-year extension proposal extended the program through December 31, 2021.
- The Global Payment Program under CalAIM will be funded solely by a portion of the State's Designated Public Hospital Disproportionate Share Hospital allotment allocation and will no longer incorporate uncompensated care funding;
- The percentage of Designated Public Hospital Disproportionate Share Hospital allotment funds to be split amongst University of California hospitals and Global Payment Program public health care systems will remain constant for the entirety of the waiver with 78.104% allocated to the Global Payment Program and 21.896% allocated to University of California hospitals;
- The Global Payment Program will include an evaluation to continue to assess whether the program is achieving its stated goals;
- The Global Payment Program will continue the shifting of point values for specific services to incentivize the provision of care in the most appropriate and cost-effective settings;
- DHCS may recalibrate the initial point thresholds for each hospital. Some public health care systems consistently exceed their thresholds, while others do not. Recalibration of the initial point thresholds will serve to minimize payment adjustments; and
- All other facets of the Global Payment Program in the CalAIM period will operate per the Medi-Cal 2020 waiver Special Terms and Conditions.

5.2.3 Rationale

The Global Payment Program was established to accomplish the following goals:

- To improve health of the remaining uninsured through coordination of care and to move away from the cost-based payment methodology restricted to mostly hospital settings to a more risk-based and/or bundled payment structure;
- To encourage public healthcare systems to provide greater primary and preventive services, as well as alternative modalities such as phone visits, group visits, telemedicine, and other electronic consultations; and
- To emphasize the value of coordinated care and alternative modalities by recognizing the higher value of primary care, ambulatory care, and care management as compared to the higher cost, avoidable emergency room visits and acute care hospital stay.

DHCS collaborated with the RAND Corporation to conduct an evaluation of the Global Payment Program from the onset of the program through March 2019. The evaluation assessed whether and to what extent, changing the payment methodology resulted in a more patient-centered system of care. Results show that there has been an increase in outpatient services, an increase in access to care for the uninsured, an improvement in the coordination of care, advancements in data collection and tracking, and an appropriate allocation of resources to effectively tailor care to more appropriate settings.

These findings provide strong support for the argument that the Global Payment Program is a powerful catalyst in helping the public health care systems deliver more cost-effective and higher-value care to the State's remaining uninsured individuals and will continue to move in this direction over the next five years.

5.2.4 Proposed Timeline

DHCS proposes to extend the Global Payment Program for the next five years according to the schedule in **Attachment G.**

6. Appendices

Appendix A: 2021 and Beyond: CalAIM Implementation Timeline[3]

Date	Implementation Activity
July 1, 2020	**PRIME transitions to Quality Incentive Program**
January 1, 2021	12-month extension of Medi-Cal 2020 demonstration
April 2021	**Submission of Section 1915(b) and 1115 waiver requests** **Pharmacy Carve-Out Effective**
June 2021	**County Oversight[4]:** DHCS will engage with counties by forming a working group that will focus on developing new county performance standards monitoring and reporting mechanism. The reinstatement of County Performance Standards will include incorporation of MEDS alert monitoring statewide **County oversight (CCS, CHDP):** Development of auditing tools. **Foster Care Model of Care Workgroup** completed
October 2021	**County oversight (CCS, CHDP):** Shift to automated Plan and Fiscal Guideline submission process, develop training documents, evaluate and analyze findings and trends, and identify gaps and vulnerabilities.
November-2021	**County Inmate Pre-Release Application Process:** Stakeholder process
December 2021	**County Oversight**: DHCS will publish an updated process for the monitoring and reporting of County Performance Standards, incorporating an outline of the tiered Corrective Action steps which will include disciplinary action ranging from CPAs for counties that do not meet performance expectations, to potential fiscal penalties for unresponsive counties. **Goal approval date of Section 1915(b) and 1115 waiver requests**
2022	

[3] Implementation date TBD: IMD SMI/SED waiver, regional contracting (will vary), improving beneficiary contact and demographic information

[4] Given the Executive Order to halt all county renewal processes and negative actions through the duration of the Public Health Emergency (PHE), the implementation timeline reflected for this initiative will shift if the PHE is extended. The dates noted are based on the PHE ending and normal county business processes resuming January 2021, allowing 12 months from the end of the PHE for counties to process and clean-up the resulting backlog. Dates are subject to change once the end of the PHE is established.

Date	Implementation Activity
January 1, 2022	**Managed Care Authority:** Shifts to 1915(b) authority **Implementation of the following CalAIM proposals:** • Enhanced care management/In lieu of services (existing WPC and/ or HHP target populations) • Incentive payments • Dental benefits and pay for performance (implementation date TBD as funding for Designated State Health Programs (DSHP) is not approved in extension of the Medi-Cal 2020 demonstration) • Managed care benefit standardization continues • Mandatory managed care • Regional Rates Phase I • DMC-ODS renewal and policy improvements • Changes to behavioral health medical necessity • Multipurpose Senior Services Program carved-out of managed care • D-SNP look-alike enrollment transition in CCI counties **County Inmate Pre-Release Application Process:** Publication of guidance and begin Technical Assistance (through December 2022)
March 2022	**County Oversight**: DHCS will begin assessing County Performance Standards, in keeping with the aforementioned updated process.
June 2022	**County Oversight**: DHCS will implement the County Performance Monitoring Dashboard. The dashboard is envisioned to represent county performance in application processing, renewal processing, and MEDS alert processing, and could potentially include other measures to be mutually agreed upon in the future.
July 2022	**Behavioral Health Payment Reform** **Enhanced care management:** • Implementation of additional enhanced care management Target Populations in HHP/WPC Counties. • Managed care plans in non- WPC and/or HHP counties begin implementing enhanced care management target populations
September 2022	**County Oversight**: DHCS will begin publishing the County Performance Monitoring Dashboard on the CHHS Open Data Portal.
October 2022	**County oversight (CCS, CHDP):** Initiate Memorandum of Understanding between State and counties, continuous monitoring and oversight, and continuous updates to standards, policies, and guidelines
December 31, 2022	**Cal MediConnect:** End of program
2023	
January 2023	**Aligned Enrollment:**

Date	Implementation Activity
	• Require statewide mandatory enrollment of dual eligibles in Medi-Cal managed care[5] • All Medi-Cal health plans in CCI counties required to operate Dual Eligible Special Needs plans in all service areas they operate as an Medi-Cal managed care plan, including dual eligible LTC residents • Require statewide mandatory enrollment for eligible LTC residents for both non-dual and dual beneficiaries **County Inmate Pre-Release Application Process:** Implementation **Shared Risk/Shared Savings** (at the earliest) **Enhanced care management:** Implementation of all enhanced care management target populations, including Individuals Transitioning from Incarceration.
December 2023	**County Oversight**: DHCS will begin taking steps toward fiscal sanctions for counties who do not demonstrate sufficient improvement in meeting performance expectations or are unresponsive.
2024	
January 2024	**Regional Rates, Phase II** (at the earliest)
2025	
January 2025	**Aligned Enrollment:** • All Medi-Cal health plans in non-CCI counties required to operate Dual Eligible Special Needs plans in all service areas they operate as a Medi-Cal managed care plan.
2026	
January 2026	**NCQA:** All Medi-Cal managed care plans required to be NCQA accredited
2027	
January 2027	**Behavioral Health Administrative Integration:** submit for a single, integrated behavioral health managed care plan in each county or region responsible for providing, or arranging for the provision of, specialty mental health and substance use disorder services under the 1915(b) waiver **Long-Term Services and Supports, Long-Term Care, Dual Eligible Special Needs Plans:** Full implementation **Full Integration Plan:** Go Live (no sooner than)

[5] Mandatory Managed Care enrollment: See **Appendix F: Managed Care Enrollment Proposed Aid Code Group Coverage.**

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Appendix B: Targeted Case Management

LGAs	Children Under the Age of 21	Medically Fragile Individuals	Individuals at Risk of Institutionalization	Individuals at Jeopardy of Negative Health or Psycho-Social Outcomes	Individuals with a Communicable Disease	LGAs not Participating in TCM
Alameda County	X	X	X	X		
Alpine County						X
Amador County						X
Butte County				X		
Calaveras County						X
Colusa County						X
Contra Costa County	X	X	X	X	X	
Del Norte County						X
El Dorado County						X
Fresno County						X
Glenn County						X
Humboldt County	X	X		X	X	
Imperial County						X
Inyo County						X
Kern County				X		
Kings County						X
Lake County						X
Lassen County						X
Los Angeles County	X			X		

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LGAs	Children Under the Age of 21	Medically Fragile Individuals	Individuals at Risk of Institutionalization	Individuals at Jeopardy of Negative Health or Psycho-Social Outcomes	Individuals with a Communicable Disease	LGAs not Participating in TCM
Madera County				X		
Marin County						X
Mariposa County	X	X	X	X	X	
Mendocino County	X	X	X	X	X	
Merced County						X
Modoc County						X
Mono County						X
Monterey County	X	X		X		
Napa County	X	X		X		
Nevada County						X
Orange County	X	X	X	X	X	
Placer County		X	X	X		
Plumas County						X
Riverside County	X	X	X	X	X	
Sacramento County				X		
San Benito County						X
San Bernardino County						X
San Diego County	X	X	X	X	X	
San Francisco County						X
San Joaquin County						X

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LGAs	Children Under the Age of 21	Medically Fragile Individuals	Individuals at Risk of Institutionalization	Individuals at Jeopardy of Negative Health or Psycho-Social Outcomes	Individuals with a Communicable Disease	LGAs not Participating in TCM
San Luis Obispo County	X	X		X		
San Mateo County	X	X		X		
Santa Barbara County						X
Santa Clara County	X	X	X	X	X	
Santa Cruz County	X	X		X		
Shasta County		X		X		
Sierra County						X
Siskiyou County						X
Solano County	X	X		X	X	
Sonoma County	X	X	X	X	X	
Stanislaus County	X	X	X	X	X	
Sutter County	X	X	X	X	X	
Tehama County						X
Trinity County				X		
Tulare County						X
Tuolumne County	X	X	X	X		
Ventura County	X	X	X	X	X	
Yolo County						X
Yuba County						X
City of Berkeley	X	X	X	X	X	
City of Long Beach	X	X	X	X	X	
Total	**23**	**24**	**16**	**30**	**15**	**30**

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Appendix C: County Inmate Pre-Release Application Process sample contracting Models

Contracting Model	Counties Currently Using a Similar Process
County Contracts with County Sheriff's Office	Butte Kern San Bernardino San Diego San Francisco Tuolumne Ventura Yolo
County Contracts with County Jail	Glenn Santa Barbara
County Contracts with Multiple Entities (e.g. Community Based Organizations and County Sheriff's Office)	Contra Costa Imperial Placer Sacramento San Luis Obispo San Mateo Solano Sutter

Appendix D: Institutions for Mental Disease/Serious Mental Illness/Severe Emotional Disturbance Demonstration Goals & Milestones

Below is a summary of demonstration goals as outlined in CMS SMD Letter #18-011:

- Reduced utilization and lengths of stay in emergency departments among Medicaid beneficiaries with serious mental illness or serious emotional disturbance while awaiting mental health treatment in specialized settings;
- Reduced preventable readmissions to acute care hospitals and residential settings;
- Improved availability of crisis stabilization services including services made available through call centers and mobile crisis units, intensive outpatient services, as well as services provided during acute short-term stays in residential crisis stabilization programs, psychiatric hospitals, and residential treatment settings throughout the state;
- Improved access to community-based services to address the chronic mental health care needs of beneficiaries with serious mental illness or serious emotional disturbance including through increased integration of primary and behavioral health care; and
- Improved care coordination, especially continuity of care in the community following episodes of acute care in hospitals and residential treatment facilities.

Below is a summary of demonstration milestones as outlined in CMS SMD Letter #18-011:

- Ensuring quality of care in psychiatric hospitals and residential settings. Involves facility accreditation, unannounced visits, use of a utilization review entity, facilities meeting federal program integrity requirements, and facilities having the capacity to address co-morbid physical health conditions;
- Improving care coordination and transitions to community-based care. Involves implementation of a process to assess housing situations, requirement that facilities have protocols to contact beneficiaries within 72-hours after discharge, strategies to prevent or decrease lengths of stays in emergency departments, and strategies to develop and enhance interoperability and data sharing;
- Increasing access to continuum of care including crisis stabilization services. Involves annual assessments of availability of mental health services across the state, commitment to an approved finance plan, strategies to improve the state's

capacity to track available beds, and implementation of an evidence-based assessment tool; and

- Earlier identification and engagement in treatment including through increased integration. Involves strategies for identifying and engaging individuals in treatment sooner, increased integration of behavioral health care in non-specialty settings and establishing specialized settings and services.

Federal Application Requirements

States wishing to pursue this demonstration opportunity must first submit an application to CMS. CMS will consider a state's commitment to ongoing maintenance of effort on funding outpatient community-based mental health services as demonstrated in their application when determining whether to approve a state's proposed demonstration project to ensure that resources are not disproportionately drawn into increasing access to treatment in inpatient and residential settings at the expense of community-based services. Below is a summary of required elements for the application;

- A comprehensive description of the demonstration, including the state's strategies for addressing the goals and milestones discussed above for this demonstration initiative;
- A comprehensive plan to address the needs of beneficiaries with serious mental illness or serious emotional disturbance, including an assessment of how this demonstration will complement and not supplant state activities called for or supported by other federal authorities and funding streams;
- A description of the proposed health care delivery system, eligibility requirements, benefit coverage and cost sharing (premiums, copayments, and deductibles) required of individuals who will be impacted by the demonstration, to the extent such provisions would vary from the state's current program features and the requirements of the Social Security Act;
- A list of the waivers and expenditure authorities that the state believes to be necessary to authorize the demonstration;
- An estimate of annual aggregate expenditures by population group impacted by the demonstration, including development of baseline cost data for these populations.
- Specifically, CMS requests that states' fiscal analysis demonstrate how the proposed changes will be budget neutral, i.e., will not increase federal Medicaid spending. CMS will work closely with states to determine the feasibility of their budget neutrality models and suggest changes as necessary;

- Enrollment data including historical mental health care coverage and projected coverage over the life of the demonstration, of each category of beneficiary whose health care coverage is impacted by the demonstration;
- Written documentation of the state's compliance with the public notice requirements at 42 CFR 431.408, with a report of the issues raised by the public during the comment period and how the State considered those comments when developing the final demonstration application submitted to CMS;
- The research hypotheses that are related to the demonstration's proposed changes, goals, and objectives, and a general plan for testing the hypotheses including, if feasible, the identification of appropriate evaluation indicators; and
- An implementation plan describing the timelines and activities necessary to achieve the demonstration milestones including a financing plan. The implementation plan can be submitted with the application, or within 90 days of application approval from CMS.

Other Demonstration Requirements

In addition to the required application elements above, states must also develop the following:

- Demonstration monitoring reports including information detailing the state's progress toward meeting the milestones and timeframes outlined in the implementation plan, as well as information and data so that CMS can monitor budget neutrality.
- A Health IT plan (health information technology plan) that describes the state's ability to leverage health IT, advance health information exchange(s), and ensure health IT interoperability in support of the demonstration's goals.
- Monitoring protocols that identify expectations for quarterly and annual monitoring reports including agreed upon performance measures (see SMD #18-011 for a list of potential measures), measure concepts, and qualitative narrative summaries. The monitoring protocol will be developed and finalized after CMS approval.
- Interim and final evaluations that will draw on the data collected for the milestones and performance measures, as well as other data and information needed to support the evaluation that will describe the effectiveness and impact of the demonstration using quantitative and qualitative outcomes and a cost analysis. An evaluation design will be developed by the state, with technical assistance from CMS, to be finalized within 180 days of the demonstration approval.

States that fail to submit an acceptable and timely evaluation design as well as any monitoring, expenditure, or other evaluation reporting are subject to a $5 million deferral per deliverable.

Key Resources

- State Medicaid Director Letter #18-011: https://www.medicaid.gov/federal-policy-guidance/downloads/smd18011.pdf
- Serious Mental Illness/Serious Emotional Disturbance Demonstration Opportunity Technical Assistance Questions & Answers: https://www.medicaid.gov/federal-policy-guidance/downloads/faq051719.pdf

Appendix E: CalAIM Benefit Changes Chart

Benefit Changes Effective April 1, 2021	
Benefits Currently Provided by Medi-Cal Managed Care Plans that will be Carved-Out to Fee-for-Service	
Pharmacy	All pharmacy benefits or services billed by a pharmacy on a pharmacy claim, which includes covered outpatient drugs (including Physician Administered Drugs), medical supplies, and enteral nutrition products. This also includes drugs currently "carved-out" of the managed care delivery system, (e.g., blood factor, HIV/AIDS, antipsychotics, and drugs used to treat substance use disorder), which are currently carved-in to some county operated health systems and AIDS Healthcare Foundation. This does not include any pharmacy benefits or services billed on medical and/or institutional claims.
Benefit Changes Effective January 1, 2022	
Benefits Currently Provided by Medi-Cal Managed Care Plans that will be Carved-Out to Fee-for-Service	
Specialty Mental Health Services	Currently full benefit in Partnership Solano (Kaiser members only) and Kaiser Sacramento
Multipurpose Senior Services Program	Currently full benefit in CCI counties (Los Angeles, Orange, San Bernardino, San Diego, San Mateo, Santa Clara, and Riverside)
Benefits to be Carved-In to Managed Care Statewide	
Major Organ Transplant	Currently full benefit in county operated health systems counties; non-county operated health systems counties currently only cover kidney transplants
Benefit Changes Effective January 1, 2023	
Benefits to be Carved-In to Managed Care Statewide	
Long Term Care	Long Term Care Umbrella • ICF-DD Disabled (excluding beneficiaries in an ICF-DD Waiver center), Disabled Habilitative, and Disabled Nursing • Pediatric Subacute Care Services • Skilled nursing facility • Specialized Rehabilitative Services in skilled nursing facility and ICF • Subacute Care Services Currently full benefit in county operated health systems and CCI counties (Los Angeles, Orange, San Bernardino, San Diego, San Mateo, Santa Clara, and Riverside); in non-county operated health systems/non-CCI counties, Medi-Cal managed care plans are responsible for the month of admission and the month following

Appendix F: Managed Care Enrollment Proposed Aid Code Group Coverage

Managed Care Enrollment Aid Code Group Coverage												
			Current			2022			2023			
Aid Code Group	**Aid Codes[6]**	**Non-Dual/ Dual[7]**	**Mandatory**	**Voluntary**	**Excluded from Enrollment**	**Mandatory**	**Voluntary**	**Excluded from Enrollment**	**Mandatory**	**Voluntary**	**Excluded from Enrollment**
Adult Expansion	7U, L1, M1	Non-Dual	All Models	N/A	N/A	All Models	N/A	N/A	All Models	N/A	N/A
Non-Disabled Adults (19 & Over)	01, 02[8], 08, 30, 34, 35, 37, 39, 38, 54, 59, 81[8], 82, 83, 84, 85, 0A, 3D, 3E, 3N, 3P, 3U, 7S, G0, J1, J2, K1, K2, K6, M3	Non-Dual	All Models	N/A	N/A	All Models	N/A	N/A	All Models	N/A	N/A

[6] Members residing in a LTC facility in a non-LTC aid code subject to the LTC benefit carve-in will be transitioned into managed care based on the Non-Dual/Dual Mandatory and Voluntary timeline.
[7] Non-Dual/Dual Definitions: (1) Non-Dual – A Medi-Cal only beneficiary or a Medi-Cal only beneficiary with Medicare Part A **or** Part B only; (2) Dual – Medi-Cal only beneficiary with Medicare Part A **and** Part B or Medicare Part A, B, and D.
[8] Aid code can have a SOC or no SOC

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Managed Care Enrollment Aid Code Group Coverage												
			Current			2022			2023			
Aid Code Group	**Aid Codes[6]**	**Non-Dual/ Dual[7]**	**Mandatory**	**Voluntary**	**Excluded from Enrollment**	**Mandatory**	**Voluntary**	**Excluded from Enrollment**	**Mandatory**	**Voluntary**	**Excluded from Enrollment**	
Aged	10[9], 14, 16, 1E, 1H, 1X, 1Y	Non-Dual	All Models	N/A	N/A	All Models	N/A	N/A	All Models	N/A	N/A	
Breast and Cervical Cancer Treatment Program (BCCTP)	0M, 0N, 0P, 0W	Non-Dual	All Models	N/A	N/A	All Models	N/A	N/A	All Models	N/A	N/A	
Disabled	20[2], 23, 24, 26, 27, 36, 60[2], 63, 64, 66, 67, 88, 89, 2E, 2H, 6A, 6C, 6E, 6J, 6G, 6H, 6N, 6R, 6V, 6W, 6X, 6Y, 8G, 9L, K4, K8, L6	Non-Dual	All Models	N/A	N/A	All Models	N/A	N/A	All Models	N/A	N/A	
Long Term Care (includes LTC SOC)	13, 23, 53, 63	Non-Dual	COHS, CCI	N/A	All Other Models	COHS, CCI	N/A	All Other Models	All Models	N/A	N/A	
Foster Children	03, 04, 06, 07, 40, 42, 43, 45, 46, 49, 2P, 2R, 2S, 2T, 2U,	Non-Dual	COHS	Non-COHS	N/A	COHS	Non-COHS	N/A	COHS	Non-COHS	N/A	

[9] Aid codes 10, 20, 60 are Supplemental Security Income (SSI)/State Supplemental Payment (SSP). Medi-Cal beneficiaries in these three aid codes have mandatory and voluntary enrollments based on different managed care models. These beneficiaries are mandatory in COHS, voluntary in San Benito, voluntary in GMC/Regional/Two-Plan for duals, and mandatory in GMC/Regional/Two-Plan for non-duals.

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Managed Care Enrollment Aid Code Group Coverage												
			Current			2022			2023			
Aid Code Group	**Aid Codes[6]**	**Non-Dual/ Dual[7]**	**Mandatory**	**Voluntary**	**Excluded from Enrollment**	**Mandatory**	**Voluntary**	**Excluded from Enrollment**	**Mandatory**	**Voluntary**	**Excluded from Enrollment**	
	4A, 4C, 4F, 4G, 4H, 4K, 4L, 4M, 4S, 4T, 4W, 5K, 5L											
Omnibus Budget Reconciliation Act (OBRA) Restricted Scope Only	58	Non-Dual	Napa, Solano, and Yolo counties	N/A	All Other Models	N/A	N/A	All Models	N/A	N/A	All Models	
Share of Cost	17, 27, 37, 50, 53, 58, 67, 71, 73, 81[8], 83, 85, 87, 89, 02[8], 1Y, 4V, 5F, 5R, 6R, 6W, 6Y, 7M, 7P, 7R, 7V, 8V, C2, C4, C6, C8, D1, D3, D5, D7, D9	Non-Dual	COHS & CCI	N/A	All Other Models	N/A	N/A	All Models	N/A	N/A	All Models	
Non-Disabled Adults (19 & Over)	01, 02[8], 08, 30, 34, 35, 37, 39, 38, 54, 59, 81[8], 82 ,83, 84, 85, 0A, 3D, 3E, 3N, 3P, 3U, 7S, G0, J1, J2, K1, K2, K6, M3	Dual	COHS, CCI	All Other Models	N/A	COHS, CCI	All Other Models	N/A	All Models	N/A	N/A	
Non-Disabled Children (Under 19)	30, 32, 33, 34, 35, 37, 38, 39, 47, 54, 59, 72, 82, 83, 2C, 3A, 3C, 3D, 3E, 3F, 3G, 3H, 3L, 3M, 3N, 3P, 3R, 3U, 3W, 4N, 4U, 5C, 5D, 5E, 6P,	Dual	COHS, CCI	All Other Models	N/A	COHS, CCI	All Other Models	N/A	All Models	N/A	N/A	

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Managed Care Enrollment

Aid Code Group Coverage

			Current			2022			2023		
Aid Code Group	**Aid Codes[6]**	**Non-Dual/ Dual[7]**	**Mandatory**	**Voluntary**	**Excluded from Enrollment**	**Mandatory**	**Voluntary**	**Excluded from Enrollment**	**Mandatory**	**Voluntary**	**Excluded from Enrollment**
	7A, 7J, 7T, 7W, 7X, 8P, 8R, 9H, E6, E7, H1, H2, H3, H4, H5, M5, P5, P7, P9, T1, T2, T3, T4, T5										
Aged	10[2], 14, 16, 1E, 1H, 1X, 1Y	Dual	COHS, CCI	All Other Models	N/A	COHS, CCI	All Other Models	N/A	All Models	N/A	N/A
Breast and Cervical Cancer Treatment Program (BCCTP)	0M, 0N, 0P, 0W	Dual	COHS, CCI	All Other Models	N/A	COHS, CCI	All Other Models	N/A	All Models	N/A	N/A
Disabled	20[2], 23, 24, 26, 27, 36, 60[2], 63, 64, 66, 67, 88, 89, 2E, 2H, 6A, 6C, 6E, 6J, 6G, 6H, 6N, 6R, 6V, 6W, 6X, 6Y, 8G, 9L, L6, K4, K8	Dual	COHS, CCI	All Other Models	N/A	COHS, CCI	All Other Models	N/A	All Models	N/A	N/A
Long Term Care (includes LTC SOC)	13, 23, 53, 63	Dual	COHS, CCI	All Other Models	N/A	COHS, CCI	All Other Models	N/A	All Models	N/A	N/A
Share of Cost	17, 27, 37, 50, 53, 58, 67, 71, 73, 81[8], 83, 85, 87, 89, 02[8], 1Y, 4V, 5F, 5R, 6R, 6W, 6Y, 7M, 7P, 7R, 7V, 8V, C2, C4, C6, C8, D1, D3, D5, D7, D9	Dual	COHS, CCI	N/A	Non-COHS & Non-CCI	N/A	N/A	All Models	N/A	N/A	All Models

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Managed Care Enrollment Aid Code Group Coverage												
			Current			2022			2023			
Aid Code Group	**Aid Codes[6]**	**Non-Dual/ Dual[7]**	**Mandatory**	**Voluntary**	**Excluded from Enrollment**	**Mandatory**	**Voluntary**	**Excluded from Enrollment**	**Mandatory**	**Voluntary**	**Excluded from Enrollment**
Presumptive Eligibility (Hospital and CHDP PE)	2A, 4E, 8L, 8W, 8X, H0, H6, H7, H8, H9, P1, P2, P3	Both	N/A	N/A	All Models	N/A	N/A	All Models	N/A	N/A	All Models
Trafficking and Crime Victims Assistance Program (TCVAP)	2V, 4V, 5V, 7V, R1	Both	N/A	N/A	All Models	All Models	N/A	TCVAP SOC	All Models	N/A	TCVAP SOC
Accelerated Enrollment (AE)	8E	Both	N/A	N/A	All Models	All Models	N/A	N/A	All Models	N/A	N/A
Child Health and Disability Prevention (CHDP) Infant Deeming	8U, 8V	Both	N/A	N/A	All Models	All Models	N/A	N/A	All Models	N/A	N/A
State Medical Parole/County Compassionate Release/Incarcerated Individuals	F1, F2, F3, F4, G0, G1, G2, G3, G4, G5, G6, G7, G8, G9, J1, J2, J3, J4, J5, J6, J7, J8, K2, K3,K4, K5, K6, K7, K8, K9, N0, N5, N6, N7, N8, N9	N/A	N/A	N/A	All Models	N/A	N/A	All Models	N/A	N/A	All Models
Limited/Restricted Scope Eligible	48, 50, 53, 55, 58, 69, 71, 73, 74, 76, 77, 80, 0L, 0R, 0T, 0U, 0V, 0X, 0Y, 1U, 3T, 3V, 5J, 5R, 5T, 5W, 6U, 7C, 7F, 7G,	Both	N/A	N/A	All Models	N/A	N/A	All Models	N/A	N/A	All Models

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Managed Care Enrollment											
Aid Code Group Coverage											
			Current			2022			2023		
Aid Code Group	Aid Codes[6]	Non-Dual/ Dual[7]	Mandatory	Voluntary	Excluded from Enrollment	Mandatory	Voluntary	Excluded from Enrollment	Mandatory	Voluntary	Excluded from Enrollment
	7H, 7K, 7M, 7N, 7P, 7R, 8N, 8T, C1, C2, C3, C4, C5, C6, C7, C8, C9, D1, D2, D3, D4, D5, D6, D7, D8, D9, E1, L7, M0, M2, M4, M6, M8, P0, P4, P6, P8, T0, T6, T7, T8, T9, F1, F2, F3, F4, G1, G2, G3, G4, G5, G6, G7, G8, G9, J3, J4, J6, J8, K3, K5, K7, K9, N0, N5, N6, N7, N8, N9										

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Pregnancy Related Aid Codes							
	Citizen/Lawfully Present				**Non-Citizen**		
	Aid Codes	**Current**	**Proposed (2021)**		**Aid Codes**	**Current**	**Proposed (2021)**
Title XXI (SCHIP) 213-322%	86, 87, 0E	Full Scope/MC	Full Scope/MC	Title XXI (SCHIP) 213-322%	0E	Full Scope/MC	Full Scope/MC
Title XIX (PRS/ES) 138-213%	44, M9	Limited Scope/FFS	Full Scope/MC	Title XXI (PRS – SCHIP) Title XIX (ES) 138-213%	48, M0	Limited Scope/FFS	Limited Scope/FFS
Title XIX (PRS/ES) 0-138%	M7	Full Scope/MC	Full Scope/MC	Title XXI (PRS – SCHIP) Title XIX (ES) 0-138%	D8, D9, M8	Limited Scope/FFS	Limited Scope/FFS

Population Exclusions									
Populations	**Current**			**2022**			**2023**		
	Mandatory	**Voluntary**	**Excluded from Enrollment**	**Mandatory**	**Voluntary**	**Excluded from Enrollment**	**Mandatory**	**Voluntary**	**Excluded from Enrollment**
American Indian[10]	COHS	Non-COHS	N/A	All Models[11]	N/A	N/A	All Models[11]	N/A	N/A
Beneficiaries with Other Healthcare Coverage (OHC)	COHS	N/A	Non-COHS	All Models[11]	N/A	N/A	All Models[11]	N/A	N/A
Beneficiaries in Rural Zip Codes[12]	COHS	Non-COHS	Non-COHS	All Models[11]	N/A	N/A	All Models[11]	N/A	N/A
Beneficiaries in Home and Community Based Services Waivers	COHS & CCI MLTSS = All Non-COHS & Non-CCI = Non-Duals	Non-COHS & Non-CCI = Duals	Cal MediConnect	COHS & CCI MLTSS = All Non-COHS & Non-CCI = Non-Duals	Non-COHS & Non-CCI = Duals	Cal MediConnect	All Models[11]	N/A	N/A

[10] American Indian Beneficiaries will be enrolled into a managed care plan, but they will have the option to opt out of enrollment if they choose to remain in FFS
[11] Would align with Mandatory/Voluntary/Excluded MC Enrollment by aid code, no special exclusions from enrollment solely based on zip code, OHC, American Indian or 1915c Waiver Enrollment
[12] The following zip codes are currently excluded from enrollment or are voluntary for enrollment: 93558, 90704, 92225, 92226, 92239, 92242, 92267, 92280, 92323, 92332, 92363, 92364, 92366, 93562, 9359293555, 93556, 93560, 92252, 92256, 92268, 92277, 92278, 92284, 92285, 92286, 92304,92305, 92309, 92310, 92311, 92312, 92314, 92315, 92317, 92321, 92322, 92325, 92327, 92333, 92338, 92339, 92341, 92342, 92347, 92352, 92356, 92358, 92365, 92368, 92372, 92378, 92382, 92385, 92386, 92391, 92397, 92398

Appendix G: Global Payment Program Extension Timeline

Program Year	Calendar Year	Federal Fiscal Year	Service Period Dates
6[13]	2021	2021	January 1, 2021-December 31, 2021
7	2022	2022	January 1, 2022 – December 31, 2022
8	2023	2023	January 1, 2023 – December 31, 2023
9	2024	2024	January 1, 2024 – December 31, 2024
10	2025	2025	January 1, 2025 – December 31, 2025
11	2026	2026	January 1, 2026 – December 31, 2026

[13] *PY 6 is part of Medi-Cal 2020 demonstration extension through 12/31/21*

Appendix H: Dental in Proposition 56 vs. CalAIM

Dental Procedure Code	Description	Proposition 56 Supplemental Payment	CalAIM Performance Payment
D0120	Periodic oral evaluation – established patient	No	Yes
D0145	Oral evaluation for a patient under three years of age and counseling with primary caregiver	No	Yes
D0150	Comprehensive oral evaluation – new or established patient	No	Yes
D0601	Caries risk assessment and documentation, with a finding of low risk (children ages 0-6)	No	Yes
D0602	Caries risk assessment and documentation, with a finding of moderate risk (children ages 0-6)	No	Yes
D0603	Caries risk assessment and documentation, with a finding of high-risk (children ages 0-6)	No	Yes
D1110	Prophylaxis – adult	Yes	No
D1120	Prophylaxis - child	No	Yes
D1206	Topical application of fluoride varnish (child)	No	Yes
	Topical application of fluoride varnish (adult)	Yes	No
D1208	Topical application of fluoride – excluding varnish (child)	No	Yes
	Topical application of fluoride – excluding varnish (adult)	Yes	No
D1310	Nutritional counseling for the control of dental disease (child)	No	Yes

Dental Procedure Code	Description	Proposition 56 Supplemental Payment	CalAIM Performance Payment
D1320	Tobacco counseling for the control and prevention of oral disease (adult)	No	Yes
D1351	Sealant – per tooth (child)	No	Yes
D1352	Preventive resin restoration in a moderate to high caries risk patient – permanent tooth (child)	No	Yes
D1354	Interim caries arresting medicament application – per tooth (children ages 0-6 and restricted adult populations)	No	Yes
D1510	Space maintainer – fixed, unilateral – per quadrant (child)	No	Yes
D1516	Space maintainer – fixed, bilateral, maxillary (child)	No	Yes
D1517	Space maintainer – fixed, bilateral, mandibular (child)	No	Yes
D1526	Space maintainer – removable, bilateral, maxillary (child)	No	Yes
D1527	Space maintainer – removable, bilateral, mandibular (child)	No	Yes
D1551	Re-cement or re-bond space maintainer – bilateral space maintainer, maxillary (child)	No	Yes
D1552	Re-cement or re-bond space maintainer – bilateral space maintainer, mandibular (child)	No	Yes
D1553	Re-cement or re-bond space maintainer – unilateral space maintainer – per quadrant (child)	No	Yes
D1556	Removal of fixed unilateral space maintainer – per quadrant (child)	No	Yes
D1557	Removal of fixed bilateral space maintainer – maxillary (child)	No	Yes
D1558	Removal of fixed bilateral space maintainer – mandibular (child)	No	Yes
D1575	Distal shoe space maintainer – fixed unilateral – per quadrant (child)	No	Yes
D1999	Unspecified preventive procedure, by report (adult)	No	Yes

Appendix I: Enhanced Care Management Target Population Descriptions

Enhanced care management is designed for populations who have the highest levels of complex health care needs as well as social factors influencing their health. To be eligible for enhanced care management, members must meet criteria below in addition to any criteria specific to the respective enhanced care management population:

1. Have complex physical or behavioral health condition with inability to successfully self-manage AND
2. Limited activity or participation in social functioning as defined by at least one of the following:
    a. Establishing and managing relationships;
    b. Major life areas, including education, employment, finances, engaging in the community

Candidates for enhanced care management have an opportunity for improved health outcomes if they receive high-touch, in-person care management and are connected to a multidisciplinary team that manages physical health, behavioral health (substance use and/or mental health), oral health, developmental disabilities, and health-related non-clinical needs as well as any needed long-term services and supports.

Enhanced care management will be implemented in phases:

- January 1, 2022: All Medi-Cal managed care plans in counties with Whole Person Care pilots and/or Health Homes Programs will begin implementation of the enhanced care management benefit, for those target populations currently receiving Health Homes Program and/or Whole Person Care services.
- July 1, 2022:
    - Medi-Cal managed care plans in counties with Whole Person Care pilots and/or Health Homes Programs will implement additional mandatory enhanced care management target populations.
    - All Medi-Cal managed care plans in counties without Whole Person Care pilots and/or Health Homes Programs must begin implementation of select enhanced care management target populations.
- January 1, 2023: All Medi-Cal managed care plans in all counties must implement enhanced care management for all target populations.

Characteristics of ECM target populations are set forth below and detailed further in this document. Risk stratification is the responsibility of the Medi-Cal managed care plans,

which will determine member needs and apply criteria to determine eligibility and facilitate ECM services. Medi-Cal managed care plans may propose additional populations to receive ECM or propose expansions of criteria within populations. ECM target populations are subject to further refinement by DHCS.

Medi-Cal managed care plans may propose additional populations to receive enhanced care management, for example to allow the transition for members receiving services under a Whole Person Care pilot. At a minimum, Medi-Cal managed care plans must provide enhanced care management to the below list of mandatory target populations:[14]

- Children and youth with complex physical, behavioral, and/or developmental health needs (i.e. California Children Services, foster care, youth with Clinical High-Risk syndrome or first episode of psychosis).
- Individuals experiencing homelessness, chronic homelessness or who are at risk of becoming homeless.
- High utilizers with frequent hospital admissions, short-term skilled nursing facility stays, or emergency room visits.
- Individuals at risk for institutionalization, eligible for long-term care.
- Nursing facility residents who want to transition to the community.
- Individuals at risk for institutionalization with Serious Mental Illness (SMI), children and youth with Serious Emotional Disturbance (SED) or Substance Use Disorder (SUD).
- Individuals transitioning from incarceration who have significant complex physical or behavioral health needs requiring immediate transition of services to the community.

These target population descriptions are intended as guidance for Medi-Cal managed care plans. Managed care plans will determine criteria for population identification and stratification in accordance with this guidance.

Settings

For all populations, the role of enhanced care management is to coordinate all primary, acute, behavioral, developmental, oral, and long-term services and supports for the

[14] Individuals transitioning from incarceration must be included no later than 1/1/2023, except where such program already exists today through an existing WPC program, in which case this target group is mandatory as of 1/1/2022.

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member, including participating in the care planning process, regardless of setting. This benefit is intended to provide primarily face-to-face services whenever possible.

Services should be offered where the members live, seek care or prefer to access services, essentially meeting the member (and, for children and youth, their family, caretaker or circle of support) where they are within the community. This may include different settings based on the target population. For example, for individuals experiencing homelessness, enhanced care management care managers may conduct street outreach or coordinate with shelters, hotels or motels including those participating in Project Homekey, homeless services providers, recuperative care providers, community partners (e.g., homeless coordinated entry systems) and other service providers to connect with target individuals in these settings. For individuals with SMI and/or SUDs, initial contact may be in settings such as psychiatric inpatient units, Institutions for Mental Disease (IMDs) or residential settings. Children and youth may receive services in a variety of community settings, including homes and schools, where appropriate. These are examples of how enhanced care management settings will reflect individualized needs of the target populations.

Risk Stratification

Enhanced care management is the highest tier of case management and is intended for members at the highest risk level who need long-term coordination for multiple chronic conditions, social determinants of health issues, and utilization of multiple service types and delivery systems. As part of their plan submitted to DHCS, Medi-Cal managed care plans will detail the algorithms, processes, and partnerships they will use to identify those individuals who have the highest levels of complex health care needs and social factors influencing their health, and who present the best opportunity for improved health outcomes through enhanced care management services.

Algorithms and data sources may vary by population. For example, some individuals may be identified using claims data and/or other health assessment information to identify multiple complex conditions or a history of utilization of high-cost services.

However, for a variety of reasons, claims data may be insufficient to identify other good candidates for enhanced care management. For some members, access to care issues and multiple social factors may limit the utility of claims data in identifying health risks. Therefore, managed care plans must also use data sources that capture social determinants of health as well as referrals. For individuals experiencing homelessness, data systems such as the Homeless Management Information System (HMIS) may be used. For individuals transitioning from incarceration, data sharing agreements with city and county jail systems to identify those at highest risk may be considered

For many populations, referrals and partnerships will be a critical method to identify enhanced care management candidates. Entities such as health care providers, community-based organizations, social services agencies, tribal partners, and local governments are important partners in identifying individuals who are at high risk of significant health care utilization and who would benefit from enhanced care management. Medi-Cal managed care plans are encouraged to partner with these entities to ensure enhanced care management benefits are highly coordinated with other service types. Medi-Cal managed care plans should also plan to establish clear protocols to receive and consider enhanced care management referrals from external entities.

Core Components of Enhanced Care Management Services

The types of supports and services provided through enhanced care management may vary based on the needs of the target populations. In the individual target population descriptions, this document describes examples of interventions that enhanced care management may support for each unique target population. However, core components of enhanced care management that are universal for all target populations include:

- Comprehensive Assessment and Care Management Plan:
    - Engage with Members authorized to receive the enhanced care management Benefit primarily through in person contact;
        - *When in-person communication is unavailable or does not meet the needs of the Member, use alternative methods to provide culturally appropriate and accessible communication.*
    - Develop a comprehensive, individualized, person-centered care plan by working with the Member, and as appropriate their chosen family/support persons, to assess strengths, risks, needs, goals, and preferences
    - Incorporate into the Member's care plan needs in the areas including, but not limited to physical and developmental health, mental health, SUD, community-based Long-Term Services and Supports (LTSS), oral health, palliative care, trauma-informed care, necessary community-based and social services, and housing;
    - Ensure the care plan is reassessed at a frequency appropriate for the Member's individual progress or changes in need.
- Enhanced Coordination of Care:
    - Organize patient care activities as laid out in the care plan, share information with the Member's key care team, and implement the Member's care plan;

- Be continuous and integrated among all service providers and refer to primary care/physical and developmental health, mental health, SUD treatment, community-based LTSS, oral health, palliative care, trauma-informed care, necessary community-based and social services, and, housing, as needed;
- Provide support for Member treatment adherence including coordination for medication review/reconciliation, scheduling appointments, providing appointment reminders, coordinating transportation, identifying barriers to adherence, ensuring continuous enrollment in Medi-Cal, and maintaining social services benefits, and accompaniment to key appointments;
- Communicate Members' needs and preferences timely to all members of the Members' care team in a manner that ensures safe, appropriate, and effective person-centered care;
- Be in regular contact with the Member, consistent with the care plan;

- Health Promotion:
  - Work with Members to identify and build on resiliencies and potential family or community supports;
  - Provide services to encourage and support Members to make lifestyle choices based on healthy behavior, with the goal of supporting Members' ability to successfully monitor and manage their health;
  - Support the Member in strengthening skills that enable them to identify and access resources to assist them in managing their conditions and preventing other chronic conditions.
- Comprehensive Transitional Care
  - Perform engagement activities that seek to reduce avoidable Member admissions and readmissions;
  - For Members that are experiencing or are likely to experience a care transition:
    - Develop and regularly update a transition plan for the Member, and incorporate it into the Member's care plan;
    - Evaluate a Member's medical care needs and coordination of any support services to facilitate safe and appropriate transitions from and among treatment facilities, including admissions and discharges;

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- Track each Member's admission or discharge to/from an emergency department, hospital inpatient facility, skilled nursing facility, residential/treatment facility, incarceration facility, or other treatment center and communicate with the appropriate care team members;
- Coordinate medication review/reconciliation; and
- Provide adherence support and referral to appropriate services.

- Member and Family Supports:
  - Document a Member's chosen caregiver or family/support person;
  - Include activities that ensure that the Member and chosen family/support persons, including as guardians and caregivers, are knowledgeable about the Member's condition(s) and care plan with the overall goal of improving the Member's care planning and follow-up, adherence to treatment, and medication management;
  - Serve as the primary point of contact for the Member and their chosen family/support persons;
  - Identify supports needed for the Member and chosen family/support persons to manage the Member's condition and direct them to access needed support services, including peer supports when applicable and available; and,
  - Provide for appropriate education of the Member, family members, guardians, and caregivers on care instructions for the Member.
- Coordination of and Referral to Community and Social Support Services:
  - Determine appropriate services to meet the needs of Members, including services that address social determinants of health needs, including housing, and services that are offered by managed care plan as an ILOS;
  - Coordinate and referring Members to available community resources and following up with Members to ensure services were rendered (i.e. "Closed loop referrals").

Target Populations

A description of each population is outlined below. Beneficiaries must be enrolled in Medi-Cal managed care to receive enhanced care management. In general, for all target populations, individuals who, after multiple outreach attempts, using different modalities, opt not to participate in enhanced care management services or whose assessment

(completed or confirmed by the managed care plan) indicates they would not benefit from the services, would not be good candidates for enhanced care management. The number of outreach attempts and approaches will vary based on the populations and individualized needs.

Enhanced care management is designed to provide support to individuals who require high levels of intensive interventions. Individuals who are receiving or who would benefit from other existing types of interventions (e.g., end of life care, standard case management, disease management or other care coordination efforts) would not be appropriate candidates for enhanced care management unless those interventions are not successful. Medi-Cal managed care plans and/or their subcontractors or contracted providers will evaluate individuals for enhanced care management and not all individuals will be good candidates. For example, individuals with the following circumstances may not be good candidates for enhanced care management:

- Individuals who have a well-treated chronic disease and are compliant with their care plan and have unavoidable or expected admissions due to the condition.
- Individuals who refuse to engage in any telephonic or face to face case management after multiple outreach attempts using different modalities.
- Individuals receiving services that the managed care plan determines to be duplicative of enhanced care management, such as 1915(c) Home and Community Based Services (HCBS) Waiver programs.

All Medi-Cal beneficiaries currently receiving care management through the Health Homes Program and Whole Person Care shall be transitioned to enhanced care management through one of the target populations listed and will be reassessed.

The populations eligible for enhanced care management are those with the highest needs who use multiple delivery systems and services, who need ongoing coordination across medical, behavioral and social needs, and who are part of the mandatory target populations described below. Note that some enhanced care management candidates will meet criteria for multiple target populations. Medi-Cal managed care plans will assign these individuals authorized to receive enhanced care management services to an enhanced care management provider that has appropriate competencies and experience for the needs of the beneficiary. For example, individuals with SMI or SUDs may also be homeless or high utilizers. These members may be assigned to an enhanced care management provider that has the necessary skills and experience to work with individuals with SMI and SUDs.

Children and Youth

Target Population:

Children and youth (up to age 21, or foster youth to age 26) with complex physical, behavioral, and/or developmental health needs, with significant functional limitations and social factors influencing their health outcomes (e.g., California Children Services, foster care, youth with Clinical High-Risk syndrome or first episode of psychosis).

For example:

- Children/Youth with complex health needs who are medically fragile or have multiple chronic conditions. This may include children with a history of trauma and children who are engaged or have history with the child welfare system. These children often access care across multiple service delivery systems and require significant coordination to ensure their needs are being met.

- Children/Youth with significant functional limitations and multiple social factors influencing their health outcomes.

Enhanced Care Management Services:

Enhanced care management can be used to assess gaps in both health care and social support needs and develop a care plan that addresses the whole health needs of the child. While Medi-Cal managed care plans may use claims data to identify good candidates, referrals will be an important mechanism to identify children and youth who would benefit from enhanced care management. Health care providers, the child welfare system, schools, community-based organizations, California Children's Services (CCS), county behavioral health, and social services agencies are examples of other important potential referral partners for children/youth. Medi-Cal managed care plans should establish a process for providers to refer for enhanced care management based on a needs assessment, behavioral health screens, other EPSDT screening, and/or ACE score which includes consideration of the community supports available for the children and their families and caretakers, as well as social factors impacting their health.

Services should be offered where the members live, seek care or where the family, caretaker, or circle of support prefers to access services, essentially meeting the member and family/caretaker/support where they are within the community. Activities may include coordination in school-based settings if permitted by the schools. Services should be offered by culturally and linguistically aligned trauma-informed providers.

For this population, enhanced care management services include (but are not limited to):

- Helping families, caretakers, and circles of support access resources such as information, coordination, and education about the child's conditions.
- Identifying coordinating, and providing (when appropriate) services that will help families, caretakers, and circles of support with the health needs of their children, which may include referrals for services those individuals need to enable them to support their children's health (e.g., referral to behavioral health, including SUD services, for a parent, or housing-related services for households experiencing homelessness, either of which could be critical to ensure the parent can support the health needs of the child).
- Referral to housing related services for youth experiencing homelessness.
- Coordination of services across various health, behavioral health, developmental disability, housing and social services providers, including facilitating cross-provider data- and information-sharing and member advocacy to ensure the child's whole person needs are met and needed services are accessible.
- Assistance with accessing respite care as needed.
- Referral to community and social services to address food insecurity and other social factors that may impact the child's health.
- Coordination of other services as required by EPSDT.
- Referral to community and social services to address food insecurity and other social factors that may impact the child's health

Homeless

Target Population:

Individuals experiencing homelessness or chronic homelessness, or who are at risk of experiencing homelessness (as defined below), with complex health and/or behavioral health needs, for whom coordination of services would likely result in improved health outcomes and decreased utilization of high-cost services.

For example:

- Individuals with complex health care needs as a result of medical, psychiatric or SUD-related conditions, who may also experience access to care issues (resulting in unmet needs or barriers to care) and multiple social factors influencing their health outcomes.
- Individuals with repeated incidents of avoidable justice involvement, emergency department use, psychiatric emergency services or hospitalizations.

Homeless: Individuals who meet the Housing and Urban Development (HUD) definition of homeless as defined in Section 91.5 of Title 24 of the Code of Federal Regulations (including those exiting institutions but not including any limits on the number of days in the institution). For the purpose of enhanced care management, qualifying institutions include hospitals, correctional facilities, mental health residential treatment facility, substance use disorder residential treatment facility, recovery residences, Institution for Mental Disease and State Hospitals.

Individuals who meet the definition of an individual experiencing chronic homelessness, either as defined:

A. In W&I Code section 14127(e) as “a homeless individual with a condition limiting his or her activities of daily living who has been continuously homeless for a year or more or had at least four episodes of homelessness in the past three years.” The definition also includes “an individual who is currently residing in transitional housing, as defined in Section 50675.2 of the Health and Safety Code, or who has been residing in permanent supportive housing as defined in Section 50675.14 of the Health and Safety Code for less than two years if the individual was chronically homeless prior to his or her residence.

B. By the Department of Housing and Urban Development (HUD) in 24 CFR 91.5 (including those exiting institutions but not including any limits on the number of days in the institution) as:

1. A ‘‘homeless individual with a disability,’’ as defined in section 401(9) of the McKinney-Vento Homeless Assistance Act (42 U.S.C. 11360(9)), who:

    i. Lives in a place not meant for human habitation, a safe haven, or in an emergency shelter; and

    ii. Has been homeless and living as described in paragraph (1) (i) of this definition continuously for at least 12 months or on at least 4 separate occasions in the last 3 years, as long as the combined occasions equal at least 12 months and each break in homelessness separating the occasions included at least 7 consecutive nights of not living as described in paragraph (1) (i). Stays in institutional care facilities will not constitute as a break in homelessness, but rather such stays are included in the 12-month total, as long as the individual was living or residing in a place not meant for human habitation, a safe haven, or an emergency shelter immediately before entering the institutional care facility;

2. An individual who has been residing in an institutional care facility, including a jail, substance use or mental health treatment facility, hospital, or other similar facility, and met all of the criteria in paragraph (1) of this definition, before entering that facility; or

3. A family with an adult head of household (or if there is no adult in the family, a minor head of household) who meets all of the criteria in paragraph (1) or (2) of this definition, including a family whose composition has fluctuated while the head of household has been homeless.

Individuals who meet the HUD definition of at risk of homelessness as defined in Section 91.5 of Title 24 of the Code of Federal Regulations as:

(1) An individual or family who:

(i) Has an annual income below 30 percent of median family income for the area, as determined by HUD;

(ii) Does not have sufficient resources or support networks, e.g., family, friends, faith-based or other social networks, immediately available to prevent them from moving to an emergency shelter or another place described in paragraph (1) of the “Homeless” definition in this section; and

(iii) Meets one of the following conditions:

(A) Has moved because of economic reasons two or more times during the 60 days immediately preceding the application for homelessness prevention assistance;

(B) Is living in the home of another because of economic hardship;

(C) Has been notified in writing that their right to occupy their current housing or living situation will be terminated within 21 days after the date of application for assistance;

(D) Lives in a hotel or motel and the cost of the hotel or motel stay is not paid by charitable organizations or by federal, State, or local government programs for low-income individuals;

(E) Lives in a single-room occupancy or efficiency apartment unit in which there reside more than two persons or lives in a larger housing unit in which there reside more than 1.5 people per room, as defined by the U.S. Census Bureau;

(F) Is exiting a publicly funded institution, or system of care (such as a health-care facility, a mental health facility, foster care or other youth facility, or correction program or institution); or

(G) Otherwise lives in housing that has characteristics associated with instability and an increased risk of homelessness, as identified in the recipient's approved consolidated plan;

(2) A child or youth who does not qualify as “homeless” under this section, but qualifies as “homeless” under section 387(3) of the Runaway and Homeless Youth Act (42 U.S.C. 5732a(3)), section 637(11) of the Head Start Act (42 U.S.C. 9832(11)), section 41403(6) of the Violence Against Women Act of 1994 (42 U.S.C. 14043e-2(6)), section 330(h)(5)(A) of the Public Health Service Act (42 U.S.C. 254b(h)(5)(A)), section 3(m) of the Food and Nutrition Act of 2008 (7 U.S.C. 2012(m)), or section 17(b)(15) of the Child Nutrition Act of 1966 (42 U.S.C. 1786(b)(15)); or

(3) A child or youth who does not qualify as “homeless” under this section, but qualifies as “homeless” under section 725(2) of the McKinney-Vento Homeless Assistance Act (42 U.S.C. 11434a(2)), and the parent(s) or guardian(s) of that child or youth if living with her or him.

Individuals who meet the State’s No Place Like Home definition for a person with SMI and/or SED “at risk of chronic homelessness,” which includes persons exiting institutions that were homeless prior to entering the institution and Transition-age youth with

significant barriers to housing stability, including one or more convictions and history of foster care or involvement with the juvenile justice system.

Enhanced Care Management Services:

Individuals experiencing or at risk of homelessness are among the highest-need individuals in Medi-Cal. They often lack access to necessities such as food and shelter that are critical to attaining health. Individuals often have high medical needs that are difficult to manage due to the social factors that influence the individual's health. This often results in high utilization of costly services such as emergency departments and inpatient settings.

Engagement for this population may include street outreach or coordinating with shelters, homeless services providers, recuperative care providers, community partners (e.g., homeless coordinated entry systems) and other service providers to connect with target individuals.[15] As individuals are connected to resources, the enhanced care management care coordinator will meet the member in the community or at provider locations.

Enhanced care management can be used to link individuals with a variety of services to meet their complex needs. This includes (but is not limited to):

- Utilizing housing-related in-lieu-of services (ILOS) to identify housing and prepare individuals to for securing and/or maintaining stable housing.
- Coordinating short-term post-hospitalization housing and recuperative care services as appropriate.
- Regular contact with members to ensure there are not gaps in the activities designed to address an individual's health and social service needs, and swiftly addressing those gaps to ensure progress towards regaining health and function continues.
- Coordinating and collaborating with various health and social services providers, including Regional Centers, including sharing data (as appropriate) to facilitate better-coordinated whole person care.
- Supporting member treatment adherence including scheduling appointments, appointment reminders, coordinating transportation, ensuring connection to

[15] These same entities will be important referral partners to identify potential enhanced care management candidates

public benefits, identifying barriers to adherence, and accompanying members to appointments as needed.

- Addressing barriers to housing stability by connecting member to housing, health, and social support resources.
- Utilize best practices for Member who are experiencing homelessness and who have complex health and/or behavioral health conditions including Housing First, Harm Reduction, Progressive Engagement, Motivational Interviewing, and Trauma Informed Care

High Utilizers

Target Population:

High utilizers are Members with multiple hospital admissions, OR multiple short-term skilled nursing facility stays, OR multiple emergency room visits that could be avoided with appropriate outpatient care or improved treatment adherence.

For example:

- Individuals that have impactable conditions or opportunities for interventions that have the potential to decrease inappropriate utilization or can be performed at an alternative location.
- Individuals with repeated incidents of avoidable emergency use, hospital admissions, or nursing facility placement. Individuals with multiple chronic or poorly managed conditions requiring intensive coordination, beyond telephonic intervention.
- Significant functional limitations and/or adverse social determinant of health that impede the ability of the individual to navigate their healthcare and other services.

Enhanced Care Management Services:

Enhanced care management will provide multiple opportunities to engage individuals by stratifying risk and need and developing care plans and strategic interventions to mitigate risk and help clients achieve improved health and well-being. Medi-Cal managed care plans will identify the algorithms they will use to identify individuals who are high utilizers of medical services. DHCS expects Medi-Cal managed care plans will rely on available healthcare research related to appropriate identification of high utilizers and will leverage the managed care plan utilization data to identify members that meet the respective criteria established by the managed care plans.

For this population enhanced care management may include, but is not limited to:

- Frequent follow up visits, culturally and linguistically appropriate education and care coordination activities to ensure the member's needs are being met where they are.
- Connection to culturally and linguistically appropriate community-based organizations, programs and resources that will meet the member's needs.
- Improving member engagement to improve adherence to the member's treatment plan, including through more culturally and linguistically aligned approaches toward member and provider education and tools on how to increase adherence.

- Medication review, reconciliation, assistance obtaining medications, and culturally and linguistically appropriate reinforcement with medication adherence.

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Risk for Institutionalization – Long Term Care

Target Population:

Individuals at risk for institutionalization, eligible for long-term care services. Medi-Cal beneficiaries who, in the absence of services and supports would otherwise require care for 90 consecutive days or more in an inpatient nursing facility (NF) would qualify.

Individuals must meet NF level of care criteria AND be able continue to live safely in the community with wrap around supports. \

Examples include, but are not limited to:

- Seniors and persons with disabilities who reside in the community but are at risk of being institutionalized.
- Individuals in need of increasing assistance with Activities of Daily Living (ADLs) and Instrumental Activities of Daily Living (IADLs).
- Possibly, individuals with changes to family or caregiver status.
- Possibly, individuals with medical or surgical setbacks resulting in a decrease in functional, cognitive, or psychological status.
- Possibly, individuals showing early signs of dementia with few or no natural supports.
- Possibly, individuals who are noncompliant with their prescribed medical regime.
- Possibly, individuals who are not appropriately engaged to take advantage of necessary health care services.
- Possibly, individuals who lack a family or community support system to assist in appropriate follow-up care at home.

Would not include:

- Individuals with complex needs but who are not at risk of institutionalization.

Enhanced Care Management Services:

Services include preventing skilled nursing admissions for individuals with an imminent need for nursing facility placement. For this population enhanced care management may include, but is not limited to:

- Assessment to determine natural supports available, risk factors, social determinants of health, and other factors to determine safety and feasibility of continued stay in the community. Assessments should be conducted face-to-face whenever possible.
- Connection to needed supportive services, including ILOS such as meals, environmental accessibility adaptations (home modifications), and personal care.
- Frequent follow up visits (including regular home visits), culturally and linguistically appropriate education and care coordination activities to ensure the member and family/caregiver needs are being met where they are.
- Connection to appropriate culturally and linguistically aligned community-based organizations, programs and resources that will meet the member's needs.
- Placement of wrap-around services to maintain the member in their current, community setting.
- Supporting member treatment adherence including scheduling appointments, appointment reminders, ensuring connection to public benefits, coordinating transportation, identifying barriers to adherence, and accompanying members to appointments as needed.

Nursing Facility Transition to Community

Target Population:

Individuals who are currently residing in a Nursing Facility (NF) but desire to return to living in the community. Transition from the NF to community is strictly voluntary. Individuals have the option to transition to the community when that can be done in a cost-effective manner. Individuals must be able to transition safely to the community.

Individuals must have an identified support network system and housing available to them. The support network system may consist of care providers, community-based organizations, family members, primary care physicians, home health agencies, members of the individual's medical team, licensed foster parent, or any other individual who is part of

the individual's circle of support. The individual's circle of support may consist of family members, legal representative/legally responsible adult, and any other person named by the individual.

Would not include:

- Individuals not interested in moving out of the institution.
- Individuals who are not medically appropriate to live in the community (high acuity).
- Individuals whose total projected costs outside the institution are greater than the cost of institutionalization.
- Individuals who do not have the supports to reside safely in the community.
- Individuals who would be at a high risk of re-institutionalization or experiencing homelessness.

Enhanced Care Management Services:

The care team will help individuals move safely between different care settings, such as entering or leaving a hospital or nursing facility and returning to their own home.

Services include facilitating nursing facility transition back into a homelike and community setting with the necessary wrap-around services, community supports, and natural supports when available.

Enhanced Care Manager care manager visits will occur face to face at the facility throughout the transition process. An in-person home visit will occur prior to the

individual's move to ensure the health and safety of the new residence. Post-transition individuals will then be visited in person at a determined schedule at their home or community placement.

SMI, SED and SUD Individuals at Risk for Institutionalization

Target Population:

Individuals who are at risk for institutionalization who have co-occurring chronic health conditions and:

- Serious Mental Illness (SMI, adults);
- Serious Emotional Disturbance (SED, children, and youth); or
- Substance Use Disorder (SUD).

Potential candidates include:

- Individuals who have the highest levels of complex health care needs as a result of psychiatric or SUD-related conditions with co-occurring chronic health conditions, who may also experience access to care issues and have multiple social factors influencing their health outcomes and as a result of these factors are at risk for institutionalization.
- Individuals with repeated incidents of emergency department use, psychiatric emergency services, psychiatric inpatient hospitalizations, including stays at psychiatric health facilities, or short-term skilled nursing facility stays who could be served in community-based settings with supports.

Enhanced Care Manager Services:

For individuals with SMI or SUD, or children and youth with SED, enhanced care management will coordinate across the delivery systems through which members access care. For these individuals, Medi-Cal managed care plans may pursue contracts with county behavioral health systems to perform enhanced care management activities, but this must include coordination of all available services including medical care, behavioral health and long-term services and supports. When managed care plans do not contract with county behavioral health, enhanced care management service providers for this population should have experience and competency in working with individuals with SMI and SUDs as well as a plan to adequately coordinate enhanced care management and behavioral health services and supports across the managed care plan and county behavioral health. Initial engagement may be in treatment settings such as psychiatric inpatient units, IMDs or residential settings.

For children and youth with SED, activities may include coordination in school-based settings if permitted by the schools.

Enhanced care management can be used to link individuals with a variety of services to meet their complex needs. Medi-Cal managed care plans should closely coordinate these

enhanced care management services and supports with county behavioral health to avoid duplication and ensure adequate communication and care coordination. This includes (but is not limited to):

- Provide post-hospitalization or post-residential medical treatment care planning to connect individuals with the supports they need to avoid rehospitalization including identifying appropriate culturally and linguistically appropriate community placements. These services should be provided in close coordination with county behavioral health plans when the hospitalization or residential treatment occurs due to mental illness or substance use disorder.

- Regular culturally and linguistically appropriate contact with members to ensure there are not gaps in the activities designed to avoid institutionalization or hospitalization and swiftly addressing those gaps to ensure the individual can remain in the community placement.

- Utilizing housing related ILOS to identify housing and prepare individuals for securing and/or maintaining stable housing, if needed, and connecting to other social services to address social factors that influence the individual's health outcomes.

- Supporting the members' behavioral health recovery goals with related improvements in physical and oral health and long-term services and supports.

- Connecting families, caretakers, and circles of support to resources regarding the member's conditions to assist them with providing support for the member's health/behavioral health.

- Coordinating and collaborating with various health, behavioral health, developmental disability, and social services providers including sharing data (as appropriate).

- Supporting member treatment adherence including scheduling appointments, appointment reminders, coordinating transportation, ensuring connection to public benefits, identifying barriers to adherence, and accompanying members to appointments as needed

Individuals Transitioning from Incarceration[16]

Target Population:

Individuals transitioning from incarceration, including justice-involved juveniles who have significant complex physical or behavioral health needs requiring immediate transition of services to the community. A Medi-Cal managed care plan may stratify eligibility based on populations that have multiple incarcerations, other institutionalizations and/or high utilization. Individuals must have been released from incarceration with the last 12 months.

In addition, this population includes individuals who are involved in pre- or post-booking diversion behavioral health and criminogenic treatment programs and therefore are at risk for incarceration and who could, through care coordination and service placement, have a treatment plan designed to avoid incarceration through the use of community-based care and services.

Enhanced Care Management Services:

Some individuals transitioning from incarceration have significant health and behavioral health care needs that require ongoing treatment in the community post-release. Individuals often also experience significant social factors that impact their ability to successfully manage their health/behavioral health conditions, such as lack of safe and stable housing and unemployment. Upon transition back to the community, individuals are required to coordinate a significant number of basic life needs and as a result often experience care disruptions, which result in deterioration of their conditions and increased use of emergency departments and inpatient settings. For some individuals, unmet health care needs can increase their likelihood of returning to incarceration; diversion programs are designed to address these needs and avoid incarceration.

For this target population, enhanced care management requires coordination with the state prison system and local corrections departments, including probation, courts and the local county jail system to both to identify/refer members and also to ensure connections to care once individuals are released from incarceration. Upon release, all individuals receiving ongoing behavioral health treatment (including treatment for SUD) should be referred to county behavioral health programs and managed care plans on an as needed basis. Medi-Cal managed care plans and county behavioral health programs should coordinate closely to better serve clients that receive services from both entities. Therefore, the enhanced care management care managers will need to coordinate and

[16] This target population must be included no later than 1/1/2023, except where such program already exists today through an existing WPC program, in which case this target group is mandatory as of 1/1/2022.

collaborate closely with county behavioral health departments, and potentially also with Medi-Cal managed care plans, for those individuals.

The initial enhanced care management engagement locations will depend on the collaborations that Medi-Cal managed care plans are able to build with local justice partners. At first, enhanced care management staff will begin work with individuals expected to transition from incarceration in the setting where they are incarcerated (or just outside that setting), or in criminogenic treatment programs.[17] Post-transition, enhanced care management care managers will engage individuals in the most easily accessible setting for the member. In addition to community-based engagement such as a member's home or regular provider office, this may also include parole or probation offices if the managed care plan builds partnerships that allow for engagement in those offices.

Enhanced care management can be used to link individuals transitioning from incarceration (or in diversion programs) with a variety of services to meet their complex needs. This includes (but is not limited to):

- Coordination of an initial risk assessment to evaluate medical, psychiatric, substance use and social needs for which the individual requires assistance.
- Direct connections with community providers to ensure continuity of care for their conditions (especially for medications) and to address any health care needs not treated while they were incarcerated. This will also include peer mentorship to help provide positive social support.
- Utilizing housing related ILOS to identify housing and prepare individuals for securing and/or maintaining stable housing.
- Regular contact with members to ensure there are not gaps in the activities designed to address an individual's health and social service needs, and swiftly addressing those gaps to prevent reincarceration and ensure progress towards regaining health and function continues.
- Screening and providing referrals for various health, developmental disabilities, mental health, substance use disorder and social service needs.

[17] DHCS is looking to leverage H.R. 6 SUPPORT Act to begin providing enhanced care management for individuals exiting from incarceration with known medical and behavioral health needs 30 days prior to release. enhanced care management dollars will not be able to be used to provide services directly to justice involved members prior to release

- Coordinating and collaborating with various health, behavioral health, and social services providers as well as parole/probation including sharing data (as appropriate) to facilitate better-coordinated whole person care.
- Supporting member treatment adherence including scheduling appointments, appointment reminders, coordinating transportation, ensuring connection to public benefits, identifying barriers to adherence, and accompanying members to appointments as needed.
- Helping members set and monitor health goals to maintain or improve their health.
- Providing culturally and linguistically appropriate education to families, caretakers, and circles of support regarding the member's health care needs and available supports.
- Navigating members to other reentry support providers to address unmet needs.
- Facilitating benefits reinstatement.[18]

[18] To complement these efforts, DHCS is proposing to mandate that all counties implement a county inmate pre-release Medi-Cal application process by January 1, 2023 The enhanced care management care manager would also help facilitate accessing other benefits as needed by the member.

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Enhanced Care Management Implementation Dates by County

Counties with Whole Person Care and/or Health Homes[19] (Begin implementation on 1/1/22)		Counties without Whole Person Care or Health Homes (Begin implementation on 7/1/22*)
Alameda	HHP, WPC	Alpine
Contra Costa	WPC	Amador
Imperial	HHP	Butte
Kern	HHP, WPC	Calaveras
Kings	WPC	Colusa
Los Angeles	HHP, WPC	Del Norte
Marin	WPC	El Dorado
Mendocino	WPC	Fresno
Monterey	WPC	Glenn
Napa	WPC	Humboldt
Orange	HHP, WPC	Inyo
Placer	WPC	Lake
Riverside	HHP, WPC	Lassen
Sacramento	HHP, WPC	Madera
San Bernardino	HHP, WPC	Mariposa
San Diego	HHP, WPC	Merced
San Francisco	HHP, WPC	Modoc
San Joaquin	WPC	Mono
San Mateo	WPC	Nevada
Santa Clara	HHP, WPC	Plumas
Santa Cruz	WPC	San Luis Obispo
Shasta	WPC	Santa Barbara
Sonoma	WPC	Sierra
Tulare	HHP	Siskiyou
Ventura	WPC	Solano
		Stanislaus
		Sutter
		Tehama
		Trinity
		Tuolumne
		Yolo
		Yuba

[19] List is subject to changed based on WPC pilots decisions to continue operating through 2021.

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Appendix J: In Lieu of Services Options

Following is the proposed menu of in lieu of services that would be covered under the CalAIM initiative. ILOS are optional for both the plan to offer and the beneficiary to accept. Individuals do not have to be enrolled in Enhanced Care Management to be eligible for in lieu of services. ECM target populations/ILOS Service definitions are subject to further refinement by DHCS.

Each set of services is described in detail below:

- Housing Transition Navigation Services
- Housing Deposits
- Housing Tenancy and Sustaining Services
- Short-term Post-Hospitalization Housing
- Recuperative Care (Medical Respite)
- Respite Services
- Day Habilitation Programs
- Nursing Facility Transition/Diversion to Assisted Living Facilities, such as Residential Care Facilities for Elderly (RCFE) and Adult Residential Facilities (ARF)
- Community Transition Services/Nursing Facility Transition to a Home
- Personal Care and Homemaker Services
- Environmental Accessibility Adaptations (Home Modifications)
- Meals/Medically Tailored Meals
- Sobering Centers
- Asthma Remediation

Housing Transition Navigation Services

Description/Overview

Housing transition services assist beneficiaries with obtaining housing and include:

1. Conducting a tenant screening and housing assessment that identifies the participant's preferences and barriers related to successful tenancy. The assessment may include collecting information on the participant's housing needs, potential housing transition barriers, and identification of housing retention barriers.
2. Developing an individualized housing support plan based upon the housing assessment that addresses identified barriers, includes short- and long-term measurable goals for each issue, establishes the participant's approach to meeting the goal, and identifies when other providers or services, both reimbursed and not reimbursed by Medi-Cal, may be required to meet the goal.
3. Searching for housing and presenting options.
4. Assisting in securing housing, including the completion of housing applications and securing required documentation (e.g., Social Security card, birth certificate, prior rental history).
5. Assisting with benefits advocacy, including assistance with obtaining identification and documentation for SSI eligibility and supporting the SSI application process. Such service can be subcontracted out to retain needed specialized skillset.
6. Identifying and securing available resources to assist with subsidizing rent (such as Section 8, state and local assistance programs etc.) and matching available rental subsidy resources to members.
7. If included in the housing support plan, identifying and securing resources to cover expenses, such as security deposit, moving costs, adaptive aids, environmental modifications, moving costs, and other one-time expenses. [20]
8. Assisting with requests for reasonable accommodation, if necessary.
9. Landlord education and engagement
10. Ensuring that the living environment is safe and ready for move-in.
11. Communicating and advocating on behalf of the client with landlords.

[20] Actual payment of these housing deposits and move-in expenses is a separate in-lieu service under Housing Deposits.

12. Assisting in arranging for and supporting the details of the move.
13. Establishing procedures and contacts to retain housing, including developing a housing support crisis plan that includes prevention and early intervention services when housing is jeopardized.[21]
14. Identifying, coordinating, securing, or funding non-emergency, non-medical transportation to assist members' mobility to ensure reasonable accommodations and access to housing options prior to transition and on move in day.
15. Identifying, coordinating, environmental modifications to install necessary accommodations for accessibility.

The services provided should be based on individualized assessment of needs and documented in the individualized housing support plan. Individuals may require and access only a subset of the services listed above.

The services provided should utilize best practices for clients who are experiencing homelessness and who have complex health, disability, and/or behavioral health conditions. Examples of best practices include Housing First Harm Reduction, Progressive Engagement, Motivational Interviewing, and Trauma Informed Care.

The services may involve additional coordination with other entities to ensure the individual has access to supports needed for successful tenancy such as County Health, Public Health, Substance Use, Mental Health and Social Services Departments; County and City Housing Authorities; Continuums of Care and Coordinated Entry System; local legal service programs, community-based organizations housing providers, local housing agencies and housing development agencies. For clients who will need rental subsidy support to secure permanent housing, the services will require close coordination with local Coordinated Entry Systems, homeless services authorities, public housing authorities, and other operators of local rental subsidies. Some housing assistance (including recovery residences and emergency assistance or rental subsidies for Full Service Partnership clients) is also funded by county behavioral health agencies, and Medi-Cal managed care plans and their contracted ILOS providers should expect to coordinate access to these housing resources through county behavioral health when appropriate.

Services do not include the provision of room and board or payment of rental costs. Coordination with local entities is crucial to ensure that available options for room and board or rental payments are also coordinated with housing services and supports.

Eligibility (Population Subset)

[21] The services associated with the crisis plan are a separate in-lieu service under Housing Tenancy and Sustaining Services.

- Individuals 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 with disabilities and/or one or more serious chronic conditions and/or serious mental illness, institutionalization or requiring residential services as a result of a substance use disorder and/or is exiting incarceration; or
- Individuals who meet the Housing and Urban Development (HUD) definition of homeless as defined in Section 91.5 of Title 24 of the Code of Federal Regulations (including those exiting institutions but not including any limits on the number of days in the institution) and who are receiving enhanced care management, or who have one or more serious chronic conditions and/or serious mental illness and/or is at risk of institutionalization or requiring residential services as a result of a substance use disorder. For the purpose of this service, qualifying institutions include hospitals, correctional facilities, mental health residential treatment facility, substance use disorder residential treatment facility, recovery residences, Institution for Mental Disease and State Hospitals; or
- Individuals who meet the definition of an individual experiencing chronic homelessness, either as defined:
    - In W&I Code section 14127(e) as “a homeless individual with a condition limiting his or her activities of daily living who has been continuously homeless for a year or more or had at least four episodes of homelessness in the past three years.” The definition also includes “an individual who is currently residing in transitional housing, as defined in Section 50675.2 of the Health and Safety Code, or who has been residing in permanent supportive housing as defined in Section 50675.14 of the Health and Safety Code for less than two years if the individual was chronically homeless prior to his or her residence.
    - By the Department of Housing and Urban Development (HUD) in 24 CFR 91.5 (including those exiting institutions but not including any limits on the number of days in the institution) as:
        - A ‘‘homeless individual with a disability,’’ as defined in section 401(9) of the McKinney-Vento Homeless Assistance Act (42 U.S.C. 11360(9)), who:
            a. Lives in a place not meant for human habitation, a safe haven, or in an emergency shelter; and
            b. Has been homeless and living as described in paragraph (1) (i) of this definition continuously for at least 12 months

or on at least 4 separate occasions in the last 3 years, as long as the combined occasions equal at least 12 months and each break in homelessness separating the occasions included at least 7 consecutive nights of not living as described in paragraph (1) (i). Stays in institutional care facilities will not constitute as a break in homelessness, but rather such stays are included in the 12-month total, as long as the individual was living or residing in a place not meant for human habitation, a safe haven, or an emergency shelter immediately before entering the institutional care facility; or

- An individual who has been residing in an institutional care facility, including a jail, substance use or mental health treatment facility, hospital, or other similar facility, and met all of the criteria in paragraph (1) of this definition, before entering that facility; or
- A family with an adult head of household (or if there is no adult in the family, a minor head of household) who meets all of the criteria in paragraph (1) or (2) of this definition, including a family whose composition has fluctuated while the head of household has been homeless; or

- Individuals who meet the HUD definition of at risk of homelessness as defined in Section 91.5 of Title 24 of the Code of Federal Regulations as:
    - (1) An individual or family who:
        - Has an annual income below 30 percent of median family income for the area, as determined by HUD;
        - Does not have sufficient resources or support networks, e.g., family, friends, faith-based or other social networks, immediately available to prevent them from moving to an emergency shelter or another place described in paragraph (1) of the "Homeless" definition in this section; and
            - Meets one of the following conditions:
                - Has moved because of economic reasons two or more times during the 60 days immediately preceding the application for homelessness prevention assistance;
                - Is living in the home of another because of economic hardship;
                - Has been notified in writing that their right to occupy their current housing or living situation will be

terminated within 21 days after the date of application for assistance;
- Lives in a hotel or motel and the cost of the hotel or motel stay is not paid by charitable organizations or by federal, State, or local government programs for low-income individuals;
- Lives in a single-room occupancy or efficiency apartment unit in which there reside more than two persons or lives in a larger housing unit in which there reside more than 1.5 people per room, as defined by the U.S. Census Bureau;
- Is exiting a publicly funded institution, or system of care (such as a health-care facility, a mental health facility, foster care or other youth facility, or correction program or institution); or
- Otherwise lives in housing that has characteristics associated with instability and an increased risk of homelessness, as identified in the recipient's approved consolidated plan;

  - (2) A child or youth who does not qualify as "homeless" under this section, but qualifies as "homeless" under section 387(3) of the Runaway and Homeless Youth Act (42 U.S.C. 5732a(3)), section 637(11) of the Head Start Act (42 U.S.C. 9832(11)), section 41403(6) of the Violence Against Women Act of 1994 (42 U.S.C. 14043e-2(6)), section 330(h)(5)(A) of the Public Health Service Act (42 U.S.C. 254b(h)(5)(A)), section 3(m) of the Food and Nutrition Act of 2008 (7 U.S.C. 2012(m)), or section 17(b)(15) of the Child Nutrition Act of 1966 (42 U.S.C. 1786(b)(15)); or
  - (3) A child or youth who does not qualify as "homeless" under this section, but qualifies as "homeless" under section 725(2) of the McKinney-Vento Homeless Assistance Act (42 U.S.C. 11434a(2)), and the parent(s) or guardian(s) of that child or youth if living with her or him; or

- Individuals who are determined to be at risk of experiencing homelessness are eligible to receive Housing Transition Navigation services if they have significant barriers to housing stability and meet at least one of the following:
  - Have one or more serious chronic conditions;
  - Have a Serious Mental Illness;
  - Are at risk of institutionalization or overdose or are requiring residential services because of a substance use disorder
  - Have a Serious Emotional Disturbance (children and adolescents);
  - Are receiving Enhanced Care Management; or
  - Are a Transition-Age Youth 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, and/or have a serious mental illness and/or a child or adolescent with serious emotional disturbance and/or who have been victims of trafficking, or

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- Individuals who meet the State's No Place Like Home definition of "at risk of chronic homelessness", which includes persons exiting institutions that were homeless prior to entering the institution and Transition-age youth with significant barriers to housing stability, including one or more convictions and history of foster care or involvement with the juvenile justice system.

Restrictions and Limitations

In lieu of services are alternative services covered under the Medi-Cal State Plan but are delivered by a different provider or in a different setting than is described in the State Plan. In lieu of services can only be covered if: 1) the State determines they are medically-appropriate and cost-effective substitutes or settings for the State Plan service, 2) beneficiaries are not required to use the in lieu of services and 3) the in lieu of services are authorized and identified in the managed care plan contracts.

Housing Transition/Navigation services must be identified as reasonable and necessary in the individual's individualized housing support plan.

Individuals may not be receiving duplicative support from other State, local tax or federally funded programs, which should always be considered first, before using Medi-Cal funding.

Licensing/Allowable Providers

Providers must have experience and expertise with providing these unique services in a culturally and linguistically appropriate manner. This list is provided as an example of the types of providers Medi-Cal managed care plans may choose to contract with, but it is not an exhaustive list of providers who may offer the services.

Providers must have demonstrated experience with providing housing-related services and supports and may include providers such as:

- Vocational services agencies;
- Providers of services for individuals experiencing homelessness;
- Life skills training and education providers;
- County agencies;
- Public hospital systems;
- Mental health or substance use disorder treatment providers, including county behavioral health agencies;
- Social services agencies;

- Affordable housing providers;
- Supportive housing providers; and
- Federally qualified health centers and rural health clinics.

Medi-Cal managed care plan network providers that have a state-level enrollment pathway must enroll in the Medi-Cal program (See Credentialing/Recredentialing and Screening/Enrollment APL 19-004) if an enrollment pathway exists, through the recognized enrollment process developed by another managed care plan, or, if applicable, through a state-level enrollment pathway established by another state department. Regardless of whether the providers are enrolled in Medi-Cal, Medi-Cal managed care plans must credential the providers as required by DHCS.

Clients who meet the eligibility requirements for Housing Transition/Navigation services should also be assessed for enhanced care management and Housing and Tenancy Support Services (if provided in their county). When enrolled in enhanced care management, in lieu of services should be managed in coordination with enhanced care management providers. When clients receive more than one of these services, the managed care plan should ensure it is coordinated by an enhanced care management provider whenever possible to minimize the number of care/case management transitions experienced by clients and to improve overall care coordination and management.[22]

If the Medi-Cal managed care plan case manager, care coordinator or housing navigator is providing the service, that individual must have demonstrated experience working with individuals experiencing homelessness or with the provision of housing-related services and supports to vulnerable populations.

State Plan Service(s) To Be Avoided

Examples of State Plan services to be avoided include but are not limited to inpatient and outpatient Hospital services, emergency department services, emergency transport services, and skilled nursing facility services.

[22] One exception to this is for benefits advocacy, which may require providers with a specialized skill set.

Housing Deposits

Description/Overview

Housing Deposits assist with identifying, coordinating, securing, or funding one-time services and modifications necessary to enable a person to establish a basic household that do not constitute room and board, such as:

1. Security deposits required to obtain a lease on an apartment or home.
2. Set-up fees/deposits for utilities or service access and utility arrearages.
3. First month coverage of utilities, including but not limited to telephone, gas, electricity, heating, and water.
4. First month's and last month's rent as required by landlord for occupancy.
5. Services necessary for the individual's health and safety, such as pest eradication and one-time cleaning prior to occupancy.
6. Goods such as an air conditioner or heater, and other medically-necessary adaptive aids and services, designed to preserve an individuals' health and safety in the home such as hospital beds, Hoyer lifts, air filters, specialized cleaning or pest control supplies etc., that are necessary to ensure access and safety for the individual upon move-in to the home.

The services provided should be based on individualized assessment of needs and documented in the individualized housing support plan. Individuals may require, and access only a subset of the services listed above.

The services provided should utilize best practices for clients who are experiencing homelessness and who have complex health, disability, and/or behavioral health conditions including Housing First, Harm Reduction, Progressive Engagement, Motivational Interviewing, and Trauma Informed Care.

Services do not include the provision of room and board or payment of ongoing rental costs beyond the first and last month's coverage as noted above.

Eligibility (Population Subset)

- Any individual who received Housing Transition/Navigation Services ILOS in counties that offer Housing Transition/Navigation Services.
- Individuals 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 with

disabilities and/or one or more serious chronic conditions and/or serious mental illness, institutionalization or requiring residential services as a result of a substance use disorder and/or is exiting incarceration; or

- Individuals who meet the Housing and Urban Development (HUD) definition of homeless as defined in Section 91.5 of Title 24 of the Code of Federal Regulations (including those exiting institutions but not including any limits on the number of days in the institution) and who are receiving enhanced care management, or who have one or more serious chronic conditions and/or serious mental illness and/or is at risk of institutionalization or requiring residential services as a result of a substance use disorder. For the purpose of this service, qualifying institutions include hospitals, correctional facilities, mental health residential treatment facility, substance use disorder residential treatment facility, recovery residences, Institution for Mental Disease and State Hospitals; or

- Individuals who meet the definition of an individual experiencing chronic homelessness, either as defined:
    - In W&I Code section 14127(e) as "a homeless individual with a condition limiting his or her activities of daily living who has been continuously homeless for a year or more or had at least four episodes of homelessness in the past three years." The definition also includes "an individual who is currently residing in transitional housing, as defined in Section 50675.2 of the Health and Safety Code, or who has been residing in permanent supportive housing as defined in Section 50675.14 of the Health and Safety Code for less than two years if the individual was chronically homeless prior to his or her residence.
    - By the Department of Housing and Urban Development (HUD) in 24 CFR 91.5 (including those exiting institutions but not including any limits on the number of days in the institution) as:
        - A ''homeless individual with a disability,'' as defined in section 401(9) of the McKinney-Vento Homeless Assistance Act (42 U.S.C. 11360(9)), who:
            c. Lives in a place not meant for human habitation, a safe haven, or in an emergency shelter; and
            d. Has been homeless and living as described in paragraph (1) (i) of this definition continuously for at least 12 months or on at least 4 separate occasions in the last 3 years, as long as the combined occasions equal at least 12 months and each break in homelessness separating the occasions

included at least 7 consecutive nights of not living as described in paragraph (1) (i). Stays in institutional care facilities will not constitute as a break in homelessness, but rather such stays are included in the 12-month total, as long as the individual was living or residing in a place not meant for human habitation, a safe haven, or an emergency shelter immediately before entering the institutional care facility; or

- An individual who has been residing in an institutional care facility, including a jail, substance use or mental health treatment facility, hospital, or other similar facility, and met all of the criteria in paragraph (1) of this definition, before entering that facility; or
- A family with an adult head of household (or if there is no adult in the family, a minor head of household) who meets all of the criteria in paragraph (1) or (2) of this definition, including a family whose composition has fluctuated while the head of household has been homeless; or

- Individuals who meet the HUD definition of at risk of homelessness as defined in Section 91.5 of Title 24 of the Code of Federal Regulations as:
    - (1) An individual or family who:
        - Has an annual income below 30 percent of median family income for the area, as determined by HUD;
        - Does not have sufficient resources or support networks, e.g., family, friends, faith-based or other social networks, immediately available to prevent them from moving to an emergency shelter or another place described in paragraph (1) of the “Homeless” definition in this section; and
            - Meets one of the following conditions:
                - Has moved because of economic reasons two or more times during the 60 days immediately preceding the application for homelessness prevention assistance;
                - Is living in the home of another because of economic hardship;
                - Has been notified in writing that their right to occupy their current housing or living situation will be terminated within 21 days after the date of application for assistance;

        - Lives in a hotel or motel and the cost of the hotel or motel stay is not paid by charitable organizations or by federal, State, or local government programs for low-income individuals;
        - Lives in a single-room occupancy or efficiency apartment unit in which there reside more than two persons or lives in a larger housing unit in which there reside more than 1.5 people per room, as defined by the U.S. Census Bureau;
        - Is exiting a publicly funded institution, or system of care (such as a health-care facility, a mental health facility, foster care or other youth facility, or correction program or institution); or
        - Otherwise lives in housing that has characteristics associated with instability and an increased risk of homelessness, as identified in the recipient's approved consolidated plan;
    - (2) A child or youth who does not qualify as "homeless" under this section, but qualifies as "homeless" under section 387(3) of the Runaway and Homeless Youth Act (42 U.S.C. 5732a(3)), section 637(11) of the Head Start Act (42 U.S.C. 9832(11)), section 41403(6) of the Violence Against Women Act of 1994 (42 U.S.C. 14043e-2(6)), section 330(h)(5)(A) of the Public Health Service Act (42 U.S.C. 254b(h)(5)(A)), section 3(m) of the Food and Nutrition Act of 2008 (7 U.S.C. 2012(m)), or section 17(b)(15) of the Child Nutrition Act of 1966 (42 U.S.C. 1786(b)(15)); or
    - (3) A child or youth who does not qualify as "homeless" under this section, but qualifies as "homeless" under section 725(2) of the McKinney-Vento Homeless Assistance Act (42 U.S.C. 11434a(2)), and the parent(s) or guardian(s) of that child or youth if living with her or him; or
- Individuals who are determined to be at risk of experiencing homelessness are eligible to receive Housing Transition Navigation services if they have significant barriers to housing stability and meet at least one of the following:
    - Have one or more serious chronic conditions;
    - Have a Serious Mental Illness;
    - Are at risk of institutionalization or overdose or are requiring residential services because of a substance use disorder
    - Have a Serious Emotional Disturbance (children and adolescents);
    - Are receiving Enhanced Care Management; or
    - Are a Transition-Age Youth 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, and/or have a serious mental illness and/or a child or adolescent with serious emotional disturbance and/or who have been victims of trafficking, or

- Individuals who meet the State's No Place Like Home definition of "at risk of chronic homelessness", which includes persons exiting institutions that were homeless prior to entering the institution and Transition-age youth with significant barriers to housing stability, including one or more convictions and history of foster care or involvement with the juvenile justice system.

Restrictions and Limitations

In lieu of services are alternative services covered under the State plan but are delivered by a different provider or in a different setting than is described in the State plan. In lieu of service can only be covered if: 1) the State determines they are medically-appropriate and a cost-effective substitutes or settings for the State plan service, 2) beneficiaries are not required to use the in lieu of service and 3) the in lieu of service is authorized and identified in the Medi-Cal managed care plan contracts.

Housing Deposits are available once in an individual's lifetime. Housing Deposits can only be approved one additional time with documentation as to what conditions have changed to demonstrate why providing Housing Deposits would be more successful on the second attempt. Plans are expected to make a good faith effort to review information available to them to determine if individual has previously received services.

These services must be identified as reasonable and necessary in the individual's individualized housing support plan and are available only when the enrollee is unable to meet such expense.

Individuals must also receive Housing Transition/Navigation services (at a minimum, the associated tenant screening, housing assessment and individualized housing support plan) in conjunction with this service.

Individuals may not be receiving duplicative support from other State, local or federally funded programs, which should always be considered first, before using Medi-Cal funding.

Licensing and Allowable Providers

Providers must have experience and expertise with providing these unique services in a culturally and linguistically appropriate manner. This list is provided as an example of the types of providers Medi-Cal managed care plans may choose to contract with, but it is not an exhaustive list of providers who may offer the services.

The entity that is coordinating an individual's Housing Transition Navigation Services, or the Medi-Cal managed care plan case manager, care coordinator or housing navigator may coordinate these services and pay for them directly (e.g., to the landlord, utility company, pest control company, etc.) or subcontract the services.

Providers must have demonstrated or verifiable experience and expertise with providing these unique services.

Medi-cal managed care plan network providers that have a state-level enrollment pathway must enroll in the Medi-Cal program. If there is no state-level enrollment pathway, managed care plans must enroll providers through their own established enrollment process, through the recognized enrollment process developed by another managed care plan, or, if applicable, through a state-level enrollment pathway established by another state department. Regardless of whether the providers are enrolled in Medi-Cal, managed care plans must credential the providers as required by DHCS.

State Plan Service(s) To Be Avoided

Examples of State Plan services to be avoided include but are not limited to inpatient and outpatient hospital services, emergency department services, emergency transport services, skilled nursing facility services.

Housing Tenancy and Sustaining Services

Description/Overview

This service provides tenancy and sustaining services, with a goal of maintaining safe and stable tenancy once housing is secured.

Services include:

1. Providing early identification and intervention for behaviors that may jeopardize housing, such as late rental payment, hoarding, substance use, and other lease violations.
2. Education and training on the role, rights and responsibilities of the tenant and landlord.
3. Coaching on developing and maintaining key relationships with landlords/property managers with a goal of fostering successful tenancy.
4. Coordination with the landlord and case management provider to address identified issues that could impact housing stability.
5. Assistance in resolving disputes with landlords and/or neighbors to reduce risk of eviction or other adverse action including developing a repayment plan or identifying funding in situations in which the client owes back rent or payment for damage to the unit.
6. Advocacy and linkage with community resources to prevent eviction when housing is or may potentially become jeopardized.
7. Assisting with benefits advocacy, including assistance with obtaining identification and documentation for SSI eligibility and supporting the SSI application process. Such service can be subcontracted out to retain needed specialized skillset.
8. Assistance with the annual housing recertification process.
9. Coordinating with the tenant to review, update and modify their housing support and crisis plan on a regular basis to reflect current needs and address existing or recurring housing retention barriers.
10. Continuing assistance with lease compliance, including ongoing support with activities related to household management.
11. Health and safety visits, including unit habitability inspections.
12. Other prevention and early intervention services identified in the crisis plan that are activated when housing is jeopardized (e.g., assisting with reasonable accommodation requests that were not initially required upon move-in).

13. Providing independent living and life skills including assistance with and training on budgeting, including financial literacy and connection to community resources.

The services provided should be based on individualized assessment of needs and documented in the individualized housing support plan. Individuals may require and access only a subset of the services listed above.

The services provided should utilize best practices for clients who are experiencing homelessness and who have complex health, disability, and/or behavioral health conditions including Housing First, Harm Reduction, Progressive Engagement, Motivational Interviewing, and Trauma Informed Care.

The services may involve coordination with other entities to ensure the individual has access to supports needed to maintain successful tenancy.

Services do not include the provision of room and board or payment of rental costs. Please see housing deposits ILOS.

Eligibility (Population Subset)

- Any individual who received Housing Transition/Navigation Services ILOS in counties that offer Housing Transition/Navigation Services.
- Individuals 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 with disabilities and/or one or more serious chronic conditions and/or serious mental illness, institutionalization or requiring residential services as a result of a substance use disorder and/or is exiting incarceration; or
- Individuals who meet the Housing and Urban Development (HUD) definition of homeless as defined in Section 91.5 of Title 24 of the Code of Federal Regulations (including those exiting institutions but not including any limits on the number of days in the institution) and who are receiving enhanced care management, or who have one or more serious chronic conditions and/or serious mental illness and/or is at risk of institutionalization or requiring residential services as a result of a substance use disorder. For the purpose of this service, qualifying institutions include hospitals, correctional facilities, mental health residential treatment facility, substance use disorder residential treatment facility, recovery residences, Institution for Mental Disease and State Hospitals; or
- Individuals who meet the definition of an individual experiencing chronic homelessness, either as defined:

- In W&I Code section 14127(e) as "a homeless individual with a condition limiting his or her activities of daily living who has been continuously homeless for a year or more or had at least four episodes of homelessness in the past three years." The definition also includes "an individual who is currently residing in transitional housing, as defined in Section 50675.2 of the Health and Safety Code, or who has been residing in permanent supportive housing as defined in Section 50675.14 of the Health and Safety Code for less than two years if the individual was chronically homeless prior to his or her residence.
- By the Department of Housing and Urban Development (HUD) in 24 CFR 91.5 (including those exiting institutions but not including any limits on the number of days in the institution) as:
    - A ''homeless individual with a disability,'' as defined in section 401(9) of the McKinney-Vento Homeless Assistance Act (42 U.S.C. 11360(9)), who:
        e. Lives in a place not meant for human habitation, a safe haven, or in an emergency shelter; and
        f. Has been homeless and living as described in paragraph (1) (i) of this definition continuously for at least 12 months or on at least 4 separate occasions in the last 3 years, as long as the combined occasions equal at least 12 months and each break in homelessness separating the occasions included at least 7 consecutive nights of not living as described in paragraph (1) (i). Stays in institutional care facilities will not constitute as a break in homelessness, but rather such stays are included in the 12-month total, as long as the individual was living or residing in a place not meant for human habitation, a safe haven, or an emergency shelter immediately before entering the institutional care facility; or
    - An individual who has been residing in an institutional care facility, including a jail, substance use or mental health treatment facility, hospital, or other similar facility, and met all of the criteria in paragraph (1) of this definition, before entering that facility; or
    - A family with an adult head of household (or if there is no adult in the family, a minor head of household) who meets all of the criteria in paragraph (1) or (2) of this definition, including a family whose

composition has fluctuated while the head of household has been homeless; or

- Individuals who meet the HUD definition of at risk of homelessness as defined in Section 91.5 of Title 24 of the Code of Federal Regulations as:
    - (1) An individual or family who:
        - Has an annual income below 30 percent of median family income for the area, as determined by HUD;
        - Does not have sufficient resources or support networks, e.g., family, friends, faith-based or other social networks, immediately available to prevent them from moving to an emergency shelter or another place described in paragraph (1) of the "Homeless" definition in this section; and
            - Meets one of the following conditions:
                - Has moved because of economic reasons two or more times during the 60 days immediately preceding the application for homelessness prevention assistance;
                - Is living in the home of another because of economic hardship;
                - Has been notified in writing that their right to occupy their current housing or living situation will be terminated within 21 days after the date of application for assistance;
        - Lives in a hotel or motel and the cost of the hotel or motel stay is not paid by charitable organizations or by federal, State, or local government programs for low-income individuals;
        - Lives in a single-room occupancy or efficiency apartment unit in which there reside more than two persons or lives in a larger housing unit in which there reside more than 1.5 people per room, as defined by the U.S. Census Bureau;
        - Is exiting a publicly funded institution, or system of care (such as a health-care facility, a mental health facility, foster care or other youth facility, or correction program or institution); or
        - Otherwise lives in housing that has characteristics associated with instability and an increased risk of homelessness, as identified in the recipient's approved consolidated plan;
    - (2) A child or youth who does not qualify as "homeless" under this section, but qualifies as "homeless" under section 387(3) of the Runaway and Homeless Youth Act (42 U.S.C. 5732a(3)), section 637(11) of the Head Start Act (42 U.S.C. 9832(11)), section 41403(6) of the Violence Against Women Act of 1994 (42 U.S.C. 14043e-2(6)), section 330(h)(5)(A) of the Public Health Service Act (42 U.S.C.

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254b(h)(5)(A)), section 3(m) of the Food and Nutrition Act of 2008 (7 U.S.C. 2012(m)), or section 17(b)(15) of the Child Nutrition Act of 1966 (42 U.S.C. 1786(b)(15)); or
    - (3) A child or youth who does not qualify as "homeless" under this section, but qualifies as "homeless" under section 725(2) of the McKinney-Vento Homeless Assistance Act (42 U.S.C. 11434a(2)), and the parent(s) or guardian(s) of that child or youth if living with her or him; or
- Individuals who are determined to be at risk of experiencing homelessness are eligible to receive Housing Transition Navigation services if they have significant barriers to housing stability and meet at least one of the following:
    - Have one or more serious chronic conditions;
    - Have a Serious Mental Illness;
    - Are at risk of institutionalization or overdose or are requiring residential services because of a substance use disorder
    - Have a Serious Emotional Disturbance (children and adolescents);
    - Are receiving Enhanced Care Management; or
    - Are a Transition-Age Youth 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, and/or have a serious mental illness and/or a child or adolescent with serious emotional disturbance and/or who have been victims of trafficking, or

- Individuals who meet the State's No Place Like Home definition of "at risk of chronic homelessness", which includes persons exiting institutions that were homeless prior to entering the institution and Transition-age youth with significant barriers to housing stability, including one or more convictions and history of foster care or involvement with the juvenile justice system.

Restrictions/Limitations

In lieu of services are alternative services covered under the State Plan but are delivered by a different provider or in a different setting than is described in the State Plan. In lieu of services can only be covered if: 1) the State determines they are medically appropriate and cost-effective substitutes or settings for the State Plan service 2) beneficiaries are not required to use the in lieu of services, and 3) the in lieu of services is authorized and identified in the Medi-Cal managed care plan contracts.

These services are available from the initiation of services through the time when the individual's housing support plan determines they are no longer needed. They are only available for a single duration in the individual's lifetime. Housing Tenancy and Sustaining Services can only be approved one additional time with documentation as to what

conditions have changed to demonstrate why providing Housing Tenancy and Sustaining Services would be more successful on the second attempt. Plans are expected to make a good faith effort to review information available to them to determine if individual has previously received services.

These services must be identified as reasonable and necessary in the individual's individualized housing support plan and are available only when the enrollee is unable to successfully maintain longer-term housing without such assistance.

Many individuals will have also received Housing Transition/Navigation services (at a minimum, the associated tenant screening, housing assessment and individualized housing support plan) in conjunction with this service but it is not a requirement.

Individuals may not be receiving duplicative support from other State, local or federally funded programs, which should always be considered first, before using Medi-Cal funding.

Licensing/Allowable Providers

Providers must have experience and expertise with providing these unique services in a culturally and linguistically appropriate manner. This list is provided as an example of the types of providers Medi-Cal managed care plans may choose to contract with, but it is not an exhaustive list of providers who may offer the services.

Providers must have demonstrated or verifiable experience or expertise with providing housing-related services and supports and may include providers such as:

- Vocational services agencies
- Providers of services for individuals experiencing homelessness
- Life skills training and education providers
- County agencies
- Public hospital systems
- Mental health or substance use disorder treatment providers, including county behavioral health agencies
- Supportive housing providers
- Federally qualified health centers and rural health clinics

Medi-cal managed care plan network providers that have a state-level enrollment pathway must enroll in the Medi-Cal program. If there is no state-level enrollment pathway, managed care plans must enroll providers through their own established

enrollment process, through the recognized enrollment process developed by another managed care plan, or, if applicable, through a state-level enrollment pathway established by another state department. Regardless of whether the providers are enrolled in Medi-Cal, managed care plans must credential the providers as required by DHCS.

If the Medi-Cal managed care plan case manager, care coordinator or housing navigator is providing the service, that individual must have demonstrated experiencing working with individuals experiencing homelessness or with the provision of housing-related services and supports to vulnerable populations. Medi-Cal managed care plans should coordinate with county homelessness entities to provide these services.

Clients who meet the eligibility requirements for Housing and Tenancy Support Services should also be assessed for enhanced care management and may have received Housing Transition/Navigation services (if provided in their county). When enrolled in enhanced care management, in lieu of services should be managed in coordination with enhanced care management providers. When clients receive more than one of these services, the managed care plan should ensure it is coordinated by an enhanced care management provider whenever possible to minimize the number of care/case management transitions experienced by clients and to improve overall care coordination and management.

State Plan Service(s) To Be Avoided

Examples of State Plan services to be avoided include but are not limited to inpatient and outpatient hospital services, emergency department services, emergency transport services, skilled nursing facility services.

Short-term Post-Hospitalization Housing

Description/Overview

Short-Term Post-Hospitalization housing provides beneficiaries who do not have a residence and who have high medical or behavioral health needs with the opportunity to continue their medical/psychiatric/substance use disorder recovery immediately after exiting an inpatient hospital (either acute or psychiatric or Chemical Dependency and Recovery hospital), residential substance use disorder treatment or recovery facility, residential mental health treatment facility, correctional facility, nursing facility, or recuperative care.[23]

This setting provides individuals with ongoing supports necessary for recuperation and recovery such as gaining (or regaining) the ability to perform activities of daily living, receiving necessary medical/psychiatric/substance use disorder care, case management and beginning to access other housing supports such as Housing Transition Navigation.[24]

This setting may include an individual or shared interim housing setting, where residents receive the services described above.

Beneficiaries must be offered Housing Transition Navigation supports during the period of Short-Term Post-Hospitalization housing to prepare them for transition from this setting. These services should include a housing assessment and the development of individualized housing support plan to identify preferences and barriers related to successful housing tenancy after Short-Term Post-Hospitalization housing.[25]

The services provided should utilize best practices for clients who are experiencing homelessness and who have complex health, disability, and/or behavioral health conditions including Housing First, Harm Reduction, Progressive Engagement, Motivational Interviewing, and Trauma Informed Care.

Eligibility (Population Subset)

- Individuals exiting recuperative care.
- Individuals exiting an inpatient hospital stay (either acute or psychiatric or Chemical Dependency and Recovery hospital), residential substance use disorder

[23] Up to 90 days of recuperative care is available under specified circumstances as a separate in-lieu service.
[24] Housing Transition/Navigation is a separate in-lieu service.
[25] The development of a housing assessment and individualized support plan are covered as a separate in-lieu service under Housing Transition/Navigation Services.

treatment or recovery facility, residential mental health treatment facility, correctional facility, or nursing facility and who meet any of the following criteria:

- Individuals who meet the Housing and Urban Development (HUD) definition of homeless as defined in Section 91.5 of Title 24 of the Code of Federal Regulations (including those exiting institutions but not including any limits on the number of days in the institution) and who are receiving enhanced care management, or who have one or more serious chronic conditions and/or serious mental illness and/or is at risk of institutionalization or requiring residential services as a result of a substance use disorder. For the purpose of this service, qualifying institutions include hospitals, correctional facilities, mental health residential treatment facility, substance use disorder residential treatment facility, recovery residences, Institution for Mental Disease and State Hospitals; or

- Individuals who meet the definition of an individual experiencing chronic homelessness, either as defined:
    - In W&I Code section 14127(e) as "a homeless individual with a condition limiting his or her activities of daily living who has been continuously homeless for a year or more or had at least four episodes of homelessness in the past three years." The definition also includes "an individual who is currently residing in transitional housing, as defined in Section 50675.2 of the Health and Safety Code, or who has been residing in permanent supportive housing as defined in Section 50675.14 of the Health and Safety Code for less than two years if the individual was chronically homeless prior to his or her residence.
    - By the Department of Housing and Urban Development (HUD) in 24 CFR 91.5 (including those exiting institutions but not including any limits on the number of days in the institution) as:
        - A ''homeless individual with a disability,'' as defined in section 401(9) of the McKinney-Vento Homeless Assistance Act (42 U.S.C. 11360(9)), who:
            g. Lives in a place not meant for human habitation, a safe haven, or in an emergency shelter; and

            h. Has been homeless and living as described in paragraph (1) (i) of this definition continuously for at least 12 months or on at least 4 separate occasions in the last 3 years, as long as the combined occasions equal at least 12 months and each break in homelessness separating the occasions included at least 7 consecutive nights of not living as

described in paragraph (1) (i). Stays in institutional care facilities will not constitute as a break in homelessness, but rather such stays are included in the 12-month total, as long as the individual was living or residing in a place not meant for human habitation, a safe haven, or an emergency shelter immediately before entering the institutional care facility; or

- An individual who has been residing in an institutional care facility, including a jail, substance use or mental health treatment facility, hospital, or other similar facility, and met all of the criteria in paragraph (1) of this definition, before entering that facility; or
- A family with an adult head of household (or if there is no adult in the family, a minor head of household) who meets all of the criteria in paragraph (1) or (2) of this definition, including a family whose composition has fluctuated while the head of household has been homeless; or

- Individuals who meet the HUD definition of at risk of homelessness as defined in Section 91.5 of Title 24 of the Code of Federal Regulations as:
    - (1) An individual or family who:
        - Has an annual income below 30 percent of median family income for the area, as determined by HUD;
        - Does not have sufficient resources or support networks, e.g., family, friends, faith-based or other social networks, immediately available to prevent them from moving to an emergency shelter or another place described in paragraph (1) of the “Homeless” definition in this section; and
            - Meets one of the following conditions:
                - Has moved because of economic reasons two or more times during the 60 days immediately preceding the application for homelessness prevention assistance;
                - Is living in the home of another because of economic hardship;
                - Has been notified in writing that their right to occupy their current housing or living situation will be terminated within 21 days after the date of application for assistance;
        - Lives in a hotel or motel and the cost of the hotel or motel stay is not paid by charitable organizations or by federal, State, or local government programs for low-income individuals;

        - Lives in a single-room occupancy or efficiency apartment unit in which there reside more than two persons or lives in a larger housing unit in which there reside more than 1.5 people per room, as defined by the U.S. Census Bureau;
        - Is exiting a publicly funded institution, or system of care (such as a health-care facility, a mental health facility, foster care or other youth facility, or correction program or institution); or
        - Otherwise lives in housing that has characteristics associated with instability and an increased risk of homelessness, as identified in the recipient's approved consolidated plan;
    - (2) A child or youth who does not qualify as "homeless" under this section, but qualifies as "homeless" under section 387(3) of the Runaway and Homeless Youth Act (42 U.S.C. 5732a(3)), section 637(11) of the Head Start Act (42 U.S.C. 9832(11)), section 41403(6) of the Violence Against Women Act of 1994 (42 U.S.C. 14043e-2(6)), section 330(h)(5)(A) of the Public Health Service Act (42 U.S.C. 254b(h)(5)(A)), section 3(m) of the Food and Nutrition Act of 2008 (7 U.S.C. 2012(m)), or section 17(b)(15) of the Child Nutrition Act of 1966 (42 U.S.C. 1786(b)(15)); or
    - (3) A child or youth who does not qualify as "homeless" under this section, but qualifies as "homeless" under section 725(2) of the McKinney-Vento Homeless Assistance Act (42 U.S.C. 11434a(2)), and the parent(s) or guardian(s) of that child or youth if living with her or him; or
- Individuals who are determined to be at risk of experiencing homelessness are eligible to receive Housing Transition Navigation services if they have significant barriers to housing stability and meet at least one of the following:
    - Have one or more serious chronic conditions;
    - Have a Serious Mental Illness;
    - Are at risk of institutionalization or overdose or are requiring residential services because of a substance use disorder
    - Have a Serious Emotional Disturbance (children and adolescents);
    - Are receiving Enhanced Care Management; or
    - Are a Transition-Age Youth 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, and/or have a serious mental illness and/or a child or adolescent with serious emotional disturbance and/or who have been victims of trafficking, or
- Individuals who meet the State's No Place Like Home definition of "at risk of chronic homelessness", which includes persons exiting institutions that were homeless prior to entering the institution and Transition-age youth with significant

barriers to housing stability, including one or more convictions and history of foster care or involvement with the juvenile justice system.

In addition to meeting one of these criteria at a minimum, individuals must have medical/behavioral health needs such that experiencing homelessness upon discharge from the hospital, substance use or mental health treatment facility, correctional facility, nursing facility, or recuperative care would likely result in hospitalization, re-hospitalization, or institutional readmission.

Restrictions/Limitations

In lieu of services are alternative services covered under the State Plan but are delivered by a different provider or in a different setting than is described in the State Plan. In lieu of services can only be covered if: 1) the State determines they are medically-appropriate and cost-effective substitutes or settings for the State plan service, 2) beneficiaries are not required to use the in lieu of services and 3) the in lieu of services is authorized and identified in the Medi-Cal managed care plan contracts.

Short-Term Post-Hospitalization services are available once in an individual's lifetime and are limited and are not to exceed a duration of six (6) months per episode (but may be authorized for a shorter period based on individual needs). Plans are expected to make a good faith effort to review information available to them to determine if individual has previously received services.

The service is only available if enrollee is unable to meet such an expense.

Individuals may not be receiving duplicative support from other State, local or federally funded programs, which should always be considered first, before using Medi-Cal funding.

Licensing/Allowable Providers

Providers must have experience and expertise with providing these unique services. The below list is provided as an example of the types of providers Medi-Cal managed care plans may choose to contract with but is not an exhaustive list of providers who may offer the services.

- Interim housing facilities with additional on-site support
- Shelter beds with additional on-site support
- Converted homes with additional on-site support
- County directly operated or contracted recuperative care facilities
- Supportive Housing providers
- County agencies
- Public Hospital Systems

- Social service agencies
- Providers of services for individuals experiencing homelessness

Facilities may be unlicensed. Medi-Cal managed care plans must apply minimum standards to ensure adequate experience and acceptable quality of care standards are maintained. Managed care plans can adopt or adapt local or national standards for short-term post-hospitalization housing. Medi-Cal managed care plans shall monitor the provision of all the services included above.

Managed care plan network providers that have a state-level enrollment pathway must enroll in the Medi-Cal program. If there is no state-level enrollment pathway, managed care plans must enroll providers through their own established enrollment process, through the recognized enrollment process developed by another managed care plan, or, if applicable, through a state-level enrollment pathway established by another state department. Regardless of whether the providers are enrolled in Medi-Cal, managed care plans must credential the providers as required by DHCS.

State Plan Service(s) To Be Avoided

Examples of State Plan services to be avoided include but are not limited to inpatient and outpatient hospital services, emergency department services, emergency transport services, skilled nursing facility services.

Recuperative Care (Medical Respite)

Description/Overview

Recuperative care, also referred to as medical respite care, is short-term residential care for individuals 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. It allows individuals to continue their recovery and receive post-discharge treatment while obtaining access to primary care, behavioral health services, case management and other supportive social services, such as transportation, food, and housing.

At a minimum, the service will include interim housing with a bed and meals and ongoing monitoring of the individual's ongoing medical or behavioral health condition (e.g., monitoring of vital signs, assessments, wound care, medication monitoring). Based on individual needs, the service may also include:

1. Limited or short-term assistance with Instrumental Activities of Daily Living &/or ADLs
2. Coordination of transportation to post-discharge appointments
3. Connection to any other on-going services an individual may require including mental health and substance use disorder services
4. Support in accessing benefits and housing
5. Gaining stability with case management relationships and programs

Recuperative care is primarily used for those individuals who are experiencing homelessness or those with unstable living situations who are too ill or frail to recover from an illness (physical or behavioral health) or injury in their usual living environment; but are not otherwise ill enough to be in a hospital.

The services provided to an individual while in recuperative care should not replace or be duplicative of the services provided to members utilizing the enhanced care management program. Recuperative Care may be utilized in conjunction with other housing in lieu of services. Whenever possible, other housing in lieu of services should be provided to members onsite in the recuperative care facility. When enrolled in enhanced care management, in lieu of services should be managed in coordination with enhanced care management providers.

The services provided should utilize best practices for clients who are experiencing homelessness and who have complex health, disability, and/or behavioral health

conditions including Housing First, Harm Reduction, Progressive Engagement, Motivational Interviewing, and Trauma Informed Care.

Eligibility (Population Subset)

- Individuals who are at risk of hospitalization or are post-hospitalization, and
- Individuals who live alone with no formal supports; or
- Individuals who face housing insecurity or have housing that would jeopardize their health and safety without modification. [26]

Restrictions/Limitations

In lieu of services are alternative services covered under the State Plan but are delivered by a different provider or in a different setting than is described in the State Plan. In lieu of services can only be covered if: 1) the State determines they are medically-appropriate and a cost-effective substitutes or setting for the State plan service, 2) beneficiaries are not required to use the in lieu of services and 3) the in lieu of services is authorized and identified in the Medi-Cal managed care plan contracts.

Recuperative care/medical respite is an allowable in lieu of services service if it is 1) necessary to achieve or maintain medical stability and prevent hospital admission or re-admission, which may require behavioral health interventions, 2) not more than 90 days in continuous duration, and 3) does not include funding for building modification or building rehabilitation.

Individuals may not be receiving duplicative support from other State, local or federally funded programs, which should always be considered first, before using Medi-Cal funding.

Licensing/Allowable Providers

Providers must have experience and expertise with providing these unique services. This list is provided as an example of the types of providers Medi-Cal managed care plans may choose to contract with, but it is not an exhaustive list of providers who may offer the services.

- Interim housing facilities with additional on-site support
- Shelter beds with additional on-site support
- Converted homes with additional on-site support

[26] For this population, the service could be coordinated with home modifications (which are covered as a separate in lieu service) and serve as a temporary placement until the individual can safely return home

- County directly operated or contracted recuperative care facilities

Facilities are unlicensed. Medi-Cal managed care plans must apply minimum standards to ensure adequate experience and acceptable quality of care standards are maintained. Managed care plans can adopt or adapt local or national standards for recuperative care or interim housing. Managed care plans shall monitor the provision of all the services included above.

Managed care plan network providers that have a state-level enrollment pathway must enroll in the Medi-Cal program. If there is no state-level enrollment pathway, managed care plans must enroll providers through their own established enrollment process, through the recognized enrollment process developed by another managed care plan, or, if applicable, through a state-level enrollment pathway established by another state department. Regardless of whether the providers are enrolled in Medi-Cal, managed care plan must credential the providers as required by DHCS.

State Plan Service(s) to Be Avoided

Examples of State Plan services to be avoided include but are not limited to inpatient and outpatient hospital services, skilled nursing facility, and emergency department services.

Respite Services

Description/Overview

Respite services are provided to caregivers of participants who require intermittent temporary supervision. The services are provided on a short-term basis because of the absence or need for relief of those persons who normally care for and/or supervise them and are non-medical in nature. This service is distinct from medical respite/recuperative care and is rest for the caregiver only.

Respite services can include any of the following:

1. Services provided by the hour on an episodic basis because of the absence of or need for relief for those persons normally providing the care to individuals.
2. Services provided by the day/overnight on a short-term basis because of the absence of or need for relief for those persons normally providing the care to individuals.
3. Services that attend to the participant's basic self-help needs and other activities of daily living, including interaction, socialization and continuation of usual daily routines that would ordinarily be performed by those persons who normally care for and/or supervise them.

The Home Respite services are provided to the participant in his or her own home or another location being used as the home.

The Facility Respite services are provided in an approved out-of-home location.

Respite should be made available when it is useful and necessary to maintain a person in their own home and to preempt caregiver burnout to avoid institutional services for which the Medi-Cal managed care plan is responsible.

Eligibility (Population Subset)

Individuals who live in the community and are compromised in their Activities of Daily Living (ADLs) and are therefore dependent upon a qualified caregiver who provides most of their support, and who require caregiver relief to avoid institutional placement.

Other subsets may include children who previously were covered for Respite Services under the Pediatrics Palliative Care Waiver, foster care program beneficiaries, beneficiaries enrolled in California Children's Services, and Genetically Handicapped Persons Program (GHPP), and Clients with Complex Care Needs.

Restrictions/Limitations

In lieu of services are alternative services covered under the State Plan but are delivered by a different provider or in a different setting than is described in the State Plan. In lieu of service can only be covered if: 1) the State determines they are medically-appropriate and a cost-effective substitutes or settings for the State plan service, 2) beneficiaries are not required to use the in lieu of service and 3) the in lieu of service is authorized and identified in the Medi-Cal managed care plan contracts.

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.

Service limit is up to 336 hours per calendar year. The service is inclusive of all in-home and in-facility services. Exceptions to the 336 hour per calendar year limit can be made, with Medi-Cal managed care plan authorization, when the caregiver experiences an episode, including medical treatment and hospitalization that leaves a Medicaid member without their caregiver. Respite support provided during these episodes can be excluded from the 336-hour annual limit.

This service is only to avoid placements for which the Medi-Cal managed care plan would be responsible.

Individuals may not be receiving duplicative support from other State, local or federally funded programs, which should always be considered first, before using Medi-Cal funding.

Licensing/Allowable Providers

Providers must have experience and expertise with providing these unique services. This list is provided as an example of the types of providers Medi-Cal managed care plans may choose to contract with, but it is not an exhaustive list of providers who may offer the services.

- Home health or respite agencies to provide services in:
  - Private residence
  - Residential facility approved by the State, such as, Congregate Living Health Facilities (CLHFs)
  - Providers contracted by county behavioral health

Other community settings that are not a private residence, such as:

- Adult Family Home/Family Teaching Home
- Certified Family Homes for Children

- Residential Care Facility for the Elderly (RCFE)
- Child Day Care Facility; Child Day Care Center; Family Child Care Home
- Respite Facility; Residential Facility: Small Family Homes (Children Only)
- Respite Facility; Residential Facility: Foster Family Agency (FFA)-Certified Family Homes (Children Only)
- Respite Facility; Residential Facility: Adult Residential Facilities (ARF)
- Respite Facility; Residential Facility: Group Homes (Children Only)
- Respite Facility; Residential Facility: Family Home Agency (FHA): Adult Family Home (AFH)/Family Teaching Home (FTH)
- Respite Facility; Residential Facility: Adult Residential Facility for Persons with Special Health Care Needs
- Respite Facility; Residential Facility: Foster Family Homes (FFHs) (Children Only)

Medi-cal managed care plan network providers that have a state-level enrollment pathway must enroll in the Medi-Cal program. If there is no state-level enrollment pathway, managed care plans must enroll providers through their own established enrollment process, through the recognized enrollment process developed by another managed care plan, or, if applicable, through a state-level enrollment pathway established by another state department. Regardless of whether the providers are enrolled in Medi-Cal, managed care plans must credential the providers as required by DHCS.

State Plan Service(s) to Be Avoided

Examples of State Plan services to be avoided include but are not limited to inpatient and outpatient hospital services, emergency department services, and skilled nursing or other institutional care.

Day Habilitation Programs

Description/Overview

Day Habilitation Programs are provided in a participant's home or an out-of-home, non-facility setting. The programs are designed to assist the participant in acquiring, retaining, and improving self-help, socialization, and adaptive skills necessary to reside successfully in the person's natural environment. The services are often considered as peer mentoring when provided by an unlicensed caregiver with the necessary training and supervision. For individuals experiencing homelessness who are receiving enhanced care management or other in lieu of services, the day habilitation program can provide a physical location for participants to meet with and engage with these providers. When possible, these services should be provided by the same entity to minimize the number of care/case management transitions experienced by clients and to improve overall care coordination and management.

Day habilitation program services include, but are not limited to, training on:

1. The use of public transportation;
2. Personal skills development in conflict resolution;
3. Community participation;
4. Developing and maintaining interpersonal relationships;
5. Daily living skills (cooking, cleaning, shopping, money management); and,
6. Community resource awareness such as police, fire, or local services to support independence in the community.

Programs may include assistance with, but not limited to:

1. Selecting and moving into a home; [27]
2. Locating and choosing suitable housemates;
3. Locating household furnishings;
4. Settling disputes with landlords; [28]
5. Managing personal financial affairs;

[27] Refer to the Housing Transition/Navigation Services In Lieu of Services
[28] Refer to the Housing- Tenancy and Sustaining Services In Lieu of Services

6. Recruiting, screening, hiring, training, supervising, and dismissing personal attendants;
7. Dealing with and responding appropriately to governmental agencies and personnel;
8. Asserting civil and statutory rights through self-advocacy;
9. Building and maintaining interpersonal relationships, including a circle of support;
10. Coordination with Medi-Cal managed care plan to link participant to any in lieu of services and/or enhanced care management services for which the client may be eligible;
11. Referral to non-in lieu of services housing resources if participant does not meet Housing Transition/Navigation Services in lieu of services eligibility criteria;
12. Assistance with income and benefits advocacy including General Assistance/General Relief and SSI if client is not receiving these services through in lieu of services or enhanced care management; and
13. Coordination with Medi-Cal managed care plan to link participant to health care, mental health services, and substance use disorder services based on the individual needs of the participant for participants who are not receiving this linkage through in lieu of services or enhanced care management.

The services provided should utilize best practices for clients who are experiencing homelessness or formerly experienced homelessness including Housing First, Harm Reduction, Progressive Engagement, Motivational Interviewing, and Trauma Informed Care.

Eligibility (Population Subset)

Individuals who are experiencing homelessness, individuals who exited homelessness and entered housing in the last 24 months, and individuals at risk of homelessness or institutionalization whose housing stability could be improved through participation in a day habilitation program.

Restrictions/Limitations

In lieu of services are alternative services covered under the State Plan but are delivered by a different provider or in a different setting than is described in the State Plan. In lieu of services can only be covered if: 1) the State determines they are medically-appropriate and a cost-effective substitutes or settings for the State plan service, 2) beneficiaries are not required to use the in lieu of services and 3) the in lieu of services is authorized and identified in the Medi-Cal managed care plan contracts.

Individuals may not be receiving duplicative support from other State, local or federally funded programs, which should always be considered first, before using Medi-Cal funding.

Licensing/Allowable Providers

Providers must have experience and expertise with providing these unique services. This list is provided as an example of the types of providers Medi-Cal managed care plans may choose to contract with, but it is not an exhaustive list of providers who may offer the services.

- Mental health or substance use disorder treatment providers, including county behavioral health agencies
- Licensed Psychologists
- Licensed Certified Social Workers
- Registered Nurses
- Home Health Agencies
- Professional Fiduciary
- Vocational Skills Agencies

Medi-Cal managed care network providers that have a state-level enrollment pathway must enroll in the Medi-Cal program. If there is no state-level enrollment pathway, managed care plans must enroll providers through their own established enrollment process, through the recognized enrollment process developed by another managed care plan, or, if applicable, through a state-level enrollment pathway established by another state department. Regardless of whether the providers are enrolled in Medi-Cal, managed care plans must credential the providers as required by DHCS.

State Plan Service(s) to Be Avoided

Examples of State Plan services to be avoided include but are not limited to: Inpatient and outpatient hospital services, skilled nursing facility, emergency department services.

Nursing Facility Transition/Diversion to Assisted Living Facilities, such as Residential Care Facilities for Elderly and Adult Residential Facilities

DESCRIPTION/OVERVIEW

Nursing Facility Transition/Diversion services assist individuals to live in the community and/or avoid institutionalization when possible.

The goal is to both facilitate nursing facility transition back into a home-like, community setting and/or prevent skilled nursing admissions for beneficiaries with an imminent need for nursing facility level of care (LOC). Individuals have a choice of residing in an assisted living setting as an alternative to long-term placement in a nursing facility when they meet eligibility requirements.

The assisted living provider is responsible for meeting the needs of the participant, including Activities of Daily Living (ADLs), Instrumental ADLs (IADLs), meals, transportation, and medication administration, as needed.

For individuals who are transitioning from a licensed health care facility to a living arrangement in a Residential Care Facilities for Elderly (RCFE) and Adult Residential Facilities (ARF); includes non-room and board costs (medical, assistance w/ ADLs.). Allowable expenses are those necessary to enable a person to establish a community facility residence that does not include room and board and includes:

1. Assessing the participant's housing needs and presenting options.[29]
2. Assessing the service needs of the participant to determine if the participant needs enhanced onsite services at the RCFE/ARF so the client can be safely and stably housed in an RCFE/ARF.
3. Assisting in securing a facility residence, including the completion of facility applications and securing required documentation (e.g., Social Security card, birth certificate, prior rental history).
4. Communicating with facility administration and coordinating the move.
5. Establishing procedures and contacts to retain facility housing.
6. Coordinating with the Medi-Cal managed care plan to ensure that the needs of participants who need enhanced services to be safely and stably housed in RCFE/ARF settings have in lieu of services and/or enhanced care management services that provide the necessary enhanced services or fund RCFE/ARF operator directly to provide enhanced services.

[29] Refer to Housing Transition/Navigation Services In Lieu of Services for additional details.

Eligibility (Population Subset)

A. For Nursing Facility Transition:
   1. Has resided 60+ days in a nursing facility;
   2. Willing to live in an assisted living setting as an alternative to a Nursing Facility; and
   3. Able to reside safely in an assisted living facility with appropriate and cost-effective supports.

B. For Nursing Facility Diversion:
   1. Interested in remaining in the community;
   2. Willing and able to reside safely in an assisted living facility with appropriate and cost-effective supports and services; and
   3. Must be currently receiving medically necessary nursing facility LOC or meet the minimum criteria to receive NF LOC services and in lieu of going into a facility, is choosing to remain in the community and continue to receive medically necessary nursing facility LOC services at an Assisted Living Facility.

Restrictions/Limitations

In lieu of services are alternative services covered under the State Plan but are delivered by a different provider or in a different setting than is described in the State Plan. In lieu of services can only be covered if: 1) the State determines they are medically-appropriate and a cost-effective substitutes or settings for the State plan service, 2) beneficiaries are not required to use the in lieu of services and 3) the in lieu of services is authorized and identified in the Medi-Cal managed care plan contracts.

Individuals are directly responsible for paying their own living expenses.

Individuals may not be receiving duplicative support from other State, local or federally funded programs, which should always be considered first, before using Medi-Cal funding.

Licensing/Allowable Providers

Providers must have experience and expertise with providing these unique services in a culturally and linguistically appropriate manner. The below list is provided as an example of the types of providers Medi-Cal managed care plans may choose to contract with but is not an exhaustive list of providers who may offer the services.

- Case management agencies

- Home Health agencies
- Medi-Cal managed care plans
- ARF/RCFE Operators

Medi-cal managed care plan network providers that have a state-level enrollment pathway must enroll in the Medi-Cal program. If there is no state-level enrollment pathway, managed care plans must enroll providers through their own established enrollment process, through the recognized enrollment process developed by another managed care plan, or, if applicable, through a state-level enrollment pathway established by another state department. Regardless of whether the providers are enrolled in Medi-Cal, managed care plans must credential the providers as required by DHCS.

The RCFE/ARFs are licensed and regulated by the California Department of Social Services, Community Care Licensing (CCL) Division.

State Plan Service(s) to Be Avoided

Examples of State Plan services to be avoided include but are not limited to skilled nursing facility services.

Community Transition Services/Nursing Facility Transition to a Home

Description/Overview

Community Transition Services/Nursing Facility Transition to a Home helps individuals to live in the community and avoid further institutionalization.

Community Transition Services/Nursing Facility Transition to a Home are non-recurring set-up expenses for individuals who are transitioning from a licensed facility to a living arrangement in a private residence 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 include:

1. Assessing the participant's housing needs and presenting options.[30]
2. Assisting in searching for and securing housing, including the completion of housing applications and securing required documentation (e.g., Social Security card, birth certificate, prior rental history).
3. Communicating with landlord, if applicable and coordinating the move.
4. Establishing procedures and contacts to retain housing.
5. Identifying, coordinating, securing, or funding non-emergency, non-medical transportation to assist members' mobility to ensure reasonable accommodations and access to housing options prior to transition and on move-in day.
6. Identifying the need for and coordinating funding for environmental modifications to install necessary accommodations for accessibility.[31]
7. Identifying the need for and coordinating funding for services and modifications necessary to enable a person to establish a basic household that does not constitute room and board, such as: security deposits required to obtain a lease on an apartment or home; set-up fees for utilities or service access; first month coverage of utilities, including telephone, electricity, heating and water; services necessary for the individual's health and safety, such as pest eradication and one-time cleaning prior to occupancy; home modifications, such as an air conditioner or heater; and other medically-necessary services, such as hospital beds, Hoyer lifts, etc. to ensure access and reasonable accommodations. [32]

Eligibility (Population Subset)

[30] Refer to Housing Transition/Navigation Services In Lieu of Services for additional details.
[31] Refer to Home Modification In Lieu of Services for additional details.
[32] Refer to Housing Deposits In Lieu of Services for additional details.

1. Currently receiving medically necessary nursing facility LOC services and in lieu of remaining in, the nursing facility setting, is choosing to transition home and continue to receive medically necessary nursing facility LOC services;
2. Has lived 60+ days in a nursing home;
3. Interested in moving back to the community; and
4. Able to reside safely in the community with appropriate and cost-effective supports and services.

Restrictions/Limitations

In lieu of services are alternative services covered under the State Plan but are delivered by a different provider or in a different setting than is described in the State Plan. In lieu of services can only be covered if: 1) the State determines they are medically-appropriate and a cost-effective substitutes or settings for the State plan service, 2) beneficiaries are not required to use the in lieu of services and 3) the in lieu of services is authorized and identified in the Medi-Cal managed care plan contracts.

- 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 diversionary/recreational purposes.
- Community Transition Services are payable up to a total lifetime maximum amount of $5,000.00. The only exception to the $5,000.00 total maximum is if the participant is compelled to move from a provider-operated living arrangement to a living arrangement in a private residence through circumstances beyond his or her control.
- Community Transition Services must be necessary to ensure the health, welfare, and safety of the participant, and without which the participant would be unable to move to the private residence and would then require continued or re-institutionalization.

Individuals may not be receiving duplicative support from other State, local or federally funded programs, which should always be considered first, before using Medi-Cal funding.

Licensing/Allowable Providers

Providers must have experience and expertise with providing these unique services. The list is provided as an example of the types of providers Medi-Cal managed care plans may choose to contract with, but it is not an exhaustive list of providers who may offer the services.

- Case management agencies
- Home Health agencies
- Medi-Cal managed care plans
- County mental health providers
- 1915c HCBA/ALW providers
- CCT/Money Follows the Person providers

Medi-cal managed care plan network providers that have a state-level enrollment pathway must enroll in the Medi-Cal program. If there is no state-level enrollment pathway, managed care plans must enroll providers through their own established enrollment process, through the recognized enrollment process developed by another managed care plan, or, if applicable, through a state-level enrollment pathway established by another state department. Regardless of whether the providers are enrolled in Medi-Cal, managed care plans must credential the providers as required by DHCS.

State Plan Service(s) to Be Avoided

Examples of State Plan services to be avoided include but are not limited to skilled nursing facility services.

Personal Care and Homemaker Services

Description/Overview

Personal Care Services and Homemaker Services provided for individuals who need assistance with Activities of Daily Living (ADL) such as bathing, dressing, toileting, ambulation or feeding. Personal Care Services can also include assistance with Instrumental Activities of Daily Living (IADL) such as meal preparation, grocery shopping and money management.

Services provided through the In-Home Support Services (In-Home Supportive Services) program include housecleaning, meal preparation, laundry, grocery shopping, personal care services (such as bowel and bladder care, bathing, grooming and paramedical services), accompaniment to medical appointments and protective supervision for the mentally impaired.

Homemaker/Chore services include help with tasks such as cleaning and shopping, laundry, and grocery shopping. Personal Care, Homemaker and Chore programs aids individuals who otherwise could not remain in their homes.

In lieu of services can be utilized:

- Above and beyond any approved county In-Home Supportive Services hours, when additional hours are required and if In-Home Supportive Services benefits are exhausted; and
- As authorized during any In-Home Supportive Services waiting period (member must be already referred to In-Home Supportive Services); this approval time period includes services prior to and up through the In-Home Supportive Services application date.
- For members not eligible to receive In-Home Supportive Services, to help avoid a short-term stay in a skilled nursing facility (not to exceed 60 days).

Similar services available through In-Home Supportive Services should always be utilized first. These Personal Care and Homemaker in lieu of services should only be utilized if appropriate and if additional hours/supports are not authorized by In-Home Supportive Services.

Eligibility (Population Subset)

- Individuals at risk for hospitalization, or institutionalization in a nursing facility; or
- Individuals with functional deficits and no other adequate support system; or

- Individuals approved for In-Home Supportive Services. Eligibility criteria can be found at: http://www.cdss.ca.gov/In-Home-Supportive-Services.

Restrictions/Limitations

In lieu of services are alternative services covered under the State Plan but are delivered by a different provider or in a different setting than is described in the State Plan. In lieu of services can only be covered if: 1) the State determines medically-appropriate and a cost-effective substitutes or settings for the State plan service, 2) beneficiaries are not required to use the in lieu of services and 3) the in lieu of services is authorized and identified in the Medi-Cal managed care plan contracts.

This service cannot be utilized in lieu of referring to the In-Home Supportive Services program. Member must be referred to the In-Home Supportive Services program when they meet referral criteria.

If a member receiving Personal Care and Homemaker services has any change in their current condition, they must be referred to In-Home Supportive Services for reassessment and determination of additional hours. Members may continue to receive Personal Care and Homemaker in lieu of services during this reassessment waiting period.

Individuals may not be receiving duplicative support from other State, local or federally funded programs, which should always be considered first, before using Medi-Cal funding.

Licensing/Allowable Providers

Providers must have experience and expertise with providing these unique services. This list is provided as an example of the types of providers Medi-Cal managed care plans may choose to contract with, but it is not an exhaustive list of providers who may offer the services.

- Home health agencies
- County agencies
- Personal care agencies
- AAA (Area Agency on Aging)

Medi-cal managed care plan network providers that have a state-level enrollment pathway must enroll in the Medi-Cal program. If there is no state-level enrollment pathway, managed care plans must enroll providers through their own established enrollment process, through the recognized enrollment process developed by another

managed care plan, or, if applicable, through a state-level enrollment pathway established by another state department. Regardless of whether the providers are enrolled in Medi-Cal, managed care plans must credential the providers as required by DHCS.

State Plan Service(s) to Be Avoided

Examples of State Plan services to be avoided include but are not limited to inpatient and outpatient hospital services, emergency department services, skilled nursing facility.

Environmental Accessibility Adaptations (Home Modifications)

Description/Overview

Environmental Accessibility Adaptations (EAAs also known as Home Modifications) are physical adaptations to a home that are necessary to ensure the health, welfare and safety of the individual, or enable the individual to function with greater independence in the home: without which the participant would require institutionalization.

Examples of environmental accessibility adaptions include:

- Ramps and grab-bars to assist beneficiaries in accessing the home;
- Doorway widening for beneficiaries who require a wheelchair;
- Stair lifts;
- Making a bathroom and shower wheelchair accessible (e.g., constructing a roll-in shower).
- Installation of specialized electric and plumbing systems that are necessary to accommodate the medical equipment and supplies of the beneficiary; and
- Installation and testing of a Personal Emergency Response System (PERS) for persons who are alone for significant parts of the day without a caregiver and who otherwise require routine supervision (including monthly service costs, as needed).

The services are available in a home that is owned, rented, leased, or occupied by the individual. For a home that is not owned by the individual, the individual must provide written consent from the owner for physical adaptations to the home or for equipment that is physically installed in the home (e.g., grab bars, chair lifts, etc.).

When authorizing environmental accessibility adaptations as an in lieu of service, the managed care plan must receive and document an order from the participant's current primary care physician or other health professional specifying the requested equipment or service as well as documentation from the provider of the equipment or service describing how the equipment or service meets the medical needs of the participant, including any supporting documentation describing the efficacy of the equipment where appropriate. Brochures will suffice in showing the purpose and efficacy of the equipment; however, a brief written evaluation specific to the participant describing how and why the equipment or service meets the needs of the individual will still be necessary.

For environmental accessibility adaptations, the managed care plan must also receive and document:

1. A physical or occupational therapy evaluation and report to evaluate the medical necessity of the requested equipment or service unless the managed care plan determines it is appropriate to approve without an evaluation. This should typically come from an entity with no connection to the provider of the requested equipment or service. The physical or occupational therapy evaluation and report should contain at least the following:

   A. An evaluation of the participant and the current equipment needs specific to the participant, describing how/why the current equipment does not meet the needs of the participant;

   B. An evaluation of the requested equipment or service that includes a description of how/why it is necessary for the participant *and reduces the risk of institutionalization*. This should also include information on the ability of the participant and/or the primary caregiver to learn about and appropriately use any requested item, and

   C. A description of similar equipment used either currently or in the past that has demonstrated to be inadequate for the participant and a description of the inadequacy.

3. If possible, a minimum of two bids from appropriate providers of the requested service, which itemize the services, cost, labor, and applicable warranties; and

4. That a home visit has been conducted to determine the suitability of any requested equipment or service.

The assessment and authorization for EAAs must take place within a 90-day time frame beginning with the request for the EAA, unless more time is required to receive documentation of homeowner consent, or the individual receiving the service requests a longer time frame.

Eligibility (Population Subset)

Individuals at risk for institutionalization in a nursing facility.

Restrictions/Limitations

In lieu of services are alternative services covered under the State Plan but are delivered by a different provider or in a different setting than is described in the State Plan. In lieu of services can only be covered if: 1) the State determines they are medically-appropriate and a cost-effective substitutes or settings for the State plan service, 2) beneficiaries are not required to use the in lieu of services and 3) the in lieu of services is authorized and identified in the Medi-Cal managed care plan contracts.

- If another State Plan service such as Durable Medical Equipment, is available and would accomplish the same goals of independence and avoiding institutional placement, that service should be used.
- EAAs must be conducted in accordance with applicable State and local building codes.
- EAAs are payable up to a total lifetime maximum of $5,000. The only exceptions to the $5,000 total maximum are if the beneficiary's place of residence changes or if the beneficiary's condition has changed so significantly that additional modifications are necessary to ensure the health, welfare and safety of the beneficiary, or are necessary to enable the beneficiary to function with greater independence in the home and avoid institutionalization or hospitalization.
- EAAs may include finishing (e.g., drywall and painting) to return the home to a habitable condition, but do not include aesthetic embellishments.
- Modifications are limited to those that are of direct medical or remedial benefit to the beneficiary and exclude adaptations or improvements that are of general utility to the household. Adaptations that add to the total square footage of the home are excluded except when necessary to complete an adaptation (e.g., to improve entrance/egress to a residence or to configure a bathroom to accommodate a wheelchair).
- Before commencement of a physical adaptation to the home or equipment that is physically installed in the home (e.g., grab bars, chair lifts, etc.), the managed care plan must provide the owner and beneficiary with written documentation that the modifications are permanent, and that the State is not responsible for maintenance or repair of any modification nor for removal of any modification if the participant ceases to reside at the residence.

Individuals may not be receiving duplicative support from other State, local or federally funded programs, which should always be considered first, before using Medi-Cal funding.

Licensing/Allowable Providers

The Medi-Cal managed care plan may manage these services directly or may coordinate with a provider to manage the service.

Medi-cal managed care plan network providers that have a state-level enrollment pathway must enroll in the Medi-Cal program. If there is no state-level enrollment pathway, managed care plans must enroll providers through their own established enrollment process, through the recognized enrollment process developed by another

managed care plan, or, if applicable, through a state-level enrollment pathway established by another state department. Regardless of whether the providers are enrolled in Medi-Cal, managed care plans must credential the providers as required by DHCS.

Providers must have experience and expertise with providing these unique services. This list is provided as an example of the types of providers Medi-Cal managed care plans may choose to contract with, but it is not an exhaustive list of providers who may offer the services.

- Area Agencies on Aging (AAA)
- Local health departments
- Community-based providers and organizations

All EAAs that are physical adaptations to a residence must be performed by an individual holding a California Contractor's License with the exception of a PERS installation, which may be performed in accordance with the system's installation requirements.

State Plan Service(s) to Be Avoided

Examples of State Plan services to be avoided include but are not limited to nursing facility services, inpatient and outpatient hospital services, emergency department services and emergency transport services.

Meals/Medically Tailored Meals

Description/Overview

Malnutrition and poor nutrition can lead to devastating health outcomes, higher utilization, and increased costs, particularly among members with chronic conditions. Meals help individuals achieve their nutrition goals at critical times to help them regain and maintain their health. Results include improved member health outcomes, lower hospital readmission rates, a well-maintained nutritional health status and increased member satisfaction.

1. Meals delivered to the home immediately following discharge from a hospital or nursing home when members are most vulnerable to readmission.
2. Medically-Tailored Meals: meals provided to the member at home that meet the unique dietary needs of those with chronic diseases.
3. Medically-Tailored meals are tailored to the medical needs of the member by a Registered Dietitian (RD) or other certified nutrition professional, reflecting appropriate dietary therapies based on evidence-based nutritional practice guidelines to address medical diagnoses, symptoms, allergies, medication management, and side effects to ensure the best possible nutrition-related health outcomes.

4. Medically-supportive food and nutrition services, including medically tailored groceries and healthy food vouchers.

Eligibility (Population Subset)

1. Individuals with chronic 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/behavioral health disorders.
2. Individuals being discharged from the hospital or a skilled nursing facility or at high risk of hospitalization or nursing facility placement; or
3. Individuals with extensive care coordination needs.

Restrictions/Limitations

In lieu of services are alternative services covered under the State Plan but are delivered by a different provider or in a different setting than is described in the State Plan. In lieu of services can only be covered if: 1) the State determines they are medically-appropriate

and a cost-effective substitutes or settings for the State plan service, 2) beneficiaries are not required to use the in lieu of services and 3) the in lieu of services is authorized and identified in the Medi-Cal managed care plan contracts.

- Up to three medically-tailored meals per day and/or medically-supportive food and nutrition services for up to 12 weeks, or longer if medically necessary.
- Meals that are eligible for or reimbursed by alternate programs are not eligible.
- Meals are not covered to respond solely to food insecurities.

Individuals may not be receiving duplicative support from other State, local or federally funded programs, which should always be considered first, before using Medi-Cal funding.

Licensing/Allowable Providers

Providers must have experience and expertise with providing these unique services. This list is provided as an example of the types of providers Medi-Cal managed care plans may choose to contract with, but it is not an exhaustive list of providers who may offer the services.

- Home delivered meal providers
- Area Agencies on Aging
- Nutritional Education Services to help sustain healthy cooking and eating habits
- Meals on Wheels providers

Medi-cal managed care plan network providers that have a state-level enrollment pathway must enroll in the Medi-Cal program. If there is no state-level enrollment pathway, managed care plans must enroll providers through their own established enrollment process, through the recognized enrollment process developed by another managed care plan, or, if applicable, through a state-level enrollment pathway established by another state department. Regardless of whether the providers are enrolled in Medi-Cal, managed care plans must credential the providers as required by DHCS.

State Plan Service(s) to Be Avoided

Examples of State Plan services to be avoided include but are not limited to inpatient and outpatient hospital services, emergency department services.

Sobering Centers

Description/Overview

Sobering centers are alternative destinations for individuals who are found to be publicly intoxicated (due to alcohol and/or other drugs) and would otherwise be transported to the emergency department or jail. Sobering centers provide these individuals, primarily those who are homeless or those with unstable living situations, with a safe, supportive environment to become sober.

Sobering centers provide services such as medical triage, lab testing, a temporary bed, rehydration and food service, treatment for nausea, wound and dressing changes, shower and laundry facilities, substance use education and counseling, navigation and warm hand-offs for additional substance use services or other necessary health care services, and homeless care support services.

- When utilizing this service, direct coordination with the county behavioral health agency is required and warm hand-offs for additional behavioral health services are strongly encouraged.
- The service also includes screening and linkage to ongoing supportive services such as follow-up mental health and substance use disorder treatment and housing options, as appropriate.
- This service requires partnership with law enforcement, emergency personnel, and outreach teams to identify and divert individuals to Sobering Centers. Sobering centers must be prepared to identify clients with emergent physical health conditions and arrange transport to a hospital or appropriate source of medical care.
- The services provided should utilize best practices for clients who are homeless and who have complex health and/or behavioral health conditions including Housing First, Harm Reduction, Progressive Engagement, Motivational Interviewing, and Trauma Informed Care.

Eligibility (Population Subset)

Individuals age 18 and older who are intoxicated but conscious, cooperative, able to walk, nonviolent, free from any medical distress (including life threatening withdrawal symptoms or apparent underlying symptoms) and 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.

Restrictions/Limitations

In lieu of services are alternative services covered under the State Plan but are delivered by a different provider or in a different setting than is described in the State Plan. In lieu

of services can only be covered if: 1) the State determines they are medically-appropriate and a cost-effective substitutes or settings for the State plan service, 2) beneficiaries are not required to use the in lieu of services and 3) the in lieu of services is authorized and identified in the Medi-Cal managed care plan contracts.

This service is covered for a duration of less than 24 hours.

Individuals may not be receiving duplicative support from other State, local or federally funded programs, which should always be considered first, before using Medi-Cal funding.

Licensing/Allowable Providers

Providers must have experience and expertise with providing these unique services. This list is provided as an example of the types of providers Medi-Cal managed care plans may choose to contract with, but it is not an exhaustive list of providers who may offer the services.

- Sobering Centers, or other appropriate and allowable substance use disorder facilities. Medi-Cal managed care plans should consult with county behavioral health agencies to ensure these facilities can offer an appropriate standard of care and properly coordinate follow up access to substance use disorder services and other behavioral health services.
- These facilities are unlicensed. Medi-Cal managed care plans must apply minimum standards, subject to review and approval by DHCS, to ensure adequate experience and acceptable quality of care standards are maintained. Medi-Cal managed care plans shall monitor the provision of all the services included above.
- All allowable providers must be approved by the managed care organization to ensure adequate experience and appropriate quality of care standards are maintained.

Medi-cal managed care plan network providers that have a state-level enrollment pathway must enroll in the Medi-Cal program. If there is no state-level enrollment pathway, managed care plans must enroll providers through their own established enrollment process, through the recognized enrollment process developed by another managed care plan, or, if applicable, through a state-level enrollment pathway established by another state department. Regardless of whether the providers are enrolled in Medi-Cal, managed care plans must credential the providers as required by DHCS.

State Plan Service(s) to Be Avoided

Examples of State Plan services to be avoided include but are not limited to inpatient and outpatient hospital services, emergency department services, emergency transportation services.

Asthma Remediation[33]

Description/Overview

Environmental Asthma Trigger Remediations are physical modifications to a home environment that are necessary to ensure the health, welfare, and safety of the individual, or enable the individual to function in the home and without which acute asthma episodes could result in the need for emergency services and hospitalization.

Examples of environmental asthma trigger remediations include:

- Allergen-impermeable mattress and pillow dustcovers;
- High-efficiency particulate air (HEPA) filtered vacuums;
- Integrated Pest Management (IPM) services;
- De-humidifiers;
- Air filters;
- Other moisture-controlling interventions;
- Minor mold removal and remediation services;
- Ventilation improvements;
- Asthma-friendly cleaning products and supplies;
- Other interventions identified to be medically appropriate and cost effective.

The services are available in a home that is owned, rented, leased, or occupied by the individual or their caregiver.

When authorizing asthma remediation as an in lieu of service, the managed care plan must receive and document:

1. The participant's current licensed health care provider's order specifying the requested remediation(s);
2. Depending on the type of remediation(s) requested, documentation from the provider describing how the remediation(s) meets the medical needs of the participant. A brief written evaluation specific to the participant describing how and why the remediation(s) meets the needs of the individual will still be necessary;
3. That a home visit has been conducted to determine the suitability of any requested remediation(s).

[33] Asthma Remediation should not interfere with EPSDT benefits. All appropriate EPSDT services should be provided and ILOS should be complementary. See https://www.hud.gov/sites/dfiles/HH/documents/HUD%20Asthma%20Guide%20Document_Final_7_18.pdf; Appendix B)

Asthma remediation includes providing information to individuals about actions to take around the home to mitigate environmental exposures that could trigger asthma symptoms and remediations designed to avoid asthma-related hospitalizations such as:

1. Identification of environmental triggers commonly found in and around the home, including allergens and irritants.
2. Using dust-proof mattress and pillow covers, high-efficiency particulate air vacuums, asthma-friendly cleaning products, dehumidifiers, and air filters.
3. Health-related minor home repairs such as pest management or patching holes and cracks through which pests can enter.

Eligibility (Population Subset)

Individuals with poorly controlled asthma (as determined by an emergency department visit or hospitalization or 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.

Restrictions/Limitations

In lieu of services are alternative services covered under the State Plan but are delivered by a different provider or in a different setting than is described in the State Plan. In lieu of services can only be covered if: 1) the State determines they are medically-appropriate and a cost-effective substitutes or settings for the State plan service, 2) beneficiaries are not required to use the in lieu of services and 3) the in lieu of services is authorized and identified in the Medi-Cal managed care plan contracts.

- If another State Plan service such as Durable Medical Equipment, is available and would accomplish the same goals of preventing asthma emergencies or hospitalizations.
- Asthma remediations must be conducted in accordance with applicable State and local building codes.
- Individuals may not be receiving duplicative support from other State, local or federally funded programs, which should always be considered first, before using Medi-Cal funding.
- Asthma remediations are payable up to a total lifetime maximum of $5,000. The only exception to the $5,000 total maximum is if the beneficiary's condition has changed so significantly that additional modifications are necessary to ensure the health, welfare, and safety of the beneficiary, or are necessary to enable the

beneficiary to function with greater independence in the home and avoid institutionalization or hospitalization.

- Asthma remediation modifications are limited to those that are of direct medical or remedial benefit to the beneficiary and exclude adaptations or improvements that are of general utility to the household. Remediations may include finishing (e.g., drywall and painting) to return the home to a habitable condition, but do not include aesthetic embellishments.

- Before commencement of a physical adaptation to the home or installation of equipment in the home, the managed care plan must provide the owner and beneficiary with written documentation that the modifications are permanent, and that the State is not responsible for maintenance or repair of any modification nor for removal of any modification if the participant ceases to reside at the residence.

Individuals may not be receiving duplicative support from other State, local or federally funded programs, which should always be considered first, before using Medi-Cal funding.

Licensing/Allowable Providers

The Medi-Cal managed care plan may: manage these services directly; coordinate with an existing Medi-Cal provider to manage the services; and/or contract with a county agency, community-based organization or other organization, as needed. The services should be provided in conjunction with culturally appropriate asthma self-management education.

Providers must have experience and expertise with providing these unique services. This list is provided as an example of the types of providers Medi-Cal managed care plans may choose to contract with, but it is not an exhaustive list of providers who may offer the services.

- American Lung Association
- Allergy and Asthma Network
- National Environmental Education Foundation
- Local health departments
- Community-based providers and organizations

Asthma Remediation that is a physical adaptation to a residence must be performed by an individual holding a California Contractor's License.

- Medi-Cal managed care plans must apply minimum standards to ensure adequate experience and acceptable quality of care standards are maintained. Medi-Cal managed care plans shall monitor the provision of all the services included above.
- All allowable providers must be approved by the managed care organization to ensure adequate experience and appropriate quality of care standards are maintained.

Medi-cal managed care plan network providers that have a state-level enrollment pathway must enroll in the Medi-Cal program. If there is no state-level enrollment pathway, managed care plans must enroll providers through their own established enrollment process, through the recognized enrollment process developed by another managed care plan, or, if applicable, through a state-level enrollment pathway established by another state department. Regardless of whether the providers are enrolled in Medi-Cal, managed care plans must credential the providers as required by DHCS.

State Plan Service(s) to Be Avoided

Examples of State Plan services to be avoided include but are not limited to inpatient and outpatient hospital services and emergency department services.

Glossary

Medicaid Section 1115 Demonstration Waivers: Section 1115 wavers permit States to use federal Medicaid funds in ways that are not otherwise allowed under federal rules, as long as the U.S. Secretary of Health and Human Services determines that the initiative is an "experimental, pilot, or demonstration project" that is "likely to assist in promoting the objectives of the program." Section 1115 waivers are generally approved for a five-year period.

Section 1915(b) "Freedom of Choice" waivers: States generally use section 1915(b) waivers to require enrollment in managed care delivery systems for certain populations. Many States originally used Section 1115 waiver authority to move enrollees into managed care, but the new federal regulations acknowledge that managed care is now the predominant delivery system in Medicaid and CMS has indicated that Section 1115 waivers may not be the most appropriate authority vehicle for managed care.

Section 1915(c) "Home and Community Based Services" waivers: States generally use 1915(c) waivers to develop programs that meet the needs of people who prefer to get long-term care services and supports in their home or community, rather than in an institutional setting.

Behavioral Health: Mental health and substance use disorder services.

Behavioral Health Managed Care Plan: The county prepaid inpatient health plan (PIHP) that would provide specialty mental health services and SUD treatment services under a single contract with DHCS, after full implementation of the behavioral health integration proposal.

CalAIM: California Advancing and Innovating Medi-Cal: DHCS' multi-year initiative to implement overarching policy changes across all Medi-Cal delivery systems with the following objectives:

- Identify and manage member risk and need through Whole Person Care Approaches and addressing Social Determinants of Health;
- Move Medi-Cal to a more consistent and seamless system by reducing complexity and increasing flexibility; and
- Improve quality outcomes, reduce health disparities, and drive delivery system transformation and innovation through value-based initiatives, modernization of systems, and payment reform.

Coordinated Care Initiative (CCI): CCI was implemented in 2014 in seven California counties with the goal of coordinating the delivery of medical, behavioral, and long-term services and supports to Medi-Cal beneficiaries also eligible for Medicare ("dual eligibles"). The CCI is composed of Cal MediConnect and Managed Medi-Cal Long-Term

Services and Supports (MLTSS). The Cal MediConnect portion of CCI is currently authorized through December 31, 2022.

County Inmate Pre-Release Application Process: A CalAIM proposal that all counties must implement an inmate pre-release Medi-Cal application process to ensure that county inmates/juveniles who are eligible for Medi-Cal and are in need of ongoing physical or behavioral health treatment receive timely access to services upon release from incarceration. The proposed process would require all county jails and juvenile facilities to implement a process for facilitated referral and linkage from county jail release to specialty mental health, Drug Medi-Cal, DMC-ODS and Medi-Cal managed care providers, in cases where the inmate was receiving behavioral health services while incarcerated, to allow for continuation of behavioral health treatment in the community.

County Organized Health System (COHS): A local agency created by a county board of supervisors to contract with the Medi-Cal program. Nearly all Medi-Cal beneficiaries in a COHS county receive their care from the COHS health plan.

Cal MediConnect: A program that coordinates medical, behavioral, and long-term services and supports (i.e. both Medicare and Medi-Cal benefits) for dual eligibles in seven California CCI counties.

Dental Transformation Initiative (DTI): The DTI is a component of the Medi-Cal 2020 demonstration that aims to increase the use of preventive dental services for children, prevent and treat more early childhood caries, and increase continuity of care for children.

Designated Public Hospitals: A California hospital operated by a county, a city and a county, or the University of California.

Designated State Health Programs: Designated State Health Programs (DSHPs) are existing State-funded health programs that have not previously qualified for federal funding, including Medicaid. CMS released a State Medicaid Director Letter informing States that they would phase-out federal funding for DSHPs beginning in 2017, meaning that California's DSHPs will not receive federal funding past December 31, 2020 when the Medi-Cal 2020 demonstration expires.

Drug Medi-Cal: Drug Medi-Cal pays for the SUD treatment services a Medi-Cal beneficiary receives through a Drug Medi-Cal certified program.

Drug Medi-Cal Organized Delivery System (DMC-ODS): DMC-ODS is a continuum of care modeled after the American Society of Addiction Medicine Criteria for substance use disorder treatment services. The program enables more local control and accountability, provides greater administrative oversight, creates utilization controls to improve care and efficient use of resources, implements evidenced based practices in substance abuse treatment, and coordinates with other systems of care. These systems are currently operating in 30 California counties. This program was initially authorized in during the

2010 Bridge to Reform demonstration and was reauthorized in the current Medi-Cal 2020 demonstration.

Enhanced Care Management: A collaborative and interdisciplinary benefit to provide intensive and comprehensive ('whole-person') care management services to high-need Medi-Cal beneficiaries.

Full Integration Plan: A CalAIM proposal to consolidate multiple Medi-Cal delivery systems (Medi-Cal managed care, mental health managed care, DMC-ODS, and dental) under one contract with DHCS. This proposal would only be implemented in select areas with managed care plans and corresponding counties who have mutually volunteered to participate.

Global Payment Program (GPP): Established a statewide pool of funding for the remaining uninsured by combining federal disproportional share hospital and uncompensated care funding, where select Designated Public Hospital systems can achieve their "global budget" by meeting a service threshold that incentivizes movement from high cost, avoidable services to providing higher value, preventive services. GPP is currently set to expire on December 31, 2020 and with approval pending under the Medi-Cal 2020 Demonstration extension to continue for calendar year 2021.

Health Homes Program: Enables participating health plans to provide a range of supports to Med-Cal beneficiaries with complex medical needs and chronic conditions. The HHP includes coordination of the full range of physical health, behavioral health, and community-based long-term services and supports.

Indian Health Care Providers: Means a health care program operated by the Indian Health Service or by an Indian Tribe, Tribal Organization, or Urban Indian Organization per 42 CFR §438.14(a).

In lieu of services: Services offered by a Medi-Cal health plan that are not included in the State Plan, but are medically appropriate, cost-effective substitutes for State Plan services included within the contract. Applicable in lieu of services must be specifically included in a managed care plan's contract. Services are offered at the plan's option and an enrollee cannot be required to use them.

Institution for Mental Diseases (IMD): A hospital, nursing facility, or other institution with more than sixteen beds that is primarily engaged in providing diagnosis, treatment, or care to persons with mental diseases (42 U.S.C. §1396d(i)).

Long Term Care: Included skilled nursing facilities, subacute facilities, pediatric subacute facilities, and intermediate care facilities.

Long Term Service and Supports: Services that include medical and non-medical care for people with a chronic illness or disability. Long-term care services are those provided

to an individual who requires a level of care equivalent to that received in a nursing facility. Most long-term care services assist people with Activities of Daily Living, such as dressing, bathing, and using the bathroom. Long-term care can be provided at home, in the community, or in a facility.

Managed Long Term Services and Supports (MLTSS) Program: The delivery of long-term services and supports through capitated Medi-Cal managed care programs.

Medi-Cal 2020: California's current Section 1115 waiver that expires on December 31, 2020. Medi-Cal 2020 authorized the Whole Person Care program, Global Payment Program, the Public Hospital Redesign and Incentives in Medi-Cal (PRIME) Program, Dental Transformation Initiative, and extended several other California waiver programs including the Drug Medi-Cal Organized Delivery System.

Medi-Cal Managed Care Plan: A health plan that has a contract with DHCS to deliver most physical health care and mild-to-moderate mental health care services to Medicaid beneficiaries through a network of providers at a capitated rate. Managed care plans emphasize primary and preventive care.

Mental Health Managed Care Plan: A health plan that has a contract with DHCS to provide specialty mental health services to Medi-Cal beneficiaries. Mental health managed care plans in California are administered by the counties.

National Committee for Quality Assurance (NCQA): A health care accreditation organization with a focus on improving health care quality.

Population Health Management Program: A cohesive plan of action for addressing member needs across the continuum of care, based on data-driven risk stratification, predictive analytics, and standardized assessment processes. Each Medi-Cal managed care plan will provide DHCS with a strategy for how it will:

- Keep all members healthy by focusing on preventive and wellness services;
- Identify and assess member risks and needs on an ongoing basis;
- Manage member safety and outcomes during transitions, across delivery systems or settings, through effective care coordination; and
- Identify and mitigate the social determinants of health and reduce health disparities or inequities.

Public Hospital Redesign and Incentives in Medi-Cal (PRIME): An incentive program for Designated Public Hospitals and District and Municipal Public Hospitals designed to improve their delivery systems through a focus on providing high quality, value-based care. PRIME is the successor program to the first-in-the-nation DSRIP (Delivery System Reform Incentive Payment) program that was authorized in the Bridge to Reform demonstration in 2010. PRIME funding is authorized under the Medi-Cal 2020 demonstration and expired on June 30, 2020.

Quality Incentive Program (QIP): The QIP ties Medi-Cal managed care payments to performance on designated performance metrics in four strategic categories: primary care, specialty care, inpatient care, and resource utilization. The payments are linked to delivery of services under Medi-Cal managed care contracts and increase the amount of funding tied to quality outcomes. California's Designated Public Hospitals receive incentive payments based on achievement of specified improvement targets. Under CalAIM, the District and Municipal Public Hospitals started to participate in the QIP once PRIME expired.

Regional Rates: A CalAIM proposal to develop regional managed care capitation rates, rather than plan- and county-based rates, in order to simplify the rate-setting process for the Medi-Cal program and allow for more capacity to implement outcomes and value based payment structures.

Safety Net Care Pools (SNCPs): Federal Medicaid funding for safety net providers' uncompensated care costs associated with Medicaid eligible and uninsured individuals. California had SNCPs in the Section 1115 demonstrations that began in 2005 and in 2010. This funding transitioned to be a component of the Global Payment Program in the Medi-Cal 2020 demonstration.

Serious Mental Illness/Seriously Emotional Disturbance Demonstration Opportunity: A federal opportunity for States to receive federal Medicaid funding for short-term residential treatment services in settings otherwise subject to the institution for mental disease (IMD) exclusion. (See SMD #18-011)

Social Determinants of Health: Conditions in 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 risks (Healthy People 2020).

Targeted Case Management: Targeted Case Management (TCM) is a Medi-Cal program that provides specialized case management services to certain Medi-Cal eligible individuals to gain access to needed medical, social, educational, and other services. The TCM Program is an optional Medi-Cal Program operated with federal and local funds. Eligible populations include:

- Children under age 21;
- Medically fragile individuals;
- Individuals at risk of institutionalization;
- Individuals in jeopardy of negative health or psycho-social outcomes; and
- Individuals with a communicable disease.

Whole Person Care: A pilot program that provides approved counties with funding to coordinate health, behavioral health, and social services for Medi-Cal beneficiaries. The program is authorized under the Medi-Cal 2020 demonstration and expires on December 31, 2020, with approval pending to extend through calendar year 2021.

CalAIM Enhanced Care Management (ECM) and In Lieu of Services (ILOS)
Contract Template Provisions

WILL LIGHTBOURNE
DIRECTOR

GAVIN NEWSOM
GOVERNOR

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Enhanced Care Management (ECM) Definitions

1. **Enhanced Care Management (ECM):** a whole-person, interdisciplinary approach to care that addresses the clinical and non-clinical needs of high-need and/or high-cost Members through systematic coordination of services and comprehensive care management that is community-based, interdisciplinary, high-touch, and person-centered. ECM is a Medi-Cal benefit.
2. **ECM Provider:** a Provider of ECM. ECM Providers are community-based entities with experience and expertise providing intensive, in-person care management services to individuals in one or more of the Populations of Focus for ECM, as described in ECM Section 3: ECM Providers.
3. **Lead Care Manager:** a Member's designated care manager for ECM, who works for the ECM Provider organization (except in circumstances under which the Lead Care Manager could be on staff with Contractor, as described in ECM Section 4: ECM Provider Capacity). The Lead Care Manager operates as part of the Member's multi-disciplinary care team and is responsible for coordinating all aspects of ECM and any In Lieu of Services (ILOS). To the extent a Member has other care managers, the Lead Care Manager will be responsible for coordinating with those individuals and/or entities to ensure a seamless experience for the Member and non-duplication of services.
4. **Model of Care:** the ECM and ILOS Model of Care (MOC) is Contractor's framework for providing ECM and ILOS, including its Policies and Procedures for partnering with ECM and ILOS Providers. The ECM and ILOS Model of Care Template (MOC Template) is the document that details the MOC. Contractor must submit its MOC Template to DHCS for review and approval prior to ECM and ILOS implementation. ECM and ILOS Provider contracts must incorporate the MOC requirements as described in ECM Section 5: Model of Care.

ECM Scope of Services

1. Contractor's Responsibility for Administration of ECM

a. Contractor shall take a whole-person approach to offering Enhanced Care Management (ECM), ensuring that ECM addresses the clinical and non-clinical needs of high-need and/or high-cost Members in distinct Populations of Focus, as defined in ECM Section 2: Populations of Focus for ECM, through systematic coordination of services and comprehensive care management. Contractor shall ensure ECM is community-based, interdisciplinary, high-touch, and person-centered.
b. Contractor shall ensure ECM is available throughout its service area.
c. Contractor shall ensure ECM is offered primarily through in-person interaction where Members and/or their family member(s), guardian, Authorized Representative(s) (AR), caregiver, and/or authorized support person(s) live, seek care, or prefer to access services in their local community. Contractor shall 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.
    i. As described in ECM Section 3: ECM Providers, Contractor must contract with ECM Providers for the provision of ECM.
        a. Under limited circumstances defined in ECM Section 4: ECM Provider Capacity, Contractor may perform ECM functions using its own staff, with prior written approval from DHCS.

b. In situations where Contractor is performing ECM functions using Contractor's own staff, Contractor shall follow the same requirements as a contracted ECM Provider.

ii. Contractor shall use ECM Provider Standard Terms and Conditions provided by DHCS to develop its contracts with ECM Providers, as described in Section 14: Oversight of ECM Providers.

iii. Contractor shall ensure it has a sufficient number of contracts in place to ensure its ECM Provider capacity meets the anticipated needs of all ECM Populations of Focus in a setting consistent with all the requirements in this Contract, as described in ECM Section 4: ECM Provider Capacity.

iv. In counties with operating Health Homes Program (HHP) and Whole Person Care (WPC) pilots, Contractor shall contract with WPC Lead Entities and HHP Community-Based Care Management Entities (CB-CMEs) for the provision of ECM, as described in ECM Section 6: Transition of Whole Person Care and Health Homes Program to ECM.

d. Contractor shall follow the appropriate processes to ensure Members who may benefit from ECM receive ECM as defined in this Contract amendment.

i. Contractor shall inform Members about ECM and how to access it. Contractor shall manage and respond promptly to any requests for ECM directly from Members and on behalf of Members from ECM Providers, other Providers, and community entities, and the Member's guardian or AR, where applicable, as described in ECM Section 7: Identifying Members for ECM.

ii. Contractor shall identify Members within the ECM Populations of Focus who may benefit from ECM, as defined in ECM Section 2: Populations of Focus for ECM.

iii. Contractor shall be responsible for authorizing ECM for Members, whether they are identified by Contractor or the Member or a family member, guardian, AR, caregiver, authorized support person, or external entity requests that the Member receive ECM, as described in ECM Section 8: Authorizing Members for ECM.

iv. Contractor shall be responsible for assigning all Members authorized to receive ECM to an appropriate ECM Provider, as described in ECM Section 9: Assignment to an ECM Provider.

v. Contractor shall ensure the Member is able to decline or end ECM at any time, as described in ECM Section 10: Initiating Delivery of ECM and ECM Section 11: Discontinuation of ECM.

e. Contractor shall ensure ECM provided to each Member encompasses the ECM Core Service Components described in ECM Section 12: Core Service Components of ECM.

i. Contractor shall ensure each Member authorized to receive ECM has a Lead Care Manager who interacts directly with the Member and/or their family member(s), guardian, AR, caregiver, and/or authorized support person(s), as appropriate, and coordinates all covered physical, behavioral, developmental, oral health, long-term services and supports (LTSS), Specialty Mental Health Services, Drug Medi-Cal/Drug Medi-Cal Organized Delivery System services, any In Lieu

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of Services (ILOS), and other services that address social determinants of health needs, regardless of setting.

f. Contractor shall ensure a Member receiving ECM is not receiving duplicative services both through ECM and outside of ECM, including by working with Local Governmental Agencies to ensure ECM services do not duplicate county-specified Targeted Case Management services for a Member.
g. Contractor shall complete an MOC Template and submit for DHCS to review and approve as described in ECM Section 5: Model of Care.
h. Contractor shall comply with all data system and data sharing requirements to support ECM, as described in ECM Section 13: Data System Requirements and Data Sharing to Support ECM.
i. Contractor shall be responsible for overseeing the delivery of ECM to authorized Members through its contracted ECM Providers, as described in ECM Section 14: Oversight of ECM Providers.
j. Contractor shall ensure all Subcontractors participating in any aspect of ECM administration uphold all applicable requirements as described in ECM Section 15: Delegation of ECM to Subcontractor(s) and in accordance with Exhibit A, Attachment 6, Provision 14, Subcontracts.
k. Contractor shall pay contracted ECM Providers for the provision of ECM in accordance with contracts established between Contractor and ECM Provider, including for outreach to assigned Members, as described in ECM Section 16: Payment of ECM Providers.
l. Contractor shall report ECM encounters, performance metrics, and supplemental information as specified by DHCS to allow DHCS appropriate oversight of ECM, as described in ECM Section 17: DHCS Oversight of ECM.
m. Contractor shall coordinate with the Medicare Advantage Plan in the provision of ECM for Members who are dually eligible for Medicare and Medi-Cal, when the Member is enrolled in a Medicare Advantage Plan, including a Dual-Eligible Special Needs Plan.
n. Contractor shall develop, submit for DHCS approval, and disseminate Member-facing written material about ECM for use across its ECM Provider Network. This material must:
    i. Explain ECM and how to request it;
    ii. Explain that ECM participation is voluntary and can be discontinued at any time;
    iii. Explain that the Member must authorize ECM-related data sharing;
    iv. Describe the process by which the Member may choose a different Lead Care Manager or ECM Provider; and
    v. Meet standards for culturally and linguistically appropriate communication outlined in Exhibit A, Attachment 9, Provision 13, Cultural and Linguistic Program and in Exhibit A, Attachment 13, Provision 3, Written Member Information.

2. Populations of Focus for ECM

a. Subject to the phase-in and Member transition requirements described in ECM Section 6: Transition of Whole Person Care and Health Homes

Program to ECM, Contractor shall provide ECM to the following Populations of Focus:

i. Adult Populations of Focus
    a. Experiencing Homelessness;
    b. High Utilizers;
    c. Serious Mental Illness (SMI) or Substance Use Disorder (SUD);
    d. Transitioning from Incarceration;
    e. Individuals At Risk for Institutionalization who are Eligible for Long-Term Care Services;
    f. Nursing Facility Residents Transitioning to the Community.
ii. Children/Youth (up to Age 21) Populations of Focus
    a. Experiencing Homelessness;
    b. High Utilizers;
    c. Serious Emotional Disturbance (SED) or Identified to be At Clinical High Risk (CHR) for Psychosis or Experiencing a First Episode of Psychosis;
    d. Enrolled in California Children's Services (CCS)/CCS Whole Child Model (WCM) with Additional Needs Beyond the CCS Qualifying Condition;
    e. Involved in, or with a History of Involvement in, Child Welfare (Including Foster Care up to Age 26);
    f. Transitioning from Incarceration.

b. Contractor may, but is not required to, offer ECM to Members who do not meet Population of Focus criteria in full, but may benefit from ECM.
c. Contractor shall follow all DHCS guidance that further defines the approach to ECM for each Population of Focus, including the criteria for each Population of Focus and the phase-in timeline for Populations of Focus.
d. To avoid duplication between existing care management and coordination approaches, Members are excluded from ECM while enrolled in the following programs:
    i. 1915(c) waivers:
        a. Multipurpose Senior Services Program (MSSP);
        b. Assisted Living Waiver;
        c. Home and Community-Based Alternatives (HCBA) Waiver;
        d. HIV/AIDS Waiver;
        e. HCBS Waiver for Individuals with Developmental Disabilities (DD); and
        f. Self-Determination Program for Individuals with I/DD.
    ii. Fully integrated programs for Members dually eligible for Medicare and Medicaid:
        a. Cal MediConnect;
        b. Fully Integrated Dual Eligible Special Needs Plans (FIDE-SNPs); and
        c. Program for All-Inclusive Care for the Elderly (PACE).
    iii. Family Mosaic Project
    iv. California Community Transitions (CCT) Money Follows the Person (MFTP)
    v. Basic or Complex Case Management

3. ECM Providers

a. Contractor shall ensure ECM is provided primarily through in-person interaction in settings that are most appropriate for the Member (i.e., 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:
    i. Counties;
    ii. County behavioral health Providers;
    iii. Primary Care Physician or Specialist or Physician groups;
    iv. Federally Qualified Health Centers;
    v. Community Health Centers;
    vi. Community-based organizations;
    vii. Hospitals or hospital-based Physician groups or clinics (including public hospitals and district and/or municipal public hospitals);
    viii. Rural Health Clinics and/or Indian Health Service Programs;
    ix. Local health departments;
    x. Behavioral health entities;
    xi. Community mental health centers;
    xii. SUD treatment Providers;
    xiii. Organizations serving individuals experiencing homelessness;
    xiv. Organizations serving justice-involved individuals;
    xv. CCS Providers; and
    xvi. Other qualified Providers or entities that are not listed above, as approved by DHCS.
c. For the adult Population of Focus with SMI or SUD and children/youth Population of Focus with SED, Contractor shall prioritize county behavioral health staff or behavioral health Providers to serve in the ECM Provider role, provided they agree and are able to coordinate all services needed by those Populations of Focus, not just their behavioral health services.
d. Contractor shall attempt to contract with each Indian Health Service Facility as set forth in Title 22 CCR Sections 55110-55180 to provide ECM, when applicable, as described in Exhibit A, Attachment 8, Provision 7(C).
e. To provide Members with ongoing care coordination previously provided in HHP and WPC Pilot Counties, Contractor shall contract with each WPC Lead Entity or HHP CB-CME as an ECM Provider unless there is an applicable exception *[See ECM Section 6: Transition of Whole Person Care and Health Homes Program to ECM].*
f. Contractor shall ensure ECM Providers:
    i. Are experienced in serving the ECM Population(s) of Focus they will serve;
    ii. Have experience and expertise with the services they will provide;
    iii. Comply with all applicable state and federal laws and regulations and all ECM program requirements in this Contract and associated guidance;
    iv. Have the capacity to provide culturally appropriate and timely in-person care management activities in accordance with Exhibit A, Attachment 6, Provision 13, Ethnic and Cultural Composition, including accompanying Members to critical appointments when necessary;

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v. Are able to communicate in culturally and linguistically appropriate and accessible ways, in accordance with Exhibit A, Attachment 9, Provision 14, Cultural and Linguistic Program;
vi. Have formal agreements and processes in place to engage and cooperate with area hospitals (when not serving as the ECM Provider), primary care practices, behavioral health Providers, Specialists, and other entities, including ILOS Providers, to coordinate care as appropriate to each Member; and
vii. Use a care management documentation system or process that supports the documentation and integration of physical, behavioral, social service, and administrative data and information from other entities to support the management and maintenance of a Member care plan that can be shared with other Providers and organizations involved in each Member's care. Care management documentation systems may include Certified Electronic Health Record Technology, or other documentation tools that can: document Member goals and goal attainment status; develop and assign care team tasks; define and support Member care coordination and care management needs; 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, long-term care facility, housing status) *[See ECM Section 13: Data System Requirements and Data Sharing to Support ECM for more detailed requirements on data exchange].*

g. Contractor shall ensure all ECM Providers for whom a state-level enrollment pathway exists enroll in Medicaid, pursuant to relevant DHCS All Plan Letters (APLs), including Provider Credentialing/Recredentialing and Screening/Enrollment APL 19-004.
    i. If APL 19-004 does not apply to an ECM Provider, Contractor shall have a process for vetting qualifications and experience of ECM Providers, which may extend to individuals employed by or delivering services on behalf of the ECM Provider, to ensure it can meet the capabilities and standards required to be an ECM Provider.
h. Contractor shall not require eligible ECM Providers to be National Committee for Quality Assurance (NCQA) certified or accredited as a condition of contracting as an ECM Provider.

4. ECM Provider Capacity

a. Contractor shall develop and manage a Network of ECM Providers.
b. Contractor shall ensure sufficient ECM Provider capacity to meet the needs of all ECM Populations of Focus *[See ECM Section 2: Populations of Focus for ECM]*.
c. DHCS will evaluate ECM Provider capacity separately from general Network Adequacy; ECM Provider capacity does not alter the general Network Adequacy provisions in Exhibit A, Attachment 6, Provider Network.
d. Contractor shall report on its ECM Provider capacity to DHCS initially in its MOC Template *[See ECM Section 5: Model of Care],* and on an ongoing basis pursuant to DHCS reporting requirements.

e. Contractor shall report 60 days in advance or as soon as possible on its ECM Provider capacity whenever there are significant changes, pursuant to DHCS reporting requirements.
f. If Contractor is unable to provide sufficient capacity to meet the needs of all ECM Populations of Focus in a community-based manner through contracts with ECM Providers, Contractor may request written approval for an exception to the ECM Provider contracting requirement from DHCS that authorizes Contractor to use Contractor's own staff for ECM. Any such request must be submitted in accordance with DHCS guidelines and must evidence one or more of the following:
    i. There are insufficient ECM Providers, or a lack of ECM Providers with experience and expertise to provide ECM for one or more of the Populations of Focus in one or more counties;
    ii. There is a justified quality of care concern with one or more of the otherwise qualified ECM Providers;
    iii. Contractor and the ECM Provider(s) are unable to agree on contracted rates;
    iv. ECM Provider(s) is/are unwilling to contract;
    v. ECM Provider(s) is/are unresponsive to multiple attempts to contract;
    vi. For ECM Providers who have a state-level pathway to Medi-Cal enrollment: Provider(s) is/are unable to comply with the Medi-Cal enrollment process or vetting by the Contractor; and/or
    vii. For ECM Providers without a state-level pathway to Medi-Cal enrollment: Provider(s) is/are unable to comply with Contractor's processes for vetting ECM Providers.
g. During any exception period approved by DHCS, Contractor shall take steps to continually develop and increase the capacity of its ECM Provider Network. The initial exception period will be in effect no longer than one year. After the initial one-year period, Contractor must submit a new exception request to DHCS for DHCS review and approval on a case-by-case basis.
h. Unless Contractor has DHCS approval, based on one of the exceptions defined above, failure of Contractor to provide ECM Provider capacity to meet the needs of all ECM Populations of Focus in a community-based manner shall result in imposition of corrective action proceedings, which may lead to sanctions as set forth in Exhibit E, Attachment 2, Provision 16, Sanctions.

5. Model of Care

a. Contractor shall develop and submit to DHCS for review and approval an MOC, which must detail Contractor's framework for providing ECM, including a listing of its ECM Providers and Policies and Procedures for partnering with ECM Providers.
b. Contractor shall detail its MOC using the DHCS-approved MOC Template for DHCS review.
c. In developing and executing contracts with ECM Providers, Contractor must incorporate all requirements and Policies and Procedures described in its MOC, in addition to the ECM Provider Standard Terms and Conditions.

d. Contractor is encouraged to collaborate on development of its MOC with other Medi-Cal Managed Care Health Plans within the same county, if applicable.
e. Contractor shall submit to DHCS any significant updates to its MOC for review and approval 60 days in advance of any changes or updates, consistent with DHCS guidance.

6. Transition of Whole Person Care and Health Homes Program to ECM

a. Contractor shall promote continuity from WPC Pilots and the HHP to ECM.
b. Contractor shall authorize ECM for Members in HHP and WPC Pilot Counties, following DHCS' implementation schedule.
c. To ensure continuity between HHP and ECM, Contractor shall:
    i. Automatically authorize ECM for all Members of ECM Populations of Focus who are enrolled in or are in the process of being enrolled in HHP; and
    ii. Ensure that each Member automatically authorized for ECM under this provision is assessed within six months, or other timeframes provided by DHCS in guidance for specific transitioning subpopulations, to determine the most appropriate level of services for the Member, to confirm whether ECM or a lower level of care coordination best meets the Member's needs.
d. To ensure continuity between WPC Pilots and ECM, Contractor shall:
    i. Automatically authorize all Members enrolled in a WPC Pilot who are identified by the WPC Lead Entity as belonging to an ECM Population of Focus; and
    ii. Ensure each Member automatically authorized under this provision is assessed within six months, or other timeframes provided by DHCS in guidance for specific transitioning subpopulations, to determine the most appropriate level of services for the Member, to confirm whether ECM or a lower level of care coordination best meets the Member's needs.
e. Contractor shall contract with each WPC Lead Entity and/or HHP CB-CME as an ECM Provider to provide Members with ongoing care coordination previously provided in HHP and WPC Pilot Counties, except under the permissible exceptions set forth in f. below.
f. Contractor shall submit to DHCS for prior approval any requests for exceptions to the contracting requirement with a WPC Lead Entity or HHP CB-CME as an ECM Provider. Permissible exceptions to contracting are:
    i. There is a justified quality of care concern with the ECM Provider(s);
    ii. Contractor and ECM Provider(s) are unable to agree on contracted rates;
    iii. ECM Provider(s) is/are unwilling to contract;
    iv. ECM Provider(s) is/are unresponsive to multiple attempts to contract;
    v. ECM Provider(s) is/are unable to comply with the Medi-Cal enrollment process or vetting by the Contractor; and/or
    vi. For ECM Provider(s) without a state-level pathway to Medi-Cal enrollment, ECM Provider(s) is/are unable to comply with Contractor processes for vetting qualifications and experience.

7. Identifying Members for ECM

a. Contractor shall proactively identify Members who may benefit from ECM and who meet the criteria for the ECM Populations of Focus described in ECM Section 2: Populations of Focus for ECM.
b. To identify such Members, Contractor must consider Members' health care utilization; needs across physical, behavioral, developmental, and oral health; health risks and needs due to social determinants of health; and LTSS needs.
c. Contractor shall identify Members for ECM through the following pathways:
    i. Analysis of Contractor's own enrollment, claims, and other relevant data and available information. Contractor shall use data analytics to identify Members who may benefit from ECM and who meet the criteria for the ECM Populations of Focus. Contractor shall 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/or behavioral health;
        h. SMI/SUD data, as available;
        i. Risk stratification information for children in County Organized Health System (COHS) counties with Whole Child Model (WCM) programs;
        j. Information about social determinants of health, including standardized assessment tools (e.g., PRAPARE) and/or 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).
    ii. Receipt of requests from ECM Providers and other Providers or community-based entities.
        a. Contractor shall accept requests for ECM on behalf of Members from:
            i. ECM Providers;
            ii. Other Providers;
            iii. Community-based entities, including those contracted to provide ILOS, as described in ILOS Section 3: ILOS Providers.
        b. Contractor shall directly engage with Network Providers and county agencies to inform these entities of ECM, the ECM Populations of Focus, and how to request ECM for Members.
        c. Contractor shall encourage ECM Providers to identify Members who meet the criteria for the ECM Populations of

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Focus, and shall develop a process for receiving and responding to requests from ECM Providers.

iii. Receipt of requests from Members.

a. Contractor shall have a process for allowing Members and/or their family member(s), guardian, AR, caregiver, and/or authorized support person(s) to request ECM on a Member's behalf, and shall provide information to Members regarding the Member and/or family ECM request and approval process.

8. Authorizing Members for ECM

a. Contractor shall be responsible for authorizing ECM for each Member identified through any of the pathways described in ECM Section 7: Identifying Members for ECM.

b. Contractor shall 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, and for Member or family requests:

i. Contractor shall ensure that authorization or a decision not to authorize ECM occurs as soon as possible and in accordance with Exhibit A, Attachment 5, Provision 3, Timeframes for Medical Authorization and APL 17-006: Grievance and Appeal Requirements and Revised Notice Templates and "Your Rights" Attachments (i.e., within five working days for routine authorizations and within 72 hours for expedited requests);

ii. If Contractor does not authorize ECM, Contractor shall ensure the Member and the requesting individual or entity (as applicable) who requested ECM on a Member's behalf 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 13, Provision 8, Denial, Deferral, or Modification of Prior Authorization Requests, and Attachment 14, Member Grievance and Appeal System and APL 17-006: Grievance and Appeal Requirements and Revised Notice Templates and "Your Rights" Attachments; and

iii. Contractor shall follow its standard Grievances and Appeals process outlined in Exhibit A, Attachment 14, Member Grievance and Appeal System and APL 17-006: Grievance and Appeal Requirements and Revised Notice Templates and "Your Rights" Attachments for Members who were not authorized to receive ECM.

d. Contractor shall follow requirements for transitioning Members previously served by WPC Pilots or HHP contained in ECM Section 6: Transition of Whole Person Care and Health Homes Program to ECM.

e. Contractor is encouraged to work with ECM Providers to define a process and appropriate circumstances for presumptive authorization or preauthorization of ECM, whereby select ECM Providers would be able to directly authorize ECM and be paid for ECM services for a fixed period of time until Contractor validates or denies ECM based on a complete assessment of Member eligibility for ECM consistent with Population of Focus criteria.

f. To inform Members that ECM has been authorized, Contractor shall follow its standard notice process outlined in Exhibit A, Attachment 13, Provision 8, Denial, Deferral, or Modification of Prior Authorization Requests and APL 17-006: Grievance and Appeal Requirements and Revised Notice Templates and "Your Rights" Attachments.

9. Assignment to an ECM Provider

a. Contractor shall 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 *[See ECM Section 4: ECM Provider Network Capacity].*
b. Contractor shall develop a process to disseminate information of assigned Members to ECM Provider(s) on a regular cycle.
c. Contractor shall ensure communication of Member assignment to the designated ECM Provider occurs within ten business days of authorization.
d. If the Member's preferences for a specific ECM Provider are known to Contractor, Contractor shall follow those preferences, to the extent practicable.
e. If the Member's assigned Primary Care Provider (PCP) is a contracted ECM Provider, Contractor shall assign the Member to the PCP as the ECM Provider, unless the Member has expressed a different preference or Contractor identifies a more appropriate ECM Provider given the Member's individual needs and health conditions.
f. If a Member receives services from a Specialty Mental Health Plan for SED, SUD, and/or SMI and the Member's behavioral health Provider is a contracted ECM Provider, Contractor shall assign that Member to that behavioral health Provider as the ECM Provider, unless the Member has expressed a different preference or Contractor identifies a more appropriate ECM Provider given the Member's individual needs and health conditions.
g. For children enrolled in CCS and when the Member's CCS Case Manager is affiliated with a contracted ECM Provider, Contractor shall assign that Member to the CCS Case Manager as the ECM Provider, unless the Member or family has expressed a different preference or Contractor identifies a more appropriate ECM Provider given the Member's individual needs and health conditions.
h. Contractor shall notify the Member's PCP, if different from the ECM Provider, of the assignment to the ECM Provider, within ten (10) business days of the date of assignment.
i. Contractor shall document the Member's ECM Lead Care Manager in its system of record.
j. Contractor shall permit Members to change ECM Providers at any time. Contractor shall implement any requested ECM Provider change within thirty days.

10. Initiating Delivery of ECM

a. Contractor shall 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 shall develop Policies and Procedures for its Network of ECM Providers to:
    i. Where required by federal law, ensure that Members authorize information sharing with the Contractor and all others involved in the ECM Member's care as needed to support the Member and maximize the benefits of ECM.
    ii. Communicate Member-level record of any authorization required by federal law, to allow data sharing (once obtained) back to Contractor.
c. Contractor shall ensure that upon the initiation of ECM, each Member receiving ECM has a Lead Care Manager with responsibility for interacting directly with the Member and/or family, AR, caretakers, and/or other authorized support person(s) as appropriate.
    i. The assigned Lead Care Manager shall be responsible for engaging with a multi-disciplinary care team to identify gaps in Member's care and ensure appropriate input is obtained to effectively coordinate all primary, behavioral, developmental, oral health, LTSS, ILOS, and other services that address social determinants of health, regardless of setting, at a minimum.
d. Contractor shall ensure accurate and up-to-date Member-level records related to the provision of ECM services are maintained for Members authorized for ECM.

11. Discontinuation of ECM

a. Contractor shall ensure Members are able to decline or end ECM upon initial outreach and engagement, or at any other time.
b. Contractor shall require the ECM Provider to notify Contractor to discontinue ECM for Members when any of the following circumstances are met:
    i. The Member has met all care plan goals;
    ii. The Member is ready to transition to a lower level of care;
    iii. The Member no longer wishes to receive ECM or is unresponsive or unwilling to engage; and/or
    iv. The ECM Provider has not been able to connect with the Member after multiple attempts.
c. Contractor shall develop processes to determine if the Member is no longer authorized to receive ECM and notify ECM Provider to initiate discontinuation of services in accordance with the NOA process as described in Exhibit A, Attachment 13, Provision 8, Denial, Deferral, or Modification of Prior Authorization Requests, and Attachment 14, Member Grievance and Appeals and APL 17-006: Grievance and Appeal Requirements and Revised Notice Templates and "Your Rights" Attachments.
d. Contractor shall develop processes for transitioning Members from ECM to lower levels of care management to provide coordination of ongoing needs.
e. Contractor shall notify the ECM Provider when ECM has been discontinued.
f. Contractor shall 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 13, Provision 8, Denial, Deferral, or Modification of Prior

Authorization Requests, and Attachment 14, Member Grievance and Appeals and APL 17-006: Grievance and Appeal Requirements and Revised Notice Templates and "Your Rights" Attachments.

12. Core Service Components of ECM

a. Contractor shall ensure all Members receive all ECM core service components described below:
    i. Outreach and Engagement
        a. Contractor shall develop Policies and Procedures for its ECM Providers with respect to outreach to and engagement of ECM-authorized Members.
    ii. Comprehensive Assessment and Care Management Plan, which must include, but is not limited to:
        a. Engaging with each Member authorized to receive ECM primarily through in-person contact;
            i. When in-person communication is unavailable or does not meet the needs of the Member, the ECM Provider shall use alternative methods (including use of telehealth) to provide culturally appropriate and accessible communication in accordance with Member choice.
        b. Identifying necessary clinical and non-clinical resources that may be needed to appropriately assess Member health status and gaps in care, and may be needed to inform the development of an individualized Care Management Plan;
        c. Developing a comprehensive, individualized, person-centered Care Management Plan with input from the Member and/or their family member(s), guardian, AR, caregiver, and/or other authorized support person(s) as appropriate to assess strengths, risks, needs, goals and preferences and make recommendations for service needs;
        d. Incorporating into the Member's Care Management Plan identified needs and strategies to address those needs, including, but not limited to, physical and developmental health, mental health, dementia, SUD, LTSS, oral health, palliative care, necessary community-based and social services, and housing;
        e. Ensuring the Member is reassessed at a frequency appropriate for the Member's individual progress or changes in needs and/or as identified in the Care Management Plan; and
        f. Ensuring the Care Management Plan is reviewed, maintained and updated under appropriate clinical oversight.
    iii. Enhanced Coordination of Care, which shall include, but is not limited to:
        a. Organizing patient care activities, as laid out in the Care Management Plan, sharing information with those involved as part of the Member's multi-disciplinary care team, and

implementing activities identified in the Member's Care Management Plan;

b. Maintaining regular contact with all Providers that are identified as being a part of the Member's multi-disciplinary care team, whose input is necessary for successful implementation of Member goals and needs;
c. Ensuring care is continuous and integrated among all service Providers and referring to and following up with primary care, physical and developmental health, mental health, SUD treatment, LTSS, oral health, palliative care, and necessary community-based and social services, including housing, as needed;
d. Providing support to engage the Member in their treatment, including coordination for medication review and/or reconciliation, scheduling appointments, providing appointment reminders, coordinating transportation, accompaniment to critical appointments, and identifying and helping to address other barriers to Member engagement in treatment;
e. Communicating the Member's needs and preferences timely to the Member's multi-disciplinary care team in a manner that ensures safe, appropriate, and effective person-centered care; and
f. Ensuring regular contact with the Member and their family member(s), guardian, AR, caregiver, and/or authorized support person(s), when appropriate, consistent with the care plan.

iv. Health Promotion, which shall include, but is not limited to:
    a. Working with Members to identify and build on successes and potential family and/or support networks;
    b. Providing services to encourage and support Members to make lifestyle choices based on healthy behavior, with the goal of supporting Members' ability to successfully monitor and manage their health; and
    c. Supporting Members in strengthening skills that enable them to identify and access resources to assist them in managing their conditions and preventing other chronic conditions.
v. Comprehensive Transitional Care, which shall include, but is not limited to:
    a. Developing strategies to reduce avoidable Member admissions and readmissions across all Members receiving ECM;
    b. For Members who are experiencing or are likely to experience a care transition:
        i. Developing and regularly updating a transition plan for the Member;
        ii. Evaluating a Member's medical care needs and coordinating any support services to facilitate safe and appropriate transitions from

and among treatment facilities, including admissions and discharges;

iii. Tracking each Member's admission and/or discharge to or from an emergency department, hospital inpatient facility, skilled nursing facility, residential or treatment facility, incarceration facility, or other treatment center and communicating with the appropriate care team members;

iv. Coordinating medication review/reconciliation; and

v. Providing adherence support and referral to appropriate services.

c. Member and Family Supports, which shall include, but are not limited to:

i. Documenting a Member's authorized family member(s), guardian, AR, caregiver, and/or other authorized support person(s) and ensuring all required authorizations are in place to ensure effective communication between the ECM Providers; the Member and/or their family member(s), AR, guardian, caregiver, and/or authorized support person(s); and Contractor, as applicable;

ii. Activities to ensure the Member and/or their family member(s), guardian, AR, caregiver, and/or authorized support person(s) are knowledgeable about the Member's condition(s), with the overall goal of improving the Member's care planning and follow-up, adherence to treatment, and medication management, in accordance with federal, tate, and local privacy and confidentiality laws;

iii. Ensuring the Member's ECM Lead Care Manager serves as the primary point of contact for the Member and/or family member(s), guardian, AR, caregiver, and/or other authorized support person(s);

iv. Identifying supports needed for the Member and/or their family member(s), AR, guardian, caregiver, and/or authorized support person(s) to manage the Member's condition and assist them in accessing needed support services;

v. Providing for appropriate education of the Member and/or their family member(s), guardian, AR, caregiver, and/or authorized support person(s) about care instructions for the Member; and

vi. Ensuring that the Member has a copy of his/her care plan and information about how to request updates.

d. Coordination of and Referral to Community and Social Support Services, which shall include, but are not limited to:
   i. Determining appropriate services to meet the needs of Members, including services that address social determinants of health needs, including housing, and services offered by Contractor as ILOS; and
   ii. Coordinating and referring Members to available community resources and following up with Members to ensure services were rendered (i.e., "closed loop referrals").

13. Data System Requirements and Data Sharing to Support ECM

a. Contractor shall have an IT infrastructure and data analytic capabilities to support ECM, including the capabilities to:
   i. Consume and use claims and encounter data, as well as other data types listed in ECM Section 7: Identifying Members for ECM, to identify Populations of Focus;
   ii. Assign Members to ECM Providers;
   iii. Keep records of Members receiving ECM and authorizations necessary for sharing Personally Identifiable Information 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;
   iv. Securely share data with ECM Providers and other Providers in support of ECM;
   v. Receive, process, and send encounters from ECM Providers to DHCS;
   vi. Receive and process supplemental reports from ECM Providers;
   vii. Send ECM supplemental reports to DHCS; and
   viii. Open, track, and manage referrals to ILOS Providers.

b. In order to support ECM, Contractor shall follow DHCS guidance on data sharing and provide the following information to all ECM Providers, at a minimum:
   i. Member assignment files, defined as a list of Medi-Cal Members authorized for ECM and assigned to the ECM Provider;
   ii. Encounter and/or claims data;
   iii. Physical, behavioral, administrative, and social determinants of health data (e.g., HMIS data) for all Members assigned to the ECM Provider; and
   iv. Reports of performance on quality measures and/or metrics, as requested.

c. Contractor shall 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, to the extent practicable.

14. Oversight of ECM Providers

a. Contractor shall perform oversight of ECM Providers, holding them accountable to all ECM requirements contained in this Contract amendment and associated guidance and Contractor's MOC.
b. Contractor shall use ECM Provider Standard Terms and Conditions to develop its ECM contracts with ECM Providers and shall incorporate all of its ECM Provider requirements, reviewed and approved by DHCS as part of its MOC, including all monitoring and reporting expectations and criteria.
c. To streamline ECM implementation:
    i. Contractor shall hold ECM Providers responsible for the same reporting requirements as those the Contractor has with DHCS.
    ii. Contractor shall not impose mandatory reporting requirements that differ from or are additional to those required for encounter and supplemental reporting; and
    iii. Contractor is encouraged to collaborate with other Medi-Cal Managed Care Health Plans within the same county on oversight of ECM Providers.
d. Contractor shall not utilize tools developed or promulgated by NCQA to perform oversight of ECM Providers, unless by mutual consent with the ECM Provider.
e. Contractor shall provide ECM training and technical assistance to ECM Providers, including in-person sessions, webinars, and/or calls, as necessary, in addition to Network Provider training requirements described in Exhibit A, Attachment 7, Provision 5, Network Provider Training.

15. Delegation of ECM to Subcontractor(s)

a. Contractor may subcontract with other entities to administer ECM in accordance with the following:
    i. Contractor shall maintain and be responsible for oversight of compliance with all Contract provisions and Covered Services, regardless of the number of layers of subcontracting, as described in Exhibit A, Attachment 6, Provision 14, Subcontracts;
    ii. Contractor shall be responsible for developing and maintaining DHCS-approved Policies and Procedures to ensure Subcontractors meet required responsibilities and functions as described in Exhibit A, Attachment 6, Provision 14, Subcontracts;
    iii. Contractor shall be responsible for evaluating the prospective Subcontractor's ability to perform services as described in Exhibit A, Attachment 6, Provision 14, Subcontracts;
    iv. Contractor shall remain responsible for ensuring the Subcontractor's ECM Provider capacity is sufficient to serve all Populations of Focus;
    v. Contractor shall report to DHCS the names of all Subcontractors by Subcontractor type and service(s) provided, and identify the county or counties in which Members are served as described in Exhibit A, Attachment 6, Provision 12, Plan Subcontractors; and
    vi. Contractor shall make all 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 6, Provision 14, Subcontracts.

b. Contractor shall ensure the agreement between Contractor and Subcontractor mirrors the requirements set forth in this Contract and the ECM Provider Standard Terms and Conditions, as applicable to Subcontractor.
c. Contractor is encouraged to collaborate with its Subcontractors on the approach to ECM to minimize divergence in how ECM will be implemented between Contractor and its Subcontractor(s) and/or across multiple Subcontractors and ensure a streamlined, seamless experience for ECM Providers and Members.

16. Payment of ECM Providers

a. Contractor shall pay contracted ECM Providers for the provision of ECM in accordance with contracts established between Contractor and each ECM Provider.
b. Contractor shall ensure that ECM Providers are eligible to receive payment when ECM is initiated for any given Member, as defined in ECM Section 10: Initiating Delivery of ECM.
c. Contractor is encouraged to 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 shall utilize the claims timeline as dictated in Exhibit A, Attachment 8, Provision 5, Claims Processing.

17. DHCS Oversight of ECM

a. Contractor shall submit the following data and reports to DHCS to support DHCS' oversight of ECM:
    i. Encounter data.
        a. Contractor must submit all ECM encounters to DHCS using national standard specifications and code sets to be defined by DHCS.
        b. Contractor shall be responsible for submitting 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 encounters to Contractor using the national standard specifications and code sets to be defined by DHCS, Contractor shall be responsible for converting the ECM Provider's encounter information into the national standard specifications and code sets, for submission to DHCS.
    ii. Supplemental reporting. Contractor shall submit ECM supplemental reports, on a schedule and in a format to be defined by DHCS.
b. Contractor shall track and report to DHCS, in a format to be defined 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, Attachment 2, Provision 16, Sanctions.

18. ECM Quality and Performance Incentive Program

a. Contractor shall meet all quality management and quality improvement requirements in Exhibit A, Attachment 4, Quality Improvement System 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/or other performance milestones and measures, to be defined in forthcoming DHCS guidance.

In Lieu of Services

In Lieu of Services Definitions

1. **In Lieu of Services (ILOS):** Pursuant to 42 CFR 438.3(e)(2), ILOS are services or settings that are offered in place of services or settings covered under the California Medicaid State Plan and are medically appropriate, cost-effective alternatives to services or settings under the State Plan. ILOS are optional for both Contractor and the Member and must be approved by DHCS. DHCS already has authorized the list of ILOS included in Section 2: DHCS-Approved ILOS ("pre-approved ILOS") services *[See ILOS Section 2: DHCS Pre-Approved ILOS].*
2. **ILOS Provider:** a contracted Provider of DHCS-approved ILOS. ILOS Providers are entities with experience and expertise providing one or more of the ILOS approved by DHCS.

In Lieu of Services

1. Contractor's Responsibility for Administration of ILOS

a. Contractor is authorized and encouraged to provide DHCS pre-approved ILOS *[See ILOS Section 2: DHCS-Pre-Approved ILOS].*
    i. The remainder of this section refers only to ILOS that the Contractor elects to offer unless otherwise specified.
b. To offer ILOS in accordance with 42 CFR 438.3(e)(2), Contractor may select from the list of ILOS "pre-approved" by DHCS as medically appropriate and cost-effective substitutes for covered services or settings under the State Plan *[See ILOS Section 2: DHCS Pre-Approved ILOS].*
    i. Contractor shall ensure the underlying State Plan services are made available to the Member if medically necessary for the Member, or if the Member declines the ILOS.
    ii. Contractor may submit a request to DHCS to offer ILOS in addition to the pre-approved ILOS *[See ILOS Section 2: DHCS Pre-Approved ILOS].*
c. With respect to pre-approved ILOS, Contractor shall adhere to DHCS guidance on eligible populations, code sets, potential ILOS Providers, and parameters for each ILOS that Contractor chooses to provide.
d. Contractor need not offer elected ILOS in each county it serves. Contractor shall report to DHCS the counties in which it intends to offer the ILOS. *[For requirements regarding the extent to which ILOS must be provided throughout a county selected by Contractor, see Section 4: ILOS Provider Network Capacity].*
e. Contractor shall identify individuals who may benefit from ILOS and for whom ILOS will be a medically appropriate and cost-effective substitute for State Plan Covered Services, and accept requests for ILOS from Members and on behalf of Members from Providers and organizations that serve them, including community-based organizations *[See ILOS Section 7: Identifying Members for ILOS].*
f. Contractor shall authorize ILOS for Members deemed eligible *[See ILOS Section 8: Authorizing Members for ILOS and Communication of Authorization Status].*

g. Electing to offer one or more ILOS shall not preclude Contractor from offering value-added services (VAS).
h. Any discontinuation of an ILOS is considered a change in the availability of services and therefore requires Contractor to adhere to the requirements of Exhibit A, Attachment 9, Provision 10, Changes in Availability or Location of Covered Services and Exhibit A, Attachment 13, Provision 5, Notification of Changes in Access to Covered Services.
i. Contractor shall coordinate with the Medicare Advantage Plan in the provision of ILOS for Members dually eligible for Medicare and Medi-Cal, when the Member is enrolled in a Medicare Advantage Plan, including a Dual-Eligible Special Needs Plan.
j. Contractor shall not require Members to use ILOS.

2. DHCS Pre-Approved ILOS

a. Contractor can choose to offer Members one or more of the following pre-approved ILOS, and any later DHCS-approved ILOS additions, in each county:
    i. Housing Transition Navigation Services;
    ii. Housing Deposits;
    iii. Housing Tenancy and Sustaining Services;
    iv. Short-Term Post-Hospitalization Housing;
    v. Recuperative Care (Medical Respite);
    vi. Respite Services;
    vii. Day Habilitation Programs;
    viii. Nursing Facility Transition/Diversion to Assisted Living Facilities;
    ix. Community Transition Services/Nursing Facility Transition to a Home;
    x. Personal Care and Homemaker Services;
    xi. Environmental Accessibility Adaptations;
    xii. Meals/Medically Tailored Meals;
    xiii. Sobering Centers; and/or
    xiv. Asthma Remediation.
b. Contractor shall indicate in Contractor's MOC Template and through MOC amendments which ILOS it will offer.
c. Contractor shall ensure ILOS are provided to Members in as timely a manner as possible, and shall develop Policies and Procedures outlining its approach to managing Provider shortages or other barriers to timely provision of ILOS.
d. Contractor is permitted to begin offering new pre-approved ILOS every six months upon notice and submission of an updated MOC to DHCS.
e. Contractor is permitted to discontinue offering ILOS annually with notice to DHCS.
    i. Contractor shall ensure ILOS that were authorized for a Member prior to the discontinuation of that specific ILOS are not disrupted by a change in ILOS offerings, either by completing the authorized service or by seamlessly transitioning the Member into other Medically Necessary services or programs that meet their needs.
f. Contractor shall notify Members affected by a decision to discontinue an ILOS of 1) the change and timing of discontinuation, and 2) the procedures

that will be used to ensure completion of the authorized ILOS or a transition into other Medically Necessary services.

g. Contractor is not restricted from providing voluntary services that are neither State-approved ILOS nor Covered Services when medically appropriate in accordance with 42 CFR 438.3(e)(1). Such voluntary services are not subject to the terms of this Provision and are subject to the limitations of 42 CFR 438.3(e)(1).

3. ILOS Providers

a. Contractor shall contract with ILOS Providers for the delivery of elected ILOS.

b. ILOS Providers are entities that Contractor has determined can provide the ILOS to eligible Members in an effective manner consistent with culturally and linguistically appropriate care.

c. Contractor shall ensure all ILOS Providers with which it contracts have sufficient experience and/or training in the provision of the ILOS being offered.
    i. ILOS Providers can include but are not limited to those listed in the In Lieu of Services – Service Description section of the ILOS Program Guide under "Licensing/Allowable Providers." Other entities that have training and/or experience providing ILOS in a culturally and linguistically competent manner may also serve as contracted ILOS Providers.

d. Contractor shall ensure ILOS Providers for whom a state-level enrollment pathway exists enroll in Medi-Cal, pursuant to relevant DHCS APLs including Provider Credentialing/Recredentialing and Screening/Enrollment APL 19-004.
    i. If APL 19-004 does not apply to an ILOS Provider, Contractor shall have a process for vetting the ILOS Provider, which may extend to individuals employed by or delivering services on behalf of the ILOS Provider, to ensure it can meet the capabilities and standards required to be an ILOS Provider.

e. Contractor shall support ILOS Provider access to systems and processes allowing them to obtain and document Member information including eligibility, ILOS authorization status, Member authorization for data sharing (to the extent required by federal law), and other relevant demographic and administrative information, and to support notification to Contractor and ECM Provider and PCP, as applicable, when a referral has been fulfilled *[See ILOS Section 10: Data System Requirements and Data Sharing to Support ILOS].*

f. To the extent Contractor elects to offer ILOS, Contractor is encouraged to coordinate its approach with other Medi-Cal Managed Care Health Plans offering ILOS in the same county.

4. ILOS Provider Capacity

a. Contractor shall make best efforts to develop a robust network of ILOS Providers to deliver all elected ILOS.

b. If Contractor is unable to offer its elected ILOS to all eligible Members for whom it is medically appropriate and cost-effective, it shall do the following:

i. Develop Policies and Procedures describing how Contractor will prioritize the delivery of ILOS when capacity is limited to avoid wait lists, including how it will ensure those Policies and Procedures are non-discriminatory in their application(s);
ii. Submit a three-year plan to DHCS detailing how it will build Network capacity over time, and update the plan annually; and
iii. Participate in regular meetings with DHCS to review progress towards expanding ILOS network capacity.

c. Contractor shall ensure its contracted ILOS Providers have sufficient capacity to receive referrals for ILOS and provide the agreed-upon volume of ILOS to Members who are authorized for such services on an ongoing basis.

5. Model of Care

a. Contractor shall develop and submit to DHCS for review and approval an MOC that shall be Contractor's framework for providing ILOS, which details:
   i. Which ILOS Contractor plans to offer;
   ii. Contractor's network of ILOS Providers; and,
   iii. All Policies and Procedures for the delivery of elected ILOS.
b. Contractor shall detail its MOC using the DHCS-developed MOC Template for DHCS review.
c. In developing and executing ILOS contracts with ILOS Providers, Contractor must incorporate requirements and Policies and Procedures described in its MOC, in addition to the ILOS Provider Standard Terms and Conditions.
d. Contractor is encouraged to collaborate on its MOC with other Medi-Cal Managed Care Health Plans within the same county, if applicable.
e. Contractor shall submit to DHCS any significant updates to its MOC for review and approval 60 days in advance of any changes or updates, consistent with DHCS guidance.

6. Transition of Whole Person Care and Health Homes Program to ILOS

a. In HHP and WPC Pilot Counties, Contractor is strongly encouraged to offer ILOS to HHP and WPC participants who are being provided similar services through WPC or HHP to provide continuity of the services being delivered as part of those programs.
b. In HHP and WPC Pilot Counties, Contractor shall contract with all WPC Lead Entities and HHP CB-CMEs as ILOS Providers unless Contractor receives prior written approval from DHCS, through the MOC review process, based on one or more of the following exceptions.
   i. ILOS Provider(s) does not provide the ILOS that Contractor has elected to offer;
   ii. There is a justified quality of care concern with the ILOS Provider(s);
   iii. Contractor and the ILOS Provider(s) are unable to agree on contracted rates;
   iv. ILOS Provider(s) is/are unwilling to contract;
   v. ILOS Provider(s) is/are unresponsive to multiple attempts to contract;
   vi. ILOS Provider(s) is/are unable to comply with the Medi-Cal enrollment process or vetting by the Contractor; and/or

vii. For ILOS Provider(s) without a state-level pathway to Medi-Cal enrollment, ILOS Provider(s) is/are unable to comply with Contractor processes for vetting qualifications and experience.

c. The requirement to contract with WPC Lead Entities and HHP CB-CMEs except as allowed under requirements b.i – vii of this section applies regardless of whether a Contractor offers an ILOS on a county-wide basis or not.

7. Identifying Members for ILOS

a. Contractor shall utilize a variety of methods to identify Members who may benefit from ILOS, including:
   i. Working with ECM Providers to identify Members receiving ECM who could benefit from ILOS;
   ii. Proactively identifying Members who may benefit from the DHCS-authorized ILOS that Contractor is offering;
   iii. Accepting requests from Providers and other community-based entities; and
   iv. Accepting Member and/or their family member(s), guardian, AR, caregiver, and/or authorized support person(s) requests.
b. Contractor shall develop Policies and Procedures for how Contractor will identify Members, and how it will accept requests for ILOS from Providers, other community-based entities, and Member and/or their family.
c. Contractor shall submit its Policies and Procedures to DHCS for review and approval.
d. Contractor shall develop Policies and Procedures to inform Members of ILOS for which they may be eligible and shall submit those Policies and Procedures and all Member notices to DHCS for review and approval prior to implementation.
   i. Contractor shall ensure that Member identification methods for ILOS are equitable and do not exacerbate or contribute to existing racial and ethnic disparities.

8. Authorizing Members for ILOS and Communication of Authorization Status

a. Contractor shall develop Policies and Procedures that explain how it will authorize ILOS for eligible Members in an equitable and non-discriminatory manner *[See ILOS Section 4: ILOS Provider Capacity].*
b. Contractor shall monitor and evaluate ILOS authorizations to ensure they are equitable and non-discriminatory. Contractor shall have Policies and Procedures for what immediate actions will be taken if monitoring/evaluation processes identify that service authorizations have had an inequitable effect.
c. Contractor shall validate Member eligibility for ILOS using a consistent methodology and authorize ILOS for Members for whom the ILOS is determined to be a medically appropriate and cost-effective alternative to services and settings covered under the State Plan.
   i. Contractor shall not restrict the authorization of ILOS only to Members who are transitioning from WPC and/or HHP.
d. Contractor shall submit Policies and Procedures to ensure Members do not experience undue delays pending the authorization process for ILOS.

i. If Medically Necessary, Contractor shall make available the State Plan Covered Services that the ILOS replaces, pending authorization of the requested ILOS.
ii. Contractor shall evaluate medical appropriateness and cost-effectiveness when determining whether to provide ILOS to a Member. Providing a particular ILOS to a Member in one instance does not automatically mean that providing another ILOS to the same Member, the same ILOS to another Member, or the same ILOS to the same Member in a different instance would be medically appropriate and cost-effective.

e. Contractor shall have Policies and Procedures for expediting the authorization of certain ILOS for urgent needs, as appropriate, and that identify the circumstances in which any expedited authorization processes apply.
    i. Contractor is encouraged to work with ILOS Providers to define a process and appropriate circumstances for presumptive authorization of ILOS whereby select ILOS Providers would be able to directly authorize an ILOS, potentially only for a limited period of time, under specified circumstances when a delay would be harmful to the Member or inconsistent with efficiency and cost-effectiveness.
f. Contractor shall permit Members who sought one or more ILOS offered by Contractor but were not authorized to receive the ILOS to submit a Grievance and/or Appeal to Contractor.
g. When a Member has requested an ILOS, directly or through a Provider, community-based organization, or other entity *[See ILOS Section 7: Identifying Members for ILOS]*, Contractor shall notify the requesting entity of Contractor's decision regarding ILOS authorization. If the Member is enrolled in ECM, Contractor shall ensure the ECM Provider is informed of the ILOS authorization decision.

9. Referring Members to ILOS Providers for ILOS

a. Contractor shall develop Policies and Procedures to define how ILOS Provider referrals will occur.
    i. For Members enrolled in ECM, Policies and Procedures must address how Contractor will work with the ECM Provider to coordinate the ILOS referral and communicate the outcome of the referral back to the ECM Provider (i.e., using closed loop referrals).
    ii. Policies and Procedures must include expectations and procedures to ensure referrals occur in a timely manner after service authorization.
b. If the Member's preferences for an ILOS Provider are known, Contractor shall follow those preferences, to the extent practicable.
c. Contractor shall track referrals to ILOS Provider(s) to verify if the authorized service has been delivered to the Member.
    i. If the Member receiving the ILOS is also receiving ECM, Contractor shall monitor to ensure that the ECM Provider tracks whether the Member receives the authorized service from the ILOS Provider.
d. Contractor shall not require Member authorization for ILOS-related data sharing (whether in writing or otherwise) as a condition of initiating delivery of ILOS, unless such authorization is required by federal law.

e. Contractor shall develop Policies and Procedures for its Network of ILOS Providers to:
    i. Ensure the Member agrees to the receipt of ILOS;
    ii. Where required by federal law, ensure that Members authorize information sharing with the Contractor and all others involved in the Member's care as needed to support the Member and maximize the benefits of ILOS; and
    iii. Communicate Member-level record of any authorization required by federal law, to allow data sharing (once obtained) back to Contractor.

10. Data System Requirements and Data Sharing to Support ILOS

a. Contractor shall use systems and processes capable of tracking ILOS referrals, access to ILOS, and grievances and appeals to Contractor.
    i. Contractor will support ILOS Provider access to systems and processes allowing them to track and manage referrals for ILOS and Member information.
b. As part of the referral process to ILOS Providers and consistent with federal, state and, if applicable, local privacy and confidentiality laws, Contractor shall ensure ILOS Providers have access to:
    i. Demographic and administrative information confirming the referred Member's eligibility and authorization for the requested service;
    ii. Appropriate administrative, clinical, and social service information the ILOS Providers might need to effectively provide the requested service; and
    iii. Billing information necessary to support the ILOS Providers' ability to submit claims or invoices to Contractor.
c. Contractor shall use defined federal and State standards, specifications, code sets, and terminologies when sharing physical, behavioral, social, and administrative data with ILOS Providers and with DHCS, to the extent practicable.

11. Oversight of ILOS Providers

a. Contractor shall perform oversight of ILOS Providers, holding them accountable to all ILOS requirements contained in this Contract amendment and associated guidance and Contractor's MOC.
b. Contractor shall use ILOS Provider Standard Terms and Conditions to develop its ILOS contracts with ILOS Providers and shall incorporate all of its ILOS Provider requirements, reviewed and approved by DHCS as part of its MOC, including all monitoring and reporting expectations and criteria.
c. To streamline ILOS implementation:
    i. Contractor shall hold ILOS Providers responsible for the same reporting requirements as those that Contractor must report to DHCS.
    ii. Contractor shall not impose mandatory reporting requirements that are alternative or additional to those required for encounter and supplemental reporting.
    iii. Contractor is encouraged to collaborate with other Medi-Cal Managed Care Health Plans within the same county on reporting requirements and oversight.

d. Contractor shall not utilize tools developed or promulgated by NCQA to perform oversight of ILOS Providers, unless by mutual consent with the ILOS Provider.
e. Contractor shall provide ILOS training and technical assistance to ILOS Providers, including in-person sessions, webinars, and/or calls, as necessary, in addition to Network Provider training requirements described in Exhibit A, Attachment 7, Provision 5, Network Provider Training.

12. Delegation of ILOS to Subcontractor(s)

a. Contractor may contract with other entities to administer ILOS in accordance with the following:
    i. Contractor shall maintain and be responsible for oversight of compliance with all Contract provisions and Covered Services, regardless of the number of layers of subcontracting, as described in Exhibit A, Attachment 6, Provision 14, Subcontracts;
    ii. Contractor shall be responsible for developing and maintaining DHCS-approved Policies and Procedures to ensure Subcontractors meet required responsibilities and functions as described in Exhibit A, Attachment 6, Provision 14, Subcontracts;
    iii. Contractor shall be responsible for evaluating the prospective Subcontractor's ability to perform services as described in Exhibit A, Attachment 6, Provision 14, Subcontracts;
    iv. Contractor shall report to DHCS the names of all Subcontractors by Subcontractor type and service(s) provided, and identify the county or counties in which Members are served as described in Exhibit A, Attachment 6, Provision 12, Plan Subcontractors; and
    v. Contractor shall make all 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 6, Provision 14, Subcontracts.
b. Contractor shall ensure the agreement between Contractor and Subcontractor mirrors the requirements set forth in this Contract and the standard ILOS Provider Terms and Conditions, as applicable to the Subcontractor.
c. Contractor is encouraged to collaborate with its Subcontractors on the approach to ILOS to minimize divergence in how the ILOS will be implemented between Contractor and its Subcontractor(s) and/or across multiple Subcontractors and ensure a streamlined, seamless experience for ILOS Providers and Members.

13. Payment of ILOS Providers

a. Contractor shall pay contracted ILOS Providers for the provision of authorized ILOS to Members in accordance with established contracts between Contractor and each ILOS Provider.
b. Contractor shall utilize the claims timeline and process as described in Exhibit A, Attachment 8, Provider Compensation Arrangements, 5. Claims Processing, B.

c. Contractor shall identify any circumstances under which payment for an ILOS must be expedited to facilitate timely delivery of the ILOS to the Member (e.g., recuperative care for an individual who is homeless and being discharged from the hospital) *[See ILOS Section 8: Authorizing Members for ILOS and Communication of Authorization Status].*
    i. For such circumstances, Contractor shall develop Policies and Procedures to ensure payment to the ILOS Provider is expedited, and share such Policies and Procedures with DHCS for prior approval.
d. Contractor shall ensure ILOS Providers submit a claim for ILOS rendered, to the greatest extent possible.
    i. If an ILOS Provider is unable to submit a claim for ILOS rendered, Contractor shall ensure the ILOS Provider documents services rendered using an invoice.
    ii. Upon receipt of such an invoice, Contractor shall be responsible for documenting the encounter for the ILOS rendered.

14. DHCS Oversight of ILOS

a. Contractor shall include details on the ILOS Contractor plans to offer in its MOC, including in which counties ILOS will be offered and its Network of ILOS Providers *[See Section 5: ILOS Model of Care].*
b. After implementation of ILOS, Contractor shall submit the following data and reports to DHCS to support DHCS' oversight of ILOS:
    i. Encounter data.
        a. Contractor must submit all ILOS encounters to DHCS using national standard specifications and code sets to be defined by DHCS. DHCS will provide guidance on invoicing standards for Contractor to use with ILOS Providers.
        b. Contractor shall be responsible for submitting to DHCS all ILOS encounter data, including encounter data for ILOS generated under subcontracting arrangements.
        c. In the event the ILOS Provider is unable to submit ILOS encounters to Contractor using the national standard specifications and code sets to be defined by DHCS, Contractor shall be responsible for converting ILOS Providers' invoice data into the national standard specifications and code sets, for submission to DHCS.
    ii. Supplemental reporting**.** Contractor shall submit supplemental reports, on a schedule and in a format to be defined by DHCS.
c. In the event of underperformance by Contractor in relation to its administration of ILOS, DHCS may administer sanctions as set out in Exhibit E, Attachment 2, Provision 16, Sanctions.

15. ILOS Quality and Performance Incentive Program

a. Contractor shall meet all quality management and quality improvement requirements described in Exhibit A, Attachment 4, Quality Improvement System and any additional quality requirements set forth in associated guidance from DHCS for ILOS offered.

b. Contractor may participate in a performance incentive program related to adoption of ILOS, building infrastructure and Provider capacity for ILOS, related health care quality and outcomes, and/or other performance milestones and measures, to be defined in forthcoming DHCS guidance.

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken October 7, 2021
Regular Meeting of the CalOptima Board of Directors

Consent Calendar
10. Consider Appointment of Whole-Child Model Family Advisory Committee Vice Chair

Contact
Ladan Khamseh, Chief Operating Officer, (714) 246-8866

Recommended Action
The Whole-Child Model Family Advisory Committee (WCM FAC) recommends the appointment of Kathleen Lear as WCM FAC Vice Chair for a term ending June 30, 2022

Background
The CalOptima Board of Directors established the WCM FAC by Resolution No. 17-1102-01 on November 2, 2017, to serve solely in an advisory capacity providing input and recommendations concerning the Whole-Child Model program. The WCM FAC is comprised of 11 voting members, seven of whom are to be designated as family representatives and the remaining four designated as community seats representing the interests of children receiving California Children Services (CCS).

Pursuant to Resolution No. 20-0806, the CalOptima Board of Directors is responsible for the appointment of the WCM FAC Chairs and Vice Chairs bi-annually from among appointed members. The Chair and Vice Chair may serve a two-year term.

Discussion
In the month leading up to the August 24, 2021, WCM FAC were asked to submit letters of interest for the Vice Chair positions to the Advisory Committees' staff. WCM FAC member Kathleen Lear submitted a letter of interest for the vice chair position that was left vacant due to the former vice chair's child aging out of the Whole Child Model program in July 2021. At their August 24, 2021, meeting, WCM FAC members voted to recommend Kathleen Lear as the WCM FAC Vice Chair to fulfill the remaining term left vacant by former member Brenda Deeley.

WCM FAC Vice Chair Candidate
Kathleen Lear

Ms. Lear is the parent of a special needs child who has recently been approved to receive CCS services. Ms. Lear is a substitute instructional assistant to special education children in the Los Alamitos Unified School District, and the Chair of the Family Advisory Committee at Children's Hospital of Orange County (CHOC). Ms. Lear is also a parent champion for CHOC's Community Outreach Parent Empowerment (COPE) group where she helps provide support for families living with epilepsy. Ms. Lear was appointed to the WCM FAC as a Consumer Advocate in October 2019 and is currently an Authorize Family Member Representative as of July 1, 2021.

Fiscal Impact
There is no fiscal impact.

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Rationale for Recommendation
Open nominations were held at the August 24, 2021, WCM FAC meeting based on the letters of interest received. During the meetings, there were no additional nominations made from the floor. The WCM FAC forwards the recommended Vice Chair candidate to the Board of Directors for consideration and appointment.

Concurrence
Whole-Child Model Family Advisory Committee
Gary Crockett, Chief Counsel

Attachments
None

/s/ Richard Sanchez — *09/30/2021*
Authorized Signature — **Date**

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Financial Summary

August 31, 2021

October 7, 2021

Board of Directors Meeting

Nancy Huang, Chief Financial Officer

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FY 2021–22: Management Summary

- Change in Net Assets Surplus or (Deficit)
  - MTD: $5.7 million, favorable to budget $11.9 million or 190.8%
  - YTD: $10.3 million, favorable to budget $20.8 million or 198.4%
- Enrollment
  - MTD: 850,239 members, favorable to budget 10,317 or 1.2%
  - YTD: 1,697,653 members, favorable to budget 19,995 or 1.2%
- Revenue
  - MTD: $358.9 million, favorable to budget $28.3 million or 8.6% driven by Medi-Cal (MC) line of business (LOB):
    - $15.3 million of Proposition 56 revenue due to the State's Fiscal Year (FY) 2021-2022 budget which extended the program and updates to the Proposition 56 risk corridor
    - $10.3 million due to favorable enrollment and increase in Long-Term Care (LTC) and pharmacy funding from the Department of Health Care Services (DHCS)
    - $1.1 million due to Prior Year (PY) retroactive eligibility
  - YTD: $712.9 million, favorable to budget $52.7 million or 8.0% driven by MC LOB:
    - $31.0 million due to the extension of Proposition 56 and updates to the Proposition 56 risk corridor
    - $17.1 million due to favorable enrollment and increase in LTC and pharmacy funding from DHCS
    - $4.8 million due to PY retroactive eligibility

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FY 2021–22: Management Summary (cont.)

- Medical Expenses
  - MTD: $341.4 million, unfavorable to budget $18.0 million or 5.6% driven by MC LOB:
    - Provider Capitation expense unfavorable variance of $12.8 million due primarily to the extension of Proposition 56
    - Professional Claims expense unfavorable variance of $4.1 million
    - Reinsurance & Other expense unfavorable variance of $2.2 million due to COVID-19 vaccination incentive
  - YTD: $680.2 million, unfavorable to budget $36.3 million or 5.6% driven by MC LOB:
    - Provider Capitation expense unfavorable variance of $26.5 million due primarily to the extension of Proposition 56
    - All other medical expense categories, with the exception of Facilities Claims and Medical Management, are experiencing higher than budgeted utilization
      - Facilities Claims expense favorable variance of $8.9 million
      - Medical Management expense favorable variance of $2.0 million
- Administrative Expenses
  - MTD: $12.0 million, favorable to budget $2.2 million or 15.3%
  - YTD: $24.0 million, favorable to budget $4.5 million or 15.9%
- Net Investment & Other Income
  - MTD: $0.3 million, unfavorable to budget $0.6 million or 67.3%
  - YTD: $1.6 million, unfavorable to budget $47,492 or 2.8%

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FY 2021–22: Key Financial Ratios

- Medical Loss Ratio (MLR)
  - MTD: Actual 95.1%, Budget 97.9%
  - YTD: Actual 95.4%, Budget 97.5%
- Administrative Loss Ratio (ALR)
  - MTD: Actual 3.3%, Budget 4.3%
  - YTD: Actual 3.4%, Budget 4.3%
- Balance Sheet Ratios
  - Current ratio: 1.7
  - Board-designated reserve funds level: 1.75
  - Net position: $1.3 billion, including required Tangible Net Equity (TNE) of $103.9 million

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Enrollment Summary: August 2021

Month-to-Date					Year-to-Date			
Actual	Budget	$ Variance	% Variance	Enrollment (by Aid Category)	Actual	Budget	$ Variance	% Variance
117,859	116,997	862	0.7%	SPD	235,569	233,891	1,678	0.7%
298,228	296,684	1,544	0.5%	TANF Child	596,932	593,205	3,727	0.6%
109,280	106,447	2,833	2.7%	TANF Adult	217,668	212,599	5,069	2.4%
3,096	3,191	(95)	(3.0%)	LTC	6,194	6,382	(188)	(2.9%)
292,533	288,267	4,266	1.5%	MCE	583,139	574,957	8,182	1.4%
11,907	11,159	748	6.7%	WCM	23,707	22,318	1,389	6.2%
832,903	**822,745**	**10,158**	**1.2%**	**Medi-Cal Total**	**1,663,209**	**1,643,352**	**19,857**	**1.2%**
14,819	**15,020**	**(201)**	**(1.3%)**	**OneCare Connect**	**29,507**	**30,003**	**(496)**	**(1.7%)**
2,110	**1,761**	**349**	**19.8%**	**OneCare**	**4,129**	**3,513**	**616**	**17.5%**
407	**396**	**11**	**2.8%**	**PACE**	**808**	**790**	**18**	**2.3%**
850,239	**839,922**	**10,317**	**1.2%**	**CalOptima Total**	**1,697,653**	**1,677,658**	**19,995**	**1.2%**

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Financial Highlights: August 2021

Month-to-Date					Year-to-Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
850,239	839,922	10,317	1.2%	Member Months	1,697,653	1,677,658	19,995	1.2%
358,865,754	330,526,596	28,339,158	8.6%	Revenues	712,872,302	660,220,284	52,652,018	8.0%
341,439,325	323,425,879	(18,013,446)	(5.6%)	Medical Expenses	680,180,074	643,854,224	(36,325,850)	(5.6%)
12,019,608	14,191,372	2,171,764	15.3%	Administrative Expenses	23,980,822	28,526,233	4,545,411	15.9%
5,406,822	**(7,090,655)**	**12,497,477**	**176.3%**	**Operating Margin**	**8,711,406**	**(12,160,173)**	**20,871,579**	**171.6%**
272,465	833,333	(560,868)	(67.3%)	Non Operating Income (Loss)	1,619,174	1,666,666	(47,492)	(2.8%)
5,679,288	**(6,257,322)**	**11,936,610**	**190.8%**	**Change in Net Assets**	**10,330,579**	**(10,493,507)**	**20,824,086**	**198.4%**
95.1%	97.9%	2.7%		Medical Loss Ratio	95.4%	97.5%	2.1%	
3.3%	4.3%	0.9%		Administrative Loss Ratio	3.4%	4.3%	1.0%	
1.5%	(2.1%)	3.7%		Operating Margin Ratio	1.2%	(1.8%)	3.1%	
100.0%	100.0%			Total Operating	100.0%	100.0%		

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Consolidated Performance Actual vs. Budget: August 2021(in millions)

MONTH-TO-DATE				YEAR-TO-DATE		
Actual	Budget	Variance		Actual	Budget	Variance
5.1	(6.7)	11.8	Medi-Cal	7.0	(11.3)	18.3
0.1	(0.5)	0.5	OCC	1.6	(0.9)	2.5
0.1	(0.1)	0.2	OneCare	(0.2)	(0.3)	0.1
0.1	0.2	(0.0)	PACE	0.3	0.3	0.0
5.4	**(7.1)**	**12.5**	**Operating**	**8.7**	**(12.2)**	**20.9**
0.3	0.8	(0.6)	Inv./Rental Inc, MCO tax	1.6	1.7	(0.0)
0.3	**0.8**	**(0.6)**	**Non-Operating**	**1.6**	**1.7**	**(0.0)**
5.7	**(6.3)**	**11.9**	**TOTAL**	**10.3**	**(10.5)**	**20.8**

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Consolidated Revenue & Expenses: August 2021 MTD

	Medi-Cal Classic	Medi-Cal Expansion	Whole Child Model	Total Medi-Cal	OneCare Connect	OneCare	PACE	Consolidated
MEMBER MONTHS	528,463	292,533	11,907	832,903	14,819	2,110	407	850,239
REVENUES								
Capitation Revenue	165,493,627	$ 135,414,987	$ 25,132,771	$ 326,041,385	$ 26,763,298	$ 2,632,051	$ 3,429,021	$ 358,865,754
Other Income	-	-	-	-	-	-	-	-
Total Operating Revenue	165,493,627	135,414,987	25,132,771	326,041,385	26,763,298	2,632,051	3,429,021	358,865,754
MEDICAL EXPENSES								
Provider Capitation	44,508,705	49,597,275	8,451,157	102,557,138	10,428,932	709,427		113,695,497
Facilities	28,867,636	25,529,641	6,917,262	61,314,540	4,435,788	569,577	931,302	67,251,206
Professional Claims	22,927,366	10,570,307	1,870,727	35,368,400	1,083,342	114,776	837,718	37,404,237
Prescription Drugs	22,773,569	29,017,609	6,369,560	58,160,738	6,279,130	869,115	339,572	65,648,555
MLTSS	38,098,768	4,153,912	2,200,667	44,453,347	1,454,891	103,284	73,531	46,085,052
Medical Management	2,157,730	1,300,765	271,603	3,730,097	938,618	30,080	820,827	5,519,623
Quality Incentives	1,451,535	933,552	53,970	2,439,057	219,855		5,088	2,663,999
Reinsurance & Other	1,577,623	1,316,991	11,143	2,905,758	145,844		119,554	3,171,155
Total Medical Expenses	162,362,932	122,420,053	26,146,090	310,929,075	24,986,400	2,396,259	3,127,591	341,439,325
Medical Loss Ratio	98.1%	90.4%	104.0%	95.4%	93.4%	91.0%	91.2%	95.1%
GROSS MARGIN	**3,130,695**	**12,994,934**	**(1,013,319)**	**15,112,310**	**1,776,898**	**235,792**	**301,430**	**17,426,430**
ADMINISTRATIVE EXPENSES								
Salaries & Benefits				7,446,570	818,062	84,990	123,092	8,472,714
Professional fees				45,175	31,946	16,000	3,232	96,353
Purchased services				943,559	79,571	9,665	3,150	1,035,946
Printing & Postage				265,425	88,559	6,103	1,671	361,758
Depreciation & Amortization				409,038			2,731	411,769
Other expenses				1,269,969	301		5,563	1,275,833
Indirect cost allocation & Occupancy				(380,620)	680,053	50,924	14,877	365,234
Total Administrative Expenses				9,999,116	1,698,493	167,682	154,316	12,019,608
Admin Loss Ratio				3.1%	6.3%	6.4%	4.5%	3.3%
INCOME (LOSS) FROM OPERATIONS				5,113,194	78,406	68,110	147,113	5,406,822
INVESTMENT INCOME								99,744
TOTAL MCO TAX				172,697				172,697
OTHER INCOME				25				25
CHANGE IN NET ASSETS				**$ 5,285,915**	**$ 78,406**	**$ 68,110**	**$ 147,113**	**$ 5,679,288**
BUDGETED CHANGE IN NET ASSETS				(6,661,862)	(465,600)	(120,176)	156,983	(6,257,322)
VARIANCE TO BUDGET - FAV (UNFAV)				$ 11,947,777	$ 544,006	$ 188,286	$ (9,870)	$ 11,936,610

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Consolidated Revenue & Expenses: August 2021 YTD

	Medi-Cal Classic	Medi-Cal Expansion	Whole Child Model	Total Medi-Cal	OneCare Connect	OneCare	PACE	Consolidated
MEMBER MONTHS	1,056,363	583,139	23,707	1,663,209	29,507	4,129	808	1,697,653
REVENUES								
Capitation Revenue	326,897,179	$ 268,599,872	$ 49,959,178	$ 645,456,230	$ 55,418,805	$ 5,290,902	$ 6,706,365	$ 712,872,302
Other Income	-	-	-	-	-	-	-	-
Total Operating Revenue	326,897,179	268,599,872	49,959,178	645,456,230	55,418,805	5,290,902	6,706,365	712,872,302
MEDICAL EXPENSES								
Provider Capitation	89,611,626	98,509,437	17,388,108	205,509,170	21,362,870	1,535,933		228,407,974
Facilities	52,736,738	48,789,901	13,986,999	115,513,638	8,024,161	1,304,508	1,832,802	126,675,110
Professional Claims	45,881,775	21,496,097	3,201,006	70,578,878	2,162,221	256,208	1,513,035	74,510,343
Prescription Drugs	44,125,365	58,936,669	13,371,038	116,433,073	13,198,019	1,745,163	642,652	132,018,907
MLTSS	80,807,232	8,719,414	4,211,911	93,738,556	2,832,116	223,580	158,787	96,953,039
Medical Management	4,727,875	2,855,670	601,205	8,184,749	1,983,604	69,181	1,686,302	11,923,835
Quality Incentives	3,008,187	1,926,818	110,863	5,045,867	441,915		10,100	5,497,882
Reinsurance & Other	1,918,634	1,513,219	22,297	3,454,150	498,149		240,686	4,192,985
Total Medical Expenses	322,817,431	242,747,225	52,893,426	618,458,082	50,503,056	5,134,573	6,084,363	680,180,074
Medical Loss Ratio	98.8%	90.4%	105.9%	95.8%	91.1%	97.0%	90.7%	95.4%
GROSS MARGIN	**4,079,748**	**25,852,647**	**(2,934,247)**	**26,998,148**	**4,915,749**	**156,329**	**622,002**	**32,692,228**
ADMINISTRATIVE EXPENSES								
Salaries & Benefits				14,533,911	1,603,895	160,925	222,924	16,521,654
Professional fees				185,273	42,369	32,000	3,356	262,998
Purchased services				1,755,855	189,233	24,815	4,551	1,974,454
Printing & Postage				763,344	155,061	10,092	19,646	948,143
Depreciation & Amortization				836,095			4,748	840,843
Other expenses				2,687,876	351		7,762	2,695,989
Indirect cost allocation & Occupancy				(744,438)	1,360,106	101,848	19,225	736,741
Total Administrative Expenses				20,017,916	3,351,014	329,680	282,211	23,980,822
Admin Loss Ratio				3.1%	6.0%	6.2%	4.2%	3.4%
INCOME (LOSS) FROM OPERATIONS				6,980,232	1,564,735	(173,351)	339,790	8,711,406
INVESTMENT INCOME								1,317,313
TOTAL MCO TAX				301,835				301,835
OTHER INCOME				25				25
CHANGE IN NET ASSETS				**$ 7,282,092**	**$ 1,564,735**	**$ (173,351)**	**$ 339,790**	**$ 10,330,579**
BUDGETED CHANGE IN NET ASSETS				(11,273,603)	(948,993)	(251,554)	313,977	(10,493,507)
VARIANCE TO BUDGET - FAV (UNFAV)				$ 18,555,695	$ 2,513,728	$ 78,203	$ 25,813	$ 20,824,086

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Balance Sheet: As of August 2021

ASSETS		LIABILITIES & NET POSITION	
Current Assets		**Current Liabilities**	
Operating Cash	$296,197,049	Accounts Payable	$35,180,064
Short-term Investments	1,065,537,455	Medical Claims liability	773,024,012
Capitation receivable	240,879,825	Accrued Payroll Liabilities	17,973,624
Receivables - Other	54,316,432	Deferred Revenue	12,282,694
Prepaid expenses	16,438,087	Deferred Lease Obligations	124,462
		Capitation and Withholds	156,243,252
Total Current Assets	**1,673,368,848**	**Total Current Liabilities**	**994,828,108**
Capital Assets			
Furniture & Equipment	46,251,085		
Building/Leasehold Improvements	5,840,138		
505 City Parkway West	51,777,223		
	103,868,446		
Less: accumulated depreciation	(58,862,455)		
Capital assets, net	45,005,991	Other (than pensions) post employment benefits liability	31,694,185
Other Assets		Net Pension Liabilities	30,420,182
Restricted Deposit & Other	300,000	Bldg 505 Development Rights	-
Homeless Health Reserve	56,798,913		
Board-designated assets:		**TOTAL LIABILITIES**	**1,056,942,476**
Cash and Cash Equivalents	411,595		
Investments	589,539,347	**Deferred Inflows**	
Total Board-designated Assets	589,950,942	Excess Earnings	344,198
		OPEB 75 Difference in Experience	536,000
Total Other Assets	647,049,855	Change in Assumptions	2,709,945
		OPEB Changes in Assumptions	773,000
		Net Position	
TOTAL ASSETS	**2,365,424,694**	TNE	103,891,712
		Funds in Excess of TNE	1,215,219,660
Deferred Outflows		**TOTAL NET POSITION**	1,319,111,372
Contributions	1,508,025		
Difference in Experience	3,236,721		
Excess Earning	2,104,780		
Changes in Assumptions	3,692,771		
OPEB 75 Changes in Assumptions	3,906,000		
Pension Contributions	544,000		
TOTAL ASSETS & DEFERRED OUTFLOWS	**2,380,416,991**	**TOTAL LIABILITIES, DEFERRED INFLOWS & NET POSITION**	**2,380,416,991**

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Board Designated Reserve and TNE Analysis: As of August 2021

Type	Reserve Name	Market Value	Benchmark		Variance	
			Low	High	Mkt - Low	Mkt - High
	Tier 1 - Payden & Rygel	241,551,590				
	Tier 1 - MetLife	240,471,607				
Board-designated Reserve		482,023,197	367,121,103	568,983,738	114,902,094	(86,960,541)
TNE Requirement	Tier 2 - MetLife	107,927,745	103,891,712	103,891,712	4,036,033	4,036,033
	Consolidated:	**589,950,942**	**471,012,815**	**672,875,450**	**118,938,127**	**(82,924,508)**
	Current reserve level	*1.75*	*1.40*	*2.00*		

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CalOptima
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Our Mission

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

CalOptima
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UNAUDITED FINANCIAL STATEMENTS

August 2021

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CalOptima - Consolidated
Financial Highlights
For the Two Months Ended August 31, 2021

Month-to-Date					Year-to-Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
850,239	839,922	10,317	1.2%	Member Months	1,697,653	1,677,658	19,995	1.2%
358,865,754	330,526,596	28,339,158	8.6%	Revenues	712,872,302	660,220,284	52,652,018	8.0%
341,439,325	323,425,879	(18,013,446)	(5.6%)	Medical Expenses	680,180,074	643,854,224	(36,325,850)	(5.6%)
12,019,608	14,191,372	2,171,764	15.3%	Administrative Expenses	23,980,822	28,526,233	4,545,411	15.9%
5,406,822	**(7,090,655)**	**12,497,477**	**176.3%**	**Operating Margin**	**8,711,406**	**(12,160,173)**	**20,871,579**	**171.6%**
272,465	833,333	(560,868)	(67.3%)	Non Operating Income (Loss)	1,619,174	1,666,666	(47,492)	(2.8%)
5,679,288	**(6,257,322)**	**11,936,610**	**190.8%**	**Change in Net Assets**	**10,330,579**	**(10,493,507)**	**20,824,086**	**198.4%**
95.1%	97.9%	2.7%		Medical Loss Ratio	95.4%	97.5%	2.1%	
3.3%	4.3%	0.9%		Administrative Loss Ratio	3.4%	4.3%	1.0%	
1.5%	(2.1%)	3.7%		Operating Margin Ratio	1.2%	(1.8%)	3.1%	
100.0%	100.0%			Total Operating	100.0%	100.0%		

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CalOptima
Financial Dashboard
For the Two Months Ended August 31, 2021

MONTH - TO - DATE

Enrollment	Actual	Budget	Fav / (Unfav)	
Medi-Cal	832,903	822,745	10,158	1.2%
OneCare Connect	14,819	15,020	(201)	(1.3%)
OneCare	2,110	1,761	349	19.8%
PACE	407	396	11	2.8%
Total	850,239	839,922	10,317	1.2%

Change in Net Assets (000)	Actual	Budget	Fav / (Unfav)	
Medi-Cal	$ 5,286	$ (6,662)	$ 11,948	179.3%
OneCare Connect	78	(466)	544	116.7%
OneCare	68	(120)	188	156.7%
PACE	147	157	(10)	(6.4%)
505 Bldg.	-	-	-	0.0%
Investment Income & Other	100	833	(733)	(88.0%)
Total	$ 5,679	$ (6,258)	$ 11,937	190.7%

MLR	Actual	Budget	% Point Var
Medi-Cal	95.4%	98.2%	2.9
OneCare Connect	93.4%	95.1%	1.7
OneCare	91.0%	97.1%	6.0

Administrative Cost (000)	Actual	Budget	Fav / (Unfav)	
Medi-Cal	$ 9,999	$ 11,975	$ 1,976	16.5%
OneCare Connect	1,698	1,829	131	7.2%
OneCare	168	179	12	6.5%
PACE	154	208	53	25.7%
Total	$ 12,020	$ 14,191	$ 2,172	15.3%

Total FTE's Month	Actual	Budget	Fav / (Unfav)
Medi-Cal	1,070	1,214	144
OneCare Connect	191	209	18
OneCare	10	9	(0)
PACE	93	110	17
Total	1,364	1,542	178

MM per FTE	Actual	Budget	Fav / (Unfav)
Medi-Cal	778	678	101
OneCare Connect	78	72	6
OneCare	216	189	26
PACE	4	4	1
Total	1,076	943	133

YEAR - TO - DATE

Year To Date Enrollment	Actual	Budget	Fav / (Unfav)	
Medi-Cal	1,663,209	1,643,352	19,857	1.2%
OneCare Connect	29,507	30,003	(496)	(1.7%)
OneCare	4,129	3,513	616	17.5%
PACE	808	790	18	2.3%
Total	1,697,653	1,677,658	19,995	1.2%

Change in Net Assets (000)	Actual	Budget	Fav / (Unfav)	
Medi-Cal	$ 7,282	$ (11,274)	$ 18,556	164.6%
OneCare Connect	1,565	(949)	2,514	264.9%
OneCare	(173)	(252)	79	31.3%
PACE	340	314	26	8.3%
505 Bldg.	-	-	-	0.0%
Investment Income & Other	1,317	1,667	(350)	(21.0%)
Total	$ 10,331	$ (10,494)	$ 20,825	198.4%

MLR	Actual	Budget	% Point Var
Medi-Cal	95.8%	97.9%	2.1
OneCare Connect	91.1%	94.9%	3.8
OneCare	97.0%	97.3%	0.3

Administrative Cost (000)	Actual	Budget	Fav / (Unfav)	
Medi-Cal	$ 20,018	$ 24,000	$ 3,982	16.6%
OneCare Connect	3,351	3,748	397	10.6%
OneCare	330	360	30	8.4%
PACE	282	418	136	32.5%
Total	$ 23,981	$ 28,526	$ 4,545	15.9%

Total FTE's YTD	Actual	Budget	Fav / (Unfav)
Medi-Cal	2,140	2,426	286
OneCare Connect	383	418	34
OneCare	20	19	(1)
PACE	182	220	38
Total	2,725	3,082	357

MM per FTE	Actual	Budget	Fav / (Unfav)
Medi-Cal	777	678	100
OneCare Connect	77	72	5
OneCare	209	189	20
PACE	4	4	1
Total	1,068	942	126

CalOptima - Consolidated
Statement of Revenues and Expenses
For the One Month Ended August 31, 2021

	Actual		Budget		Variance	
	$	PMPM	$	PMPM	$	PMPM
MEMBER MONTHS	850,239		839,922		10,317	
REVENUE						
Medi-Cal	$ 326,041,385	$ 391.45	$ 297,692,938	$ 361.83	$ 28,348,447	$ 29.62
OneCare Connect	26,763,298	1,806.01	27,598,277	1,837.44	(834,979)	(31.43)
OneCare	2,632,051	1,247.42	2,025,149	1,150.00	606,902	97.42
PACE	3,429,021	8,425.11	3,210,232	8,106.65	218,789	318.46
Total Operating Revenue	358,865,754	422.08	330,526,596	393.52	28,339,158	28.56
MEDICAL EXPENSES						
Medi-Cal	310,929,075	373.31	292,379,847	355.37	(18,549,228)	(17.94)
OneCare Connect	24,986,400	1,686.11	26,234,560	1,746.64	1,248,160	60.53
OneCare	2,396,259	1,135.67	1,965,951	1,116.38	(430,308)	(19.29)
PACE	3,127,591	7,684.50	2,845,521	7,185.66	(282,070)	(498.84)
Total Medical Expenses	341,439,325	401.58	323,425,879	385.07	(18,013,446)	(16.51)
GROSS MARGIN	17,426,430	20.50	7,100,717	8.45	10,325,713	12.05
ADMINISTRATIVE EXPENSES						
Salaries and benefits	8,472,714	9.97	9,109,817	10.85	637,103	0.88
Professional fees	96,353	0.11	504,813	0.60	408,460	0.49
Purchased services	1,035,946	1.22	1,300,514	1.55	264,568	0.33
Printing & Postage	361,758	0.43	556,990	0.66	195,232	0.23
Depreciation & Amortization	411,769	0.48	492,900	0.59	81,131	0.11
Other expenses	1,275,833	1.50	1,787,404	2.13	511,571	0.63
Indirect cost allocation & Occupancy expense	365,234	0.43	438,934	0.52	73,700	0.09
Total Administrative Expenses	12,019,608	14.14	14,191,372	16.90	2,171,764	2.76
INCOME (LOSS) FROM OPERATIONS	5,406,822	6.36	(7,090,655)	(8.44)	12,497,477	14.80
INVESTMENT INCOME						
Interest income	608,668	0.72	833,333	0.99	(224,665)	(0.27)
Realized gain/(loss) on investments	250,615	0.29	-	-	250,615	0.29
Unrealized gain/(loss) on investments	(759,539)	(0.89)	-	-	(759,539)	(0.89)
Total Investment Income	99,744	0.12	833,333	0.99	(733,589)	(0.87)
TOTAL MCO TAX	172,697	0.20	-	-	172,697	0.20
OTHER INCOME	25	-	-	-	25	-
CHANGE IN NET ASSETS	**5,679,288**	**6.68**	**(6,257,322)**	**(7.45)**	**11,936,610**	**14.13**
MEDICAL LOSS RATIO	**95.1%**		**97.9%**		**2.7%**	
ADMINISTRATIVE LOSS RATIO	**3.3%**		**4.3%**		**0.9%**	

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CalOptima - Consolidated
Statement of Revenues and Expenses
For the Two Months Ended August 31, 2021

	Actual		Budget		Variance	
	$	PMPM	$	PMPM	$	PMPM
MEMBER MONTHS	1,697,653		1,677,658		19,995	
REVENUE						
Medi-Cal	$ 645,456,230	$ 388.08	$ 594,559,614	$ 361.80	$ 50,896,616	$ 26.28
OneCare Connect	55,418,805	1,878.16	55,216,527	1,840.37	202,278	37.79
OneCare	5,290,902	1,281.40	4,040,505	1,150.16	1,250,397	131.24
PACE	6,706,365	8,299.96	6,403,638	8,105.87	302,727	194.09
Total Operating Revenue	712,872,302	419.92	660,220,284	393.54	52,652,018	26.38
MEDICAL EXPENSES						
Medi-Cal	618,458,082	371.85	581,833,180	354.05	(36,624,902)	(17.80)
OneCare Connect	50,503,056	1,711.56	52,417,382	1,747.07	1,914,326	35.51
OneCare	5,134,573	1,243.54	3,931,965	1,119.26	(1,202,608)	(124.28)
PACE	6,084,363	7,530.15	5,671,697	7,179.36	(412,666)	(350.79)
Total Medical Expenses	680,180,074	400.66	643,854,224	383.78	(36,325,850)	(16.88)
GROSS MARGIN	32,692,228	19.26	16,366,060	9.76	16,326,168	9.50
ADMINISTRATIVE EXPENSES						
Salaries and benefits	16,521,654	9.73	18,321,700	10.92	1,800,046	1.19
Professional fees	262,998	0.15	1,064,170	0.63	801,172	0.48
Purchased services	1,974,454	1.16	2,582,851	1.54	608,397	0.38
Printing & Postage	948,143	0.56	1,113,996	0.66	165,853	0.10
Depreciation & Amortization	840,843	0.50	985,800	0.59	144,957	0.09
Other expenses	2,695,989	1.59	3,579,848	2.13	883,859	0.54
Indirect cost allocation & Occupancy expense	736,741	0.43	877,868	0.52	141,127	0.09
Total Administrative Expenses	23,980,822	14.13	28,526,233	17.00	4,545,411	2.87
INCOME (LOSS) FROM OPERATIONS	8,711,406	5.13	(12,160,173)	(7.25)	20,871,579	12.38
INVESTMENT INCOME						
Interest income	1,161,861	0.68	1,666,666	0.99	(504,805)	(0.31)
Realized gain/(loss) on investments	249,078	0.15	-	-	249,078	0.15
Unrealized gain/(loss) on investments	(93,626)	(0.06)	-	-	(93,626)	(0.06)
Total Investment Income	1,317,313	0.78	1,666,666	0.99	(349,353)	(0.21)
TOTAL MCO TAX	301,835	0.18	-	-	301,835	0.18
OTHER INCOME	25	-	-	-	25	-
CHANGE IN NET ASSETS	**10,330,579**	**6.09**	**(10,493,507)**	**(6.25)**	**20,824,086**	**12.34**
MEDICAL LOSS RATIO	**95.4%**		**97.5%**		**2.1%**	
ADMINISTRATIVE LOSS RATIO	**3.4%**		**4.3%**		**1.0%**	

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CalOptima - Consolidated - Month to Date
Statement of Revenues and Expenses by LOB
For the One Month Ended August 31, 2021

	Medi-Cal Classic	Medi-Cal Expansion	Whole Child Model	Total Medi-Cal	OneCare Connect	OneCare	PACE	Consolidated
MEMBER MONTHS	528,463	292,533	11,907	832,903	14,819	2,110	407	850,239
REVENUES								
Capitation Revenue	165,493,627	$ 135,414,987	$ 25,132,771	$ 326,041,385	$ 26,763,298	$ 2,632,051	$ 3,429,021	$ 358,865,754
Other Income	-	-	-	-	-	-	-	-
Total Operating Revenue	165,493,627	135,414,987	25,132,771	326,041,385	26,763,298	2,632,051	3,429,021	358,865,754
MEDICAL EXPENSES								
Provider Capitation	44,508,705	49,597,275	8,451,157	102,557,138	10,428,932	709,427		113,695,497
Facilities	28,867,636	25,529,641	6,917,262	61,314,540	4,435,788	569,577	931,302	67,251,206
Professional Claims	22,927,366	10,570,307	1,870,727	35,368,400	1,083,342	114,776	837,718	37,404,237
Prescription Drugs	22,773,569	29,017,609	6,369,560	58,160,738	6,279,130	869,115	339,572	65,648,555
MLTSS	38,098,768	4,153,912	2,200,667	44,453,347	1,454,891	103,284	73,531	46,085,052
Medical Management	2,157,730	1,300,765	271,603	3,730,097	938,618	30,080	820,827	5,519,623
Quality Incentives	1,451,535	933,552	53,970	2,439,057	219,855		5,088	2,663,999
Reinsurance & Other	1,577,623	1,316,991	11,143	2,905,758	145,844		119,554	3,171,155
Total Medical Expenses	162,362,932	122,420,053	26,146,090	310,929,075	24,986,400	2,396,259	3,127,591	341,439,325
Medical Loss Ratio	98.1%	90.4%	104.0%	95.4%	93.4%	91.0%	91.2%	95.1%
GROSS MARGIN	**3,130,695**	**12,994,934**	**(1,013,319)**	**15,112,310**	**1,776,898**	**235,792**	**301,430**	**17,426,430**
ADMINISTRATIVE EXPENSES								
Salaries & Benefits				7,446,570	818,062	84,990	123,092	8,472,714
Professional fees				45,175	31,946	16,000	3,232	96,353
Purchased services				943,559	79,571	9,665	3,150	1,035,946
Printing & Postage				265,425	88,559	6,103	1,671	361,758
Depreciation & Amortization				409,038			2,731	411,769
Other expenses				1,269,969	301		5,563	1,275,833
Indirect cost allocation & Occupancy				(380,620)	680,053	50,924	14,877	365,234
Total Administrative Expenses				9,999,116	1,698,493	167,682	154,316	12,019,608
Admin Loss Ratio				3.1%	6.3%	6.4%	4.5%	3.3%
INCOME (LOSS) FROM OPERATIONS				5,113,194	78,406	68,110	147,113	5,406,822
INVESTMENT INCOME								99,744
TOTAL MCO TAX				172,697				172,697
OTHER INCOME				25				25
CHANGE IN NET ASSETS				**$ 5,285,915**	**$ 78,406**	**$ 68,110**	**$ 147,113**	**$ 5,679,288**
BUDGETED CHANGE IN NET ASSETS				(6,661,862)	(465,600)	(120,176)	156,983	(6,257,322)
VARIANCE TO BUDGET - FAV (UNFAV)				$ 11,947,777	$ 544,006	$ 188,286	$ (9,870)	$ 11,936,610

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CalOptima - Consolidated - Year to Date
Statement of Revenues and Expenses by LOB
For the Two Months Ended August 31, 2021

	Medi-Cal Classic	Medi-Cal Expansion	Whole Child Model	Total Medi-Cal	OneCare Connect	OneCare	PACE	Consolidated
MEMBER MONTHS	1,056,363	583,139	23,707	1,663,209	29,507	4,129	808	1,697,653
REVENUES								
Capitation Revenue	326,897,179	$ 268,599,872	$ 49,959,178	$ 645,456,230	$ 55,418,805	$ 5,290,902	$ 6,706,365	$ 712,872,302
Other Income	-	-	-	-	-	-	-	-
Total Operating Revenue	326,897,179	268,599,872	49,959,178	645,456,230	55,418,805	5,290,902	6,706,365	712,872,302
MEDICAL EXPENSES								
Provider Capitation	89,611,626	98,509,437	17,388,108	205,509,170	21,362,870	1,535,933		228,407,974
Facilities	52,736,738	48,789,901	13,986,999	115,513,638	8,024,161	1,304,508	1,832,802	126,675,110
Professional Claims	45,881,775	21,496,097	3,201,006	70,578,878	2,162,221	256,208	1,513,035	74,510,343
Prescription Drugs	44,125,365	58,936,669	13,371,038	116,433,073	13,198,019	1,745,163	642,652	132,018,907
MLTSS	80,807,232	8,719,414	4,211,911	93,738,556	2,832,116	223,580	158,787	96,953,039
Medical Management	4,727,875	2,855,670	601,205	8,184,749	1,983,604	69,181	1,686,302	11,923,835
Quality Incentives	3,008,187	1,926,818	110,863	5,045,867	441,915		10,100	5,497,882
Reinsurance & Other	1,918,634	1,513,219	22,297	3,454,150	498,149		240,686	4,192,985
Total Medical Expenses	322,817,431	242,747,225	52,893,426	618,458,082	50,503,056	5,134,573	6,084,363	680,180,074
Medical Loss Ratio	98.8%	90.4%	105.9%	95.8%	91.1%	97.0%	90.7%	95.4%
GROSS MARGIN	**4,079,748**	**25,852,647**	**(2,934,247)**	**26,998,148**	**4,915,749**	**156,329**	**622,002**	**32,692,228**
ADMINISTRATIVE EXPENSES								
Salaries & Benefits				14,533,911	1,603,895	160,925	222,924	16,521,654
Professional fees				185,273	42,369	32,000	3,356	262,998
Purchased services				1,755,855	189,233	24,815	4,551	1,974,454
Printing & Postage				763,344	155,061	10,092	19,646	948,143
Depreciation & Amortization				836,095			4,748	840,843
Other expenses				2,687,876	351		7,762	2,695,989
Indirect cost allocation & Occupancy				(744,438)	1,360,106	101,848	19,225	736,741
Total Administrative Expenses				20,017,916	3,351,014	329,680	282,211	23,980,822
Admin Loss Ratio				3.1%	6.0%	6.2%	4.2%	3.4%
INCOME (LOSS) FROM OPERATIONS				6,980,232	1,564,735	(173,351)	339,790	8,711,406
INVESTMENT INCOME								1,317,313
TOTAL MCO TAX				301,835				301,835
OTHER INCOME				25				25
CHANGE IN NET ASSETS				**$ 7,282,092**	**$ 1,564,735**	**$ (173,351)**	**$ 339,790**	**$ 10,330,579**
BUDGETED CHANGE IN NET ASSETS				(11,273,603)	(948,993)	(251,554)	313,977	(10,493,507)
VARIANCE TO BUDGET - FAV (UNFAV)				$ 18,555,695	$ 2,513,728	$ 78,203	$ 25,813	$ 20,824,086

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August 31, 2021 Unaudited Financial Statements

SUMMARY MONTHLY RESULTS:

- Change in Net Assets is $5.7 million, $11.9 million favorable to budget
- Operating surplus is $5.4 million, with a surplus in non-operating income of $0.3 million

YEAR TO DATE RESULTS:

- Change in Net Assets is $10.3 million, $20.8 million favorable to budget
- Operating surplus is $8.7 million, with a surplus in non-operating income of $1.6 million

Change in Net Assets by Line of Business (LOB) ($ millions):

MONTH-TO-DATE				YEAR-TO-DATE		
Actual	Budget	Variance		Actual	Budget	Variance
5.1	(6.7)	11.8	Medi-Cal	7.0	(11.3)	18.3
0.1	(0.5)	0.5	OCC	1.6	(0.9)	2.5
0.1	(0.1)	0.2	OneCare	(0.2)	(0.3)	0.1
0.1	0.2	(0.0)	PACE	0.3	0.3	0.0
5.4	**(7.1)**	**12.5**	**Operating**	**8.7**	**(12.2)**	**20.9**
0.3	0.8	(0.6)	Inv./Rental Inc, MCO tax	1.6	1.7	(0.0)
0.3	**0.8**	**(0.6)**	**Non-Operating**	**1.6**	**1.7**	**(0.0)**
5.7	**(6.3)**	**11.9**	**TOTAL**	**10.3**	**(10.5)**	**20.8**

CalOptima - Consolidated
Enrollment Summary
For the Two Months Ended August 31, 2021

Month-to-Date					Year-to-Date			
Actual	Budget	$ Variance	% Variance	Enrollment (by Aid Category)	Actual	Budget	$ Variance	% Variance
117,859	116,997	862	0.7%	SPD	235,569	233,891	1,678	0.7%
298,228	296,684	1,544	0.5%	TANF Child	596,932	593,205	3,727	0.6%
109,280	106,447	2,833	2.7%	TANF Adult	217,668	212,599	5,069	2.4%
3,096	3,191	(95)	(3.0%)	LTC	6,194	6,382	(188)	(2.9%)
292,533	288,267	4,266	1.5%	MCE	583,139	574,957	8,182	1.4%
11,907	11,159	748	6.7%	WCM	23,707	22,318	1,389	6.2%
832,903	**822,745**	**10,158**	**1.2%**	**Medi-Cal Total**	**1,663,209**	**1,643,352**	**19,857**	**1.2%**
14,819	**15,020**	**(201)**	**(1.3%)**	**OneCare Connect**	**29,507**	**30,003**	**(496)**	**(1.7%)**
2,110	**1,761**	**349**	**19.8%**	**OneCare**	**4,129**	**3,513**	**616**	**17.5%**
407	**396**	**11**	**2.8%**	**PACE**	**808**	**790**	**18**	**2.3%**
850,239	**839,922**	**10,317**	**1.2%**	**CalOptima Total**	**1,697,653**	**1,677,658**	**19,995**	**1.2%**
				Enrollment (by Network)				
193,852	190,232	3,620	1.9%	HMO	387,033	379,856	7,177	1.9%
227,587	227,471	116	0.1%	PHC	455,263	454,569	694	0.2%
204,076	202,472	1,604	0.8%	Shared Risk Group	407,605	404,281	3,324	0.8%
207,388	202,570	4,818	2.4%	Fee for Service	413,308	404,646	8,662	2.1%
832,903	**822,745**	**10,158**	**1.2%**	**Medi-Cal Total**	**1,663,209**	**1,643,352**	**19,857**	**1.2%**
14,819	**15,020**	**(201)**	**(1.3%)**	**OneCare Connect**	**29,507**	**30,003**	**(496)**	**(1.7%)**
2,110	**1,761**	**349**	**19.8%**	**OneCare**	**4,129**	**3,513**	**616**	**17.5%**
407	**396**	**11**	**2.8%**	**PACE**	**808**	**790**	**18**	**2.3%**
850,239	**839,922**	**10,317**	**1.2%**	**CalOptima Total**	**1,697,653**	**1,677,658**	**19,995**	**1.2%**

CalOptima
Enrollment Trend by Network
Fiscal Year 2022

	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	YTD Actual	YTD Budget	Variance
HMOs															
SPD	10,759	10,772											21,531	21,561	(30)
TANF Child	57,684	57,453											115,137	113,962	1,175
TANF Adult	33,827	34,099											67,926	65,985	1,941
LTC		1											1		1
MCE	88,797	89,334											178,131	174,328	3,803
WCM	2,114	2,193											4,307	4,020	287
Total	**193,181**	**193,852**											**387,033**	**379,856**	**7,177**
PHCs															
SPD	6,896	6,819											13,715	14,221	(506)
TANF Child	155,214	154,985											310,199	309,151	1,048
TANF Adult	14,006	14,054											28,060	27,470	590
LTC		2											2		2
MCE	44,256	44,359											88,615	89,983	(1,368)
WCM	7,304	7,368											14,672	13,744	928
Total	**227,676**	**227,587**											**455,263**	**454,569**	**694**
Shared Risk Groups															
SPD	10,063	10,104											20,167	20,642	(475)
TANF Child	59,085	58,837											117,922	119,031	(1,109)
TANF Adult	33,013	33,123											66,136	65,939	197
LTC	1	1											2		2
MCE	99,994	100,643											200,637	195,837	4,800
WCM	1,373	1,368											2,741	2,832	(91)
Total	**203,529**	**204,076**											**407,605**	**404,281**	**3,324**
Fee for Service (Dual)															
SPD	79,829	80,117											159,946	156,785	3,161
TANF Child	1	1											2		2
TANF Adult	1,318	1,351											2,669	2,322	347
LTC	2,788	2,778											5,566	5,774	(208)
MCE	3,612	3,813											7,425	5,139	2,286
WCM	16	16											32	30	2
Total	**87,564**	**88,076**											**175,640**	**170,050**	**5,590**
Fee for Service (Non-Dual - Total)															
SPD	10,163	10,047											20,210	20,682	(472)
TANF Child	26,720	26,952											53,672	51,061	2,611
TANF Adult	26,224	26,653											52,877	50,883	1,994
LTC	309	314											623	608	15
MCE	53,947	54,384											108,331	109,670	(1,339)
WCM	993	962											1,955	1,692	263
Total	**118,356**	**119,312**											**237,668**	**234,596**	**3,072**
SPD	117,710	117,859											235,569	233,891	1,678
TANF Child	298,704	298,228											596,932	593,205	3,727
TANF Adult	108,388	109,280											217,668	212,599	5,069
LTC	3,098	3,096											6,194	6,382	(188)
MCE	290,606	292,533											583,139	574,957	8,182
WCM	11,800	11,907											23,707	22,318	1,389
Total Medi-Cal MM	**830,306**	**832,903**											**1,663,209**	**1,643,352**	**19,857**
OneCare Connect	**14,688**	**14,819**											**29,507**	**30,003**	**(496)**
OneCare	**2,019**	**2,110**											**4,129**	**3,513**	**616**
PACE	**401**	**407**											**808**	**790**	**18**
Grand Total	**847,414**	**850,239**											**1,697,653**	**1,677,658**	**19,995**

ENROLLMENT:

Overall, August enrollment was 850,239

- Favorable to budget 10,317 or 1.2%
- Increased 2,825 or 0.3% from Prior Month (PM) (July 2021)
- Increased 65,498 or 8.3% from Prior Year (PY) (August 2020)

Medi-Cal enrollment was 832,903

- Favorable to budget 10,158 or 1.2%
  - Temporary Assistance for Needy Families (TANF) favorable 4,377
  - Medi-Cal Expansion (MCE) favorable 4,266
  - Seniors and Persons with Disabilities (SPD) favorable 862
  - Whole Child Model (WCM) favorable 748
  - Long-Term Care (LTC) unfavorable 95
- Increased 2,597 from PM

OneCare Connect enrollment was 14,819

- Unfavorable to budget 201 or 1.3%
- Increased 131 from PM

OneCare enrollment was 2,110

- Favorable to budget 349 or 19.8%
- Increased 91 from PM

PACE enrollment was 407

- Favorable to budget 11 or 2.8%
- Increased 6 from PM

CalOptima
Medi-Cal Total
Statement of Revenues and Expenses
For the Two Months Ending August 31, 2021

Month					Year to Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
832,903	**822,745**	**10,158**	**1.2%**	**Member Months**	**1,663,209**	**1,643,352**	**19,857**	**1.2%**
				Revenues				
326,041,385	297,692,938	28,348,447	9.5%	Capitation Revenue	645,456,230	594,559,614	50,896,616	8.6%
-	-	-	0.0%	Other Income	-	-	-	0.0%
326,041,385	**297,692,938**	**28,348,447**	**9.5%**	**Total Operating Revenue**	**645,456,230**	**594,559,614**	**50,896,616**	**8.6%**
				Medical Expenses				
104,996,195	92,187,466	(12,808,729)	(13.9%)	Provider Capitation	210,555,038	184,074,741	(26,480,297)	(14.4%)
61,314,540	62,987,816	1,673,276	2.7%	Facilities Claims	115,513,638	124,414,696	8,901,058	7.2%
35,368,400	31,226,573	(4,141,827)	(13.3%)	Professional Claims	70,578,878	62,004,540	(8,574,338)	(13.8%)
58,160,738	57,872,939	(287,799)	(0.5%)	Prescription Drugs	116,433,073	115,454,709	(978,364)	(0.8%)
44,453,347	42,371,703	(2,081,644)	(4.9%)	MLTSS	93,738,556	84,283,996	(9,454,560)	(11.2%)
3,730,097	5,032,666	1,302,569	25.9%	Medical Management	8,184,749	10,199,130	2,014,381	19.8%
2,905,758	700,684	(2,205,074)	(314.7%)	Reinsurance & Other	3,454,150	1,401,368	(2,052,782)	(146.5%)
310,929,075	**292,379,847**	**(18,549,228)**	**(6.3%)**	**Total Medical Expenses**	**618,458,082**	**581,833,180**	**(36,624,902)**	**(6.3%)**
15,112,310	**5,313,091**	**9,799,219**	**184.4%**	**Gross Margin**	**26,998,148**	**12,726,434**	**14,271,714**	**112.1%**
				Administrative Expenses				
7,446,570	8,029,085	582,515	7.3%	Salaries, Wages & Employee Benefits	14,533,911	16,141,880	1,607,969	10.0%
45,175	463,730	418,555	90.3%	Professional Fees	185,273	907,004	721,731	79.6%
943,559	1,141,814	198,255	17.4%	Purchased Services	1,755,855	2,265,449	509,594	22.5%
265,425	383,822	118,397	30.8%	Printing and Postage	763,344	767,656	4,312	0.6%
409,038	492,500	83,462	16.9%	Depreciation & Amortization	836,095	985,000	148,905	15.1%
1,269,969	1,760,989	491,020	27.9%	Other Operating Expenses	2,687,876	3,527,022	839,146	23.8%
(380,620)	(296,987)	83,633	28.2%	Indirect Cost Allocation, Occupancy Expense	(744,438)	(593,974)	150,464	25.3%
9,999,116	**11,974,953**	**1,975,837**	**16.5%**	**Total Administrative Expenses**	**20,017,916**	**24,000,037**	**3,982,121**	**16.6%**
				Operating Tax				
14,026,863	13,855,027	171,836	1.2%	Tax Revenue	28,010,169	27,674,051	336,118	1.2%
27,708,333	13,855,027	(13,853,306)	(100.0%)	Premium Tax Expense	27,708,333	27,674,051	(34,282)	(0.1%)
(13,854,167)	-	13,854,167	0.0%	Sales Tax Expense	-	-	-	0.0%
172,697	-	172,697	**0.0%**	**Total Net Operating Tax**	301,835	-	301,835	**0.0%**
25	**-**	**25**	**0.0%**	**Other income**	**25**	**-**	**25**	**0.0%**
5,285,915	**(6,661,862)**	**11,947,777**	**179.3%**	**Change in Net Assets**	**7,282,092**	**(11,273,603)**	**18,555,695**	**164.6%**
95.4%	***98.2%***	***2.9%***	***2.9%***	***Medical Loss Ratio***	***95.8%***	***97.9%***	***2.0%***	***2.1%***
3.1%	***4.0%***	***1.0%***	***23.8%***	***Admin Loss Ratio***	***3.1%***	***4.0%***	***0.9%***	***23.2%***

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MEDI-CAL INCOME STATEMENT– AUGUST MONTH:

REVENUES of $326.0 million are favorable to budget $28.3 million driven by:

- Favorable volume related variance of $3.7 million
- Favorable price related variance of $24.7 million
  - $12.0 million of Proposition 56 revenue due to the Department of Health Care Services (DHCS) extending all Proposition 56 programs
  - $6.6 million due to increase in LTC and pharmacy funding from DHCS in primary and Coordinated Care Initiative (CCI) revenue
  - $3.3 million due to Proposition 56 risk corridor

MEDICAL EXPENSES of $310.9 million are unfavorable to budget $18.5 million driven by:

- Unfavorable volume related variance of $3.6 million
- Unfavorable price related variance of $14.9 million
  - Provider Capitation expense unfavorable variance of $11.7 million due to Proposition 56 estimates
  - Professional Claims expense unfavorable variance of $3.8 million
  - Reinsurance & Other expense unfavorable variance of $2.2 million
  - Managed Long-Term Services and Supports (MLTSS) expense unfavorable variance of $1.6 million
  - Offset by Facilities Claims expense favorable variance of $2.5 million due to lower than expected utilization
  - Medical Management expense favorable variance of $1.4 million

ADMINISTRATIVE EXPENSES of $10.0 million are favorable to budget $2.0 million driven by:

- Other Non-Salary expense favorable to budget $1.4 million
- Salaries & Benefit expense favorable to budget $0.6

CHANGE IN NET ASSETS is $5.3 million for the month, favorable to budget $11.9 million

CalOptima
OneCare Connect Total
Statement of Revenue and Expenses
For the Two Months Ending August 31, 2021

Month					Year to Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
14,819	**15,020**	**(201)**	**(1.3%)**	**Member Months**	**29,507**	**30,003**	**(496)**	**(1.7%)**
				Revenues				
2,841,788	2,809,323	32,465	1.2%	Medi-Cal Capitation Revenue	5,438,449	5,619,119	(180,670)	(3.2%)
17,859,484	19,094,953	(1,235,469)	(6.5%)	Medicare Capitation Revenue Part C	37,194,573	38,221,880	(1,027,307)	(2.7%)
6,062,027	5,694,001	368,026	6.5%	Medicare Capitation Revenue Part D	12,785,782	11,375,528	1,410,254	12.4%
-	-	-	0.0%	Other Income	-	-	-	0.0%
26,763,298	**27,598,277**	**(834,979)**	**(3.0%)**	**Total Operating Revenue**	**55,418,805**	**55,216,527**	**202,278**	**0.4%**
				Medical Expenses				
10,648,787	11,491,295	842,508	7.3%	Provider Capitation	21,804,785	23,002,999	1,198,214	5.2%
4,435,788	4,305,103	(130,685)	(3.0%)	Facilities Claims	8,024,161	8,590,733	566,572	6.6%
1,083,342	1,041,850	(41,492)	(4.0%)	Ancillary	2,162,221	2,078,294	(83,927)	(4.0%)
1,454,891	1,465,161	10,270	0.7%	MLTSS	2,832,116	2,934,493	102,377	3.5%
6,279,130	6,534,092	254,962	3.9%	Prescription Drugs	13,198,019	13,017,803	(180,216)	(1.4%)
938,618	1,219,540	280,922	23.0%	Medical Management	1,983,604	2,439,081	455,477	18.7%
145,844	177,519	31,675	17.8%	Other Medical Expenses	498,149	353,979	(144,170)	(40.7%)
24,986,400	**26,234,560**	**1,248,160**	**4.8%**	**Total Medical Expenses**	**50,503,056**	**52,417,382**	**1,914,326**	**3.7%**
1,776,898	**1,363,717**	**413,181**	**30.3%**	**Gross Margin**	**4,915,749**	**2,799,145**	**2,116,604**	**75.6%**
				Administrative Expenses				
818,062	869,722	51,660	5.9%	Salaries, Wages & Employee Benefits	1,603,895	1,753,946	150,051	8.6%
31,946	11,750	(20,196)	(171.9%)	Professional Fees	42,369	98,500	56,131	57.0%
79,571	108,608	29,037	26.7%	Purchased Services	189,233	217,218	27,985	12.9%
88,559	138,107	49,548	35.9%	Printing and Postage	155,061	276,218	121,157	43.9%
301	21,077	20,776	98.6%	Other Operating Expenses	351	42,150	41,799	99.2%
680,053	680,053	-	0.0%	Indirect Cost Allocation	1,360,106	1,360,106	-	0.0%
1,698,493	**1,829,317**	**130,824**	**7.2%**	**Total Administrative Expenses**	**3,351,014**	**3,748,138**	**397,124**	**10.6%**
78,406	**(465,600)**	**544,006**	**116.8%**	**Change in Net Assets**	**1,564,735**	**(948,993)**	**2,513,728**	**264.9%**
93.4%	***95.1%***	***1.7%***	***1.8%***	***Medical Loss Ratio***	***91.1%***	***94.9%***	***3.8%***	***4.0%***
6.3%	***6.6%***	***0.3%***	***4.3%***	***Admin Loss Ratio***	***6.0%***	***6.8%***	***0.7%***	***10.9%***

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ONECARE CONNECT INCOME STATEMENT– AUGUST MONTH:

REVENUES of $26.8 million are unfavorable to budget $0.8 million driven by:

- Unfavorable volume related variance of $0.4 million
- Unfavorable price related variance of $0.5 million

MEDICAL EXPENSES of $25.0 million are favorable to budget $1.2 million driven by:

- Favorable volume related variance of $0.4 million
- Favorable price related variance of $0.9 million
  - Provider Capitation expense favorable variance of $0.7 million
  - Medical Management expense favorable variance of $0.3 million
  - Prescription Drugs expense favorable variance of $0.2 million
  - Offset by Facilities Claims expense unfavorable variance of $0.2 million

ADMINISTRATIVE EXPENSES of $1.7 million are favorable to budget $0.1 million

CHANGE IN NET ASSETS is $0.1 million, favorable to budget $0.5 million

CalOptima
OneCare
Statement of Revenues and Expenses
For the Two Months Ending August 31, 2021

Month					Year to Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
2,110	**1,761**	**349**	**19.8%**	**Member Months**	**4,129**	**3,513**	**616**	**17.5%**
				Revenues				
1,787,421	1,391,507	395,914	28.5%	Medicare Part C revenue	3,512,481	2,776,075	736,406	26.5%
844,630	633,642	210,988	33.3%	Medicare Part D revenue	1,778,421	1,264,430	513,991	40.7%
2,632,051	**2,025,149**	**606,902**	**30.0%**	**Total Operating Revenue**	**5,290,902**	**4,040,505**	**1,250,397**	**30.9%**
				Medical Expenses				
709,427	540,415	(169,012)	(31.3%)	Provider Capitation	1,535,933	1,078,133	(457,800)	(42.5%)
569,577	599,643	30,066	5.0%	Inpatient	1,304,508	1,194,585	(109,923)	(9.2%)
114,776	72,077	(42,699)	(59.2%)	Ancillary	256,208	143,573	(112,635)	(78.5%)
103,284	29,773	(73,511)	(246.9%)	Skilled Nursing Facilities	223,580	59,461	(164,119)	(276.0%)
869,115	677,645	(191,470)	(28.3%)	Prescription Drugs	1,745,163	1,348,928	(396,235)	(29.4%)
30,080	45,095	15,015	33.3%	Medical Management	69,181	104,686	35,505	33.9%
-	1,303	1,303	100.0%	Other Medical Expenses	-	2,599	2,599	100.0%
2,396,259	**1,965,951**	**(430,308)**	**(21.9%)**	**Total Medical Expenses**	**5,134,573**	**3,931,965**	**(1,202,608)**	**(30.6%)**
235,792	**59,198**	**176,594**	**298.3%**	**Gross Margin**	**156,329**	**108,540**	**47,789**	**44.0%**
				Administrative Expenses				
84,990	73,265	(11,725)	(16.0%)	Salaries, wages & employee benefits	160,925	147,876	(13,049)	(8.8%)
16,000	29,166	13,166	45.1%	Professional fees	32,000	58,332	26,332	45.1%
9,665	9,167	(498)	(5.4%)	Purchased services	24,815	18,334	(6,481)	(35.3%)
6,103	15,823	9,720	61.4%	Printing and postage	10,092	31,646	21,554	68.1%
-	1,029	1,029	100.0%	Other operating expenses	-	2,058	2,058	100.0%
50,924	50,924	-	0.0%	Indirect cost allocation, occupancy expense	101,848	101,848	-	0.0%
167,682	**179,374**	**11,692**	**6.5%**	**Total Administrative Expenses**	**329,680**	**360,094**	**30,414**	**8.4%**
68,110	**(120,176)**	**188,286**	**156.7%**	**Change in Net Assets**	**(173,351)**	**(251,554)**	**78,203**	**31.1%**
91.0%	***97.1%***	***6.0%***	***6.2%***	***Medical Loss Ratio***	***97.0%***	***97.3%***	***0.3%***	***0.3%***
6.4%	***8.9%***	***2.5%***	***28.1%***	***Admin Loss Ratio***	***6.2%***	***8.9%***	***2.7%***	***30.1%***

CalOptima
PACE
Statement of Revenues and Expenses
For the Two Months Ending August 31, 2021

Month					Year to Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
407	**396**	**11**	**2.8%**	**Member Months**	**808**	**790**	**18**	**2.3%**
				Revenues				
2,536,796	2,461,976	74,820	3.0%	Medi-Cal Capitation Revenue	5,006,806	4,911,665	95,141	1.9%
628,473	604,037	24,436	4.0%	Medicare Part C Revenue	1,195,297	1,204,252	(8,955)	(0.7%)
263,752	144,219	119,533	82.9%	Medicare Part D Revenue	504,263	287,721	216,542	75.3%
3,429,021	**3,210,232**	**218,789**	**6.8%**	**Total Operating Revenue**	**6,706,365**	**6,403,638**	**302,727**	**4.7%**
				Medical Expenses				
820,827	981,280	160,453	16.4%	Medical Management	1,686,302	1,957,604	271,302	13.9%
931,302	723,913	(207,389)	(28.6%)	Facilities Claims	1,832,802	1,443,038	(389,764)	(27.0%)
837,718	655,339	(182,379)	(27.8%)	Professional Claims	1,513,035	1,306,166	(206,869)	(15.8%)
119,554	129,258	9,704	7.5%	Patient Transportation	240,686	257,863	17,177	6.7%
339,572	315,416	(24,156)	(7.7%)	Prescription Drugs	642,652	627,001	(15,651)	(2.5%)
73,531	35,325	(38,206)	(108.2%)	MLTSS	158,787	70,070	(88,717)	(126.6%)
5,088	4,990	(98)	(2.0%)	Other Expenses	10,100	9,955	(145)	(1.5%)
3,127,591	**2,845,521**	**(282,070)**	**(9.9%)**	**Total Medical Expenses**	**6,084,363**	**5,671,697**	**(412,666)**	**(7.3%)**
301,430	**364,711**	**(63,281)**	**-17.4%**	**Gross Margin**	**622,002**	**731,941**	**(109,939)**	**-15.0%**
				Administrative Expenses				
123,092	137,745	14,653	10.6%	Salaries, wages & employee benefits	222,924	277,998	55,074	19.8%
3,232	167	(3,065)	(1835.5%)	Professional fees	3,356	334	(3,022)	(904.6%)
3,150	40,925	37,775	92.3%	Purchased services	4,551	81,850	77,299	94.4%
1,671	19,238	17,567	91.3%	Printing and postage	19,646	38,476	18,830	48.9%
2,731	400	(2,331)	(582.8%)	Depreciation & amortization	4,748	800	(3,948)	(493.5%)
5,563	4,309	(1,254)	(29.1%)	Other operating expenses	7,762	8,618	856	9.9%
14,877	4,944	(9,933)	(200.9%)	Indirect Cost Allocation, Occupancy Expense	19,225	9,888	(9,337)	(94.4%)
154,316	**207,728**	**53,412**	**25.7%**	**Total Administrative Expenses**	**282,211**	**417,964**	**135,753**	**32.5%**
				Operating Tax				
6,040	-	6,040	0.0%	Tax Revenue	11,991	-	11,991	0.0%
6,040	-	(6,040)	0.0%	Premium Tax Expense	11,991	-	(11,991)	0.0%
-	**-**	**-**	**0.0%**	**Total Net Operating Tax**	**-**	**-**	**-**	**0.0%**
147,113	**156,983**	**(9,870)**	**(6.3%)**	**Change in Net Assets**	**339,790**	**313,977**	**25,813**	**8.2%**
91.2%	***88.6%***	***(2.6%)***	***(2.9%)***	***Medical Loss Ratio***	***90.7%***	***88.6%***	***(2.2%)***	***(2.4%)***
4.5%	***6.5%***	***2.0%***	***30.5%***	***Admin Loss Ratio***	***4.2%***	***6.5%***	***2.3%***	***35.5%***

CalOptima
Building 505 - City Parkway
Statement of Revenues and Expenses
For the Two Months Ending August 31, 2021

Month					Year to Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
				Revenues				
-	-	-	0.0%	Rental Income	-	-	-	0.0%
-	-	-	**0.0%**	**Total Operating Revenue**	-	-	-	**0.0%**
				Administrative Expenses				
36,799	54,250	17,451	32.2%	Purchase services	75,328	108,500	33,172	30.6%
172,617	206,000	33,383	16.2%	Depreciation & amortization	345,235	412,000	66,765	16.2%
19,565	19,750	185	0.9%	Insurance expense	39,130	39,500	370	0.9%
99,622	131,583	31,961	24.3%	Repair and maintenance	195,376	263,166	67,790	25.8%
61,993	43,000	(18,993)	(44.2%)	Other Operating Expense	135,011	86,000	(49,011)	(57.0%)
(390,596)	(454,583)	(63,987)	(14.1%)	Indirect allocation, Occupancy	(790,080)	(909,166)	(119,086)	(13.1%)
-	-	-	**0.0%**	**Total Administrative Expenses**	-	-	-	**0.0%**
-	-	-	**0.0%**	**Change in Net Assets**	-	-	-	**0.0%**

OTHER INCOME STATEMENTS – AUGUST MONTH:

ONECARE INCOME STATEMENT

CHANGE IN NET ASSETS is $0.1 million, favorable to budget $0.2 million

PACE INCOME STATEMENT

CHANGE IN NET ASSETS is $0.1 million, unfavorable to budget $9,870

CalOptima
Balance Sheet
August 31, 2021

ASSETS			**LIABILITIES & NET POSITION**		
Current Assets			Current Liabilities		
Operating Cash		$296,197,049	Accounts Payable		$35,180,064
Short-term Investments		1,065,537,455	Medical Claims liability		773,024,012
Capitation receivable		240,879,825	Accrued Payroll Liabilities		17,973,624
Receivables - Other		54,316,432	Deferred Revenue		12,282,694
Prepaid expenses		16,438,087	Deferred Lease Obligations		124,462
			Capitation and Withholds		156,243,252
Total Current Assets		**1,673,368,848**	**Total Current Liabilities**		**994,828,108**
Capital Assets					
Furniture & Equipment	46,251,085				
Building/Leasehold Improvements	5,840,138				
505 City Parkway West	51,777,223				
	103,868,446				
Less: accumulated depreciation	(58,862,455)				
Capital assets, net		45,005,991	Other (than pensions) post employment benefits liability		31,694,185
Other Assets			Net Pension Liabilities		30,420,182
Restricted Deposit & Other		300,000	Bldg 505 Development Rights		-
Homeless Health Reserve		56,798,913			
Board-designated assets:			**TOTAL LIABILITIES**		**1,056,942,476**
Cash and Cash Equivalents	411,595				
Investments	589,539,347		Deferred Inflows		
Total Board-designated Assets	589,950,942		Excess Earnings		344,198
			OPEB 75 Difference in Experience		536,000
			Change in Assumptions		2,709,945
Total Other Assets		647,049,855	OPEB Changes in Assumptions		773,000
			Net Position		
TOTAL ASSETS		**2,365,424,694**	TNE		103,891,712
			Funds in Excess of TNE		1,215,219,660
Deferred Outflows			**TOTAL NET POSITION**		1,319,111,372
Contributions		1,508,025			
Difference in Experience		3,236,721			
Excess Earning		2,104,780			
Changes in Assumptions		3,692,771			
OPEB 75 Changes in Assumptions		3,906,000			
Pension Contributions		544,000			
TOTAL ASSETS & DEFERRED OUTFLOWS		**2,380,416,991**	**TOTAL LIABILITIES, DEFERRED INFLOWS & NET POSITION**		**2,380,416,991**

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CalOptima
Board Designated Reserve and TNE Analysis
as of August 31, 2021

Type	Reserve Name	Market Value	Benchmark		Variance	
			Low	High	Mkt - Low	Mkt - High
	Tier 1 - Payden & Rygel	241,551,590				
	Tier 1 - MetLife	240,471,607				
Board-designated Reserve		482,023,197	367,121,103	568,983,738	114,902,094	(86,960,541)
TNE Requirement	Tier 2 - MetLife	107,927,745	103,891,712	103,891,712	4,036,033	4,036,033
	Consolidated:	**589,950,942**	**471,012,815**	**672,875,450**	**118,938,127**	**(82,924,508)**
	Current reserve level	*1.75*	*1.40*	*2.00*		

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CalOptima
Statement of Cash Flows
August 31, 2021

	Month Ended	Year-To-Date
CASH FLOWS FROM OPERATING ACTIVITIES:		
Change in net assets	5,679,288	10,330,579
Adjustments to reconcile change in net assets		
to net cash provided by operating activities		
Depreciation and amortization	584,386	1,186,078
Changes in assets and liabilities:		
Prepaid expenses and other	(2,580,621)	(4,459,476)
Catastrophic reserves		
Capitation receivable	7,859,200	179,699,761
Medical claims liability	1,641,418	(171,294,936)
Deferred revenue	(24,544,606)	(1,304,132)
Payable to health networks	6,454,294	11,463,463
Accounts payable	13,419,063	(11,234,357)
Accrued payroll	1,080,923	1,641,067
Other accrued liabilities	-	(2,867)
Net cash provided by/(used in) operating activities	9,593,344	16,025,182
GASB 68 CalPERS Adjustments	-	-
CASH FLOWS FROM CAPITAL AND RELATED FINANCING ACTIVITIES:		
Net Asset transfer from Foundation	-	-
Net cash provided by (used in) in capital and related financing activities	-	-
CASH FLOWS FROM INVESTING ACTIVITIES		
Change in Investments	41,989,824	(127,648)
Change in Property and Equipment	(339,430)	(464,193)
Change in Board designated reserves	20,668	(1,070,790)
Change in Homeless Health Reserve	-	-
Net cash provided by/(used in) investing activities	41,671,063	(1,662,631)
NET INCREASE/(DECREASE) IN CASH & CASH EQUIVALENTS	51,264,407	14,362,550
CASH AND CASH EQUIVALENTS, beginning of period	$244,932,642	281,834,499
CASH AND CASH EQUIVALENTS, end of period	**296,197,049**	**296,197,049**

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BALANCE SHEET – AUGUST MONTH:

ASSETS of $2.4 billion increased $3.7 million from July or 0.2%

- Operating Cash and Short-term Investments net increase of $9.3 million due primarily to the receipt of prior period maternity kick payments from DHCS
  - Operating Cash increased $51.3 million
  - Short-term Investments decreased $42.0 million
- Prepaid Expenses increased $2.6 million due to timing for service contract payments
- Capitation Receivables decreased $8.5 million due to timing of cash receipts

LIABILITIES of $1.1 billion decreased $1.9 million from July or 0.2%

- Deferred Revenue decreased $24.5 million due to timing of capitation payments from Centers for Medicare and Medicaid Services (CMS)
- Accounts Payable increased $13.4 million due to the timing of accruals for the quarterly premium tax
- Capitation and Withholds increased $6.5 million
- Claims Liabilities increased $1.6 million

NET ASSETS of $1.3 billion, increased $5.7 million from July or 0.4%

Summary of Homeless Health Initiatives and Allocated Funds
As of August 31, 2021

			Amount
Program Commitment		**$**	**100,000,000**
Funds Allocation, approved initiatives:			
Enhanced Medi-Cal Services at the Be Well OC Regional Mental Health and Wellness Campus	11,400,000		
Recuperative Care	8,250,000		
Medical Respite	250,000		
Day Habilitation (County for HomeKey)	2,500,000		
Clinical Field Team Start-up & Federal Qualified Health Center (FQHC)	1,600,000		
CalOptima Homeless Response Team	6,000,000		
Homeless Coordination at Hospitals	10,000,000		
CalOptima Days & QI Program - Homeless Clinic Access Program or HCAP	1,231,087		
FQHC (Community Health Center) Expansion and HHI Support	570,000		
HCAP Expansion for Telehealth and CFT On Call Days	1,000,000		
Vaccination Intervention and Member Incentive Strategy	400,000		
Funds Allocation Total		**$**	**43,201,087**
Program Commitment Balance, available for new initiatives*		**$**	**56,798,913**

On June 27, 2019 at a Special Board meeting, the Board approved four funding categories.

This report only lists Board approved projects.

* Funding sources of the remaining balance are IGT8 and CalOptima's operating income, which must be used for Medi-Cal covered services for the Medi-Cal population

Budget Allocation Changes
Reporting Changes for August 2021

Transfer Month	Line of Business	From	To	Amount	Expense Description	Fiscal Year
July	No budget reallocations for July					
August	No budget reallocations for August					

This report summarizes budget transfers between general ledger classes that are greater than $10,000 and less than $100,000.
This is the result of Board Resolution No. 12-0301-01 which permits the CEO to make budget allocation changes within certain parameters.

Board of Directors Meeting
October 7, 2021

Monthly Compliance Report

The purpose of this report is to provide compliance updates to CalOptima's Board of Directors, including, but not limited to, updates on internal and health network monitoring and audits conducted by CalOptima's Audit & Oversight department, regulatory audits, privacy updates, fraud, waste, and abuse (FWA) updates, and any notices of non-compliance or enforcement action issued by regulators.

A. Updates on Regulatory Audits

1. OneCare

- Analysis of Prescription Drug Event Records for Nuedexta for Beneficiaries without a Medically Accepted Indication (MAI):

  On July 13, 2021, CMS informed CalOptima that its OneCare program was selected to participate in the Analysis of Prescription Drug Event Records for Nuedexta for beneficiaries without a Medically Accepted Indication (MAI). CMS, in collaboration with the Plan Program Integrity Medicare Drug Integrity Contractor (PPI MEDIC), conducted a review of Medicare Part D payments for Nuedexta without a documented MAI under the Medicare Part A, Part B, or Part C programs and has determined that CalOptima submitted potentially inappropriate payments for prescription drug event (PDE) records. The Nuedexta national audit covers PDE records from January 1, 2019, through December 31, 2021.

  On July 21, 2021, the PDE records in question were provided to CalOptima for review and response. CalOptima completed its review of the PDE records in question and determined that submission for payment for these PDEs were appropriate. The response and supporting documents were submitted on July 30, 2021 and is now pending CMS' review.

- 2021 CMS Program Audit Engagement (applicable to OneCare and OneCare Connect):

  CMS conducted a program audit on both OneCare and OneCare Connect. CMS has released the preliminary draft audit report on 8/6/21 and completed the exit conference. CMS is currently reviewing additional documentation and once completed, CMS will issue the Draft Audit Report no later than the first week of October, including audit scores and conditions. CalOptima will have 10 business days to submit any comments and rebuttals. CMS will then issue the Final Audit Report by the end of October 2021. If there are non-ICAR conditions, CMS will request for a response within 30 calendar days of the final audit report issuance. Once CMS reviews the CAPs and accepts the CAP responses, CMS will follow up with a request to the plan to demonstrate correction of all conditions cited in the

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final audit report, by undergoing a validation audit. CalOptima will have 180 calendar days from the date of the CAP acceptance to complete a validation audit and submit the validation audit report to CMS for review.

On August 27, 2021, CalOptima received an ICAR notification letter from CMS for the following ICAR condition:

> Part C Organization Determinations, Appeals, and Grievances (ODAG)
> Element: Timeliness
> ICAR Condition #4.16: Sponsor failed to notify enrollees of its favorable standard pre-service reconsidered decisions, or to auto-forward its upheld adverse decisions to the IRE, within 30 days, plus extension (if applicable).

CMS requested for a response within 3 business days of notification, or by September 1, 2021.

2. PACE

- PACE Audit Program Readiness:

On August 23, 2021, RAC conducted the PACE Program Audit Readiness kickoff meeting with the PACE leadership team, in anticipation of a program audit of the PACE program. By way of background, the last time, PACE underwent the program audit was in 2018. During the kickoff meeting, RAC provided an overview of the PACE audit workplan as well as the audit process, and requested for PACE leadership to review the workplan and audit protocols, with any feedback to the workplan to be provided no later than September 3, 2021.

B. Regulatory Notices of Non-Compliance

- CalOptima did not receive any notices of non-compliance from its regulators for the month of August 2021.

C. Updates on Internal and Health Network Monitoring and Audits

1. Internal Monitoring Dashboard: Medi-Cal Grievance & Appeals Resolution Services (GARS) [a\]

- As part of its monitoring process, CalOptima's Audit & Oversight department, in collaboration with business areas, maintains a dashboard to monitor key performance metrics for internal and external operations on a monthly basis. Dashboard results are presented to CalOptima's Audit & Oversight Committee and Compliance Committee for oversight. Below are the dashboard results for the months of May 2021 – July 2021 for Medi-Cal GARS. CalOptima's GARS department continues to not meet resolution timeliness requirements for five (5) consecutive months for Medi-Cal expedited appeals.

a\ "N/A" indicates that the category is not applicable to that file type. "Nothing to Report" indicates that there were no files submitted for review for that file type.

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Month	Compliance Goal	Expedited Appeals Resolved within ≤ 72 Hours of Receipt
May 2021	98%	90%
June 2021	98%	89%
July 2021	98%	89%

- CalOptima's Audit & Oversight (A&O) department escalated the corrective action plan (CAP) that was previously issued to an immediate corrective action plan (ICAP), as issues with non-timely processing of Medi-Cal standard appeals appear to be systemic, may have the potential to cause member harm, and have been ongoing for at least three (3) months. The A&O department continues to work with the GARS department to remediate the deficiencies by identifying accurate root causes and implementing quality controls to ensure accurate and timely processing of standard appeals. In addition, CalOptima's Audit & Oversight department has increased its monitoring of the GARS department by requiring case status reports twice a day and weekly updates on staffing and remediation activities.

- CalOptima's Audit & Oversight (A&O) department will issue a request for a corrective action plan (CAP) for deficiencies identified during the department's file review of Medi-Cal expedited appeals. The A&O department continues to work with the GARS department to remediate the deficiencies by identifying accurate root causes and implementing quality controls to ensure accurate and timely processing of expedited appeals.

2. Internal Monitoring: Medi-Cal[a\]

   - Medi-Cal GARS: Standard Appeals

Month(s)	Classification Score	Standard Appeals Acknowledged within ≤ 5 Calendar Days of Receipt	Language Preference	Member Notice Content	Resolution of Appeals within ≤ 30 Calendar Days of Receipt
May 2021	100%	100%	100%	100%	0%
June 2021	100%	100%	100%	100%	9%
July 2021	Unavailable	Unavailable	Unavailable	Unavailable	Unavailable

- July results will be available at the end of September.

a\ "N/A" indicates that the category is not applicable to that file type. "Nothing to Report" indicates that there were no files submitted for review for that file type.

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- Medi-Cal GARS: Expedited Appeals

Month(s)	Classification Score	Expedited Appeals Verbally Acknowledged within ≤ 24 Hours of Receipt	Language Preference	Member Notice Content	Resolution of Expedited Appeals within 72 Hours of Receipt
May 2021	100%	N/A	100%	100%	90%
June 2021	100%	100%	100%	100%	88.89%
July 2021	Unavailable	Unavailable	Unavailable	Unavailable	Unavailable

  - July results will be available at the end of September.

3. Internal Monitoring: OneCare [a\]

- OneCare GARS: Standard Appeals

Month(s)	Classification Score	Standard Appeals Acknowledged within ≤ 5 Calendar Days of Receipt	Language Preference	Member Notice Content	Resolution of Appeals within ≤ 30 Calendar Days of Receipt
May 2021	100%	100%	100%	100%	100%
June 2021	100%	100%	100%	0%	100%
July 2021	Unavailable	Unavailable	Unavailable	Unavailable	Unavailable

  - July results will be available at the end of September.

- OneCare GARS: Payment Reconsiderations (PREC)

Month(s)	Classification Score	Standard Appeals Acknowledged within ≤ 5 Calendar Days of Receipt	Language Preference	Member Notice Content	Resolution of Appeals within ≤ 30 Calendar Days of Receipt
May 2021	100%	100%	N/A	N/A	100%
June 2021	Nothing to Report	Nothing to Report	Nothing to Report	Nothing to Report	Nothing to Report
July 2021	Unavailable	Unavailable	Unavailable	Unavailable	Unavailable

a\ "N/A" indicates that the category is not applicable to that file type. "Nothing to Report" indicates that there were no files submitted for review for that file type.

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- July results will be available at the end of September.

4. Internal Monitoring: OneCare Connect [a\]

- OneCare Connect GARS: Standard Appeals

Month(s)	Classification Score	Standard Appeals Acknowledged within ≤ 5 Calendar Days of Receipt	Language Preference	Member Notice Content	Resolution of Appeals within ≤ 30 Calendar Days of Receipt
May 2021	100%	91.67%	100%	100%	58.30%
June 2021	100%	100%	100%	94.11%	100%
July 2021	Unavailable	Unavailable	Unavailable	Unavailable	Unavailable

- July results will be available at the end of September.

- OneCare Connect GARS: Expedited Appeals

Month(s)	Classification Score	Language Preference	Clinical Decision Making	Member Notice Content	Resolution of Appeals within 72 Hours of Receipt
May 2021	100%	100%	100%	100%	100%
June 2021	Nothing to Report	Nothing to Report	Nothing to Report	Nothing to Report	Nothing to Report
July 2021	Unavailable	Unavailable	Unavailable	Unavailable	Unavailable

- July results will be available at the end of September.

a\ "N/A" indicates that the category is not applicable to that file type. "Nothing to Report" indicates that there were no files submitted for review for that file type.

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5. Health Network Monitoring: Medi-Cal [a\]

- Medi-Cal Utilization Management (UM): Prior Authorization (PA) Requests

Month	Timely Urgent Requests	Clinical Decision Making (CDM) for Urgent Requests	Letter Score for Urgent Requests	Timely Routine Requests	Timely Denials	CDM for Denials	Letter Score for Denials	Timely Modified Requests	CDM for Modified Requests	Letter Score for Modified Requests	Timely Deferrals	CDM for Deferrals	Letter Score for Deferrals
April 2021	87%	82%	89%	81%	97%	92%	91%	90%	85%	93%	50%	84%	86%
May 2021	86%	89%	96%	86%	89%	88%	93%	99%	90%	97%	93%	97%	97%
June 2021	87%	93%	98%	92%	86%	94%	95%	95%	83%	98%	80%	100%	86%

- Based on a focused review of select files, four (4) health networks drove the lower compliance score for timeliness during the month June 2021. Of the thirty-three (33) files submitted in the aggregate by four (4) health networks, seven (7) files were deficient for timeliness. The deficiency for the lower scores for timeliness were due to the following:
  - Failure to meet timeframe for provider initial notification (24 hours)
  - Failure to meet timeframe for provider written notification (2 business days)
  - Failure to meet timeframe for member notification (2 business days)

- Based on a focused review of select files, five (5) health networks drove the lower compliance score for clinical decision making (CDM) during the month of June 2021. Of the thirty-seven (37) files submitted in the aggregate by five (5) health networks, twenty-four (24) files were deficient for CDM. The deficiency for the lower scores for CDM were due to the following:
  - Failure to obtain adequate clinical information
  - Failure to include appropriate professional that makes decision
  - Failure to cite criteria for decision

- Based on a focused review of select files, one (1) health network drove the lower compliance score for letter criteria during the month of June 2021. Of the ten (10) files submitted in the aggregate by the one (1) health network, seven (7) files were deficient for letter criteria. The deficiency for the lower scores for letter criteria were due to the following:
  - Failure to provide information on how to file appeal and grievance
  - Failure to provide letter in member preferred language
  - Failure to provide Language Assistance Taglines insert with approved threshold languages

a\ "N/A" indicates that the category is not applicable to that file type. "Nothing to Report" indicates that there were no files submitted for review for that file type.

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- Failure to provide description of service in lay language
- Failure to provide why the request did not meet the criteria in lay language
- Failure to provide name and contact information for health care professional responsible for the decision to deny or modify
- Failure to provide peer-to-peer discussion of the decision with medical reviewer

➢ Based on the overall universe of Medi-Cal authorizations for June 2021, CalOptima's health networks received an aggregate compliance score of 99.87% for timely processing of routine authorization requests and a compliance score of 96.68% for timely processing of expedited authorization requests.

➢ CalOptima's utilization management department issued requests for corrective action plans (CAPs) or Pre-CAP to all health networks with deficiencies identified during the focused review of prior authorization requests. The utilization management department continues to work with each health network to remediate the deficiencies by ensuring they identify accurate root causes and implement quality controls such as but may not be limited to --- staff training, process development, system enhancements, ongoing inline monitoring, and policy revisions to ensure timely and accurate processing of authorizations within regulatory requirements.

- Medi-Cal Claims: Professional Claims

Month	Paid Claims Timeliness	Paid Claims Accuracy	Denied Claims Timeliness	Denied Claims Accuracy
April 2021	91%	99%	95%	92%
May 2021	94%	99%	99%	92%
June 2021	84%	94%	96%	95%

➢ Based on a focused review of select files, five (5) health networks drove the lower compliance score for Paid Claims Timeliness during the month of June 2021. Of the fifty-eight (58) files submitted in the aggregate by the five (5) health networks, twenty-two (22) files were deficient due to the failure to meet non-contracted paid claim timeliness (30) calendar day from date of claim receipt).

➢ Based on a focused review of select files, four (4) health networks drove the lower compliance score for Paid Claims Accuracy during the month of June 2021. Of the forty-nine (49) files submitted in the aggregate by four (4) health networks, nine (9) files were deficient due to the
- failure to pay interest and missing documentation for clean claims processing
- failure to pay claim at correct contract rate
- failure to exclude provider dispute resolution from claims universe
- failure to exclude duplicate claims from universe
- failure to pay emergency services

a\ "N/A" indicates that the category is not applicable to that file type. "Nothing to Report" indicates that there were no files submitted for review for that file type.

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- Based on a focused review of select files, four (4) health networks drove the lower compliance score for Denied Claims Timeliness during the month of June 2021. Of the ninety-three (93) files submitted in the aggregate by four (4) health networks, thirteen (13) files were deficient due to the failure to meet non-contracted denied claim timeliness (30 calendar day from date of claim receipt).

- Based on a focused review of select files, five (5) health networks drove the lower compliance score for Denied Claims Accuracy during the month of June 2021. Of the one hundred twenty-nine (129) files submitted in the aggregate by five (5) health networks, sixteen (16) files were deficient for accuracy criteria. The deficiency for the lower scores for accuracy were due to the following:
  - Failure to provide all necessary documentation for clean claims processing
  - Failure to process correct payment rate on process claims
  - Failure to exclude duplicate claims from universe
  - Failure to pay emergency services
  - Failure to correctly process payable services such as contraceptives

- Based on the overall universe of Medi-Cal claims for June 2021, CalOptima's health networks received an overall compliance score of 92% for timely processing of claims.

- CalOptima's claims department issued requests for corrective action plans (CAPs) or Pre-CAP to all health networks with deficiencies identified during the review of claims processing for timeliness and accuracy. The claims department continues to work with each health network to remediate the deficiencies by identifying accurate root causes and implementing quality controls such as but may not be limited to --- staff training, process development, system enhancements, ongoing inline monitoring, and policy revisions to ensure timely and accurate processing of claims within regulatory requirements.

6. Health Network Monitoring: OneCare [a\]

- OneCare Utilization Management (UM): Prior Authorization Requests

Month	Timeliness for Expedited Initial Organization Determinations (EIOD)	Clinical Decision Making for EIOD	Letter Score for EIOD	Timeliness for Standard Organization Determinations (SOD)	Letter Score for SOD	Timeliness for Denials	Clinical Decision Making for Denials	Letter Score for Denials
April 2021	83%	84%	85%	88%	94%	75%	100%	99%
May 2021	86%	84%	88%	88%	95%	100%	100%	98%
June 2021	100%	N/A	100%	96%	95%	94%	90%	98%

a\ "N/A" indicates that the category is not applicable to that file type. "Nothing to Report" indicates that there were no files submitted for review for that file type.

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- Based on a focused review of select files, one (1) health network drove the lower compliance score for timeliness during the month of May 2021. Of the ten (10) files submitted by the one (1) health network, three (3) files were deficient for timeliness. The deficiency for the lower scores for timeliness were due to the following:
  - Failure to meet timeframe for member notification (Routine – 14 calendar days)

- Based on a focused review of select files, two (2) health networks drove the lower compliance score for clinical decision making (CDM) during the month of June 2021. Of the three (3) files submitted in the aggregate by two (2) health networks, two (2) files were deficient for CDM. The deficiency for the lower scores for CDM were due to the following:
  - Failure to cite criteria for decision

- Based on the overall universe of OneCare authorization requests for CalOptima's health networks for June 2021, CalOptima's health networks received an overall compliance score 89% for timely processing of standard Part C authorization requests and 82% for timely processing of expedited Part C authorization requests**.**

- CalOptima's utilization management department issued requests for corrective action plans (CAPs) or Pre-CAP to all health networks with deficiencies identified during the review of prior authorization requests. The utilization management department continues to work with each health network to remediate the deficiencies by ensuring they identify accurate root causes and implement quality controls such as but may not be limited to --- staff training, process development, system enhancements, ongoing inline monitoring, and policy revisions to ensure timely and accurate processing of authorizations within regulatory requirements.

- <u>OneCare Claims</u>: Professional Claims

Month	Paid Claims Timeliness	Paid Claims Accuracy	Denied Claims Timeliness	Denied Claims Accuracy
April 2021	95%	99%	100%	100%
May 2021	100%	100%	100%	100%
June 2021	97%	99%	100%	99%

- Based on a focused review of select files, two (2) health networks drove the lower compliance score for Paid Claims Timeliness during the month of June 2021. Of the ten (10) files submitted in the aggregate by the two (2) health networks, one (1) file was deficient due to the failure to meet non-contracted paid claim timeliness (30 calendar day from date of claim receipt).

a\ "N/A" indicates that the category is not applicable to that file type. "Nothing to Report" indicates that there were no files submitted for review for that file type.

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- Based on a focused review of select files, one (1) health network drove the lower compliance score for Paid Claims Accuracy during the month of June 2021. Of the ten (10) files submitted in the aggregate by one (1) health network, one (1) file was deficient due to missing documentation for clean claims processing.

- Based on a focused review of select files, one (1) health network drove the lower compliance score for Denied Claims Accuracy during the month of June 2021. Of the eleven (11) files submitted in the aggregate by one (1) health network, one (1) file was deficient for accuracy criteria. The deficiency for the lower scores for accuracy were due to failure to provide all necessary documentation for clean claims processing.

- Based on the overall universe of OneCare claims for June 2021, CalOptima's health networks received an overall compliance score of 89% for timely processing of claims.

- CalOptima's claims department issued requests for corrective action plans (CAPs) or Pre-CAP to all health networks with deficiencies identified during the review of claims processing for timeliness and accuracy. The claims department continues to work with each health network to remediate the deficiencies by identifying accurate root causes and implementing quality controls such as but may not be limited to --- staff training, process development, system enhancements, ongoing inline monitoring, and policy revisions to ensure timely and accurate processing of claims within regulatory requirements.

7. Health Network Monitoring: OneCare Connect [a\]

- OneCare Connect Utilization Management (UM): Prior Authorization Requests

Month	Timeliness for Urgent Requests	Clinical Decision Making (CDM) for Urgent Requests	Letter Score for Urgent Requests	Timeliness for Routine Requests	Letter Score for Routine Requests	Timeliness for Denials	CDM for Denials	Letter Score for Denials	Timeliness for Modified Requests	CDM for Modified Requests	Letter Score for Modified Requests
April 2021	98%	100%	93%	99%	94%	100%	89%	94%	97%	99%	100%
May 2021	90%	100%	91%	87%	95%	98%	78%	93%	100%	100%	100%
June 2021	100%	100%	93%	97%	95%	94%	97%	98%	100%	89%	99%

- Based on a focused review of select files, one (1) health network drove the lower compliance score for timeliness during the month of June 2021. Of the eight (8) files submitted in the aggregate by the one (1) health network, two (2) files were deficient for timeliness. The deficiency for the lower score for timeliness were due to the following:
  - Failure to meet timeframe for provider written notification (Urgent – 72 hours)
  - Failure to meet timeframe for provider initial notification (24 hours)

- Based on a focused review of select files, one (1) health network drove the lower compliance score for clinical decision making (CDM) during the month of June 2021.

a\ "N/A" indicates that the category is not applicable to that file type. "Nothing to Report" indicates that there were no files submitted for review for that file type.

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Of the three (3) files submitted in the aggregate by one (1) health network, two (2) files were deficient for CDM. The deficiency for the lower scores for CDM were due to the following:
– Failure to cite criteria for decision

➢ Based on a focused review of select files, one (1) health network drove the lower compliance score for letter criteria during the month of June 2021. Of the three (3) files submitted in the aggregate by the one (1) health network, one (1) file was deficient for letter criteria. The deficiency for the lower score for letter criteria were due to the following:
– Failure to provide letter in member preferred language

➢ Based on the overall universe of OneCare Connect authorization requests for CalOptima's health networks for June 2021, CalOptima's health networks received an overall compliance score of 100% for timely processing of routine authorization requests and 100 % for timely processing of expedited authorization requests.

➢ CalOptima's utilization management department issued requests for corrective action plans (CAPs) or Pre-CAP to all health networks with deficiencies identified during the review of prior authorization requests. The utilization management department continues to work with each health network to remediate the deficiencies by ensuring they identify accurate root causes and implement quality controls such as but may not be limited to --- staff training, process development, system enhancements, ongoing inline monitoring, and policy revisions to ensure timely and accurate processing of authorizations within regulatory requirements.

- OneCare Connect Claims: Professional Claims

Month	Paid Claims Timeliness	Paid Claims Accuracy	Denied Claims Timeliness	Denied Claims Accuracy
April 2021	93%	93%	100%	95%
May 2021	99%	98%	98%	94%
June 2021	84%	98%	99%	98%

➢ Based on a focused review of select files, three (3) health networks drove the lower compliance score for Denied Claims Timeliness during the month of June 2021. Of the three (3) health networks that submitted thirty (30) files in the aggregate, six (6) files were deficient for timeliness. The deficiency for the lower score for timeliness was due to the failure to meet non-contracted clean denied claim timeliness (30 calendar day from date of claim receipt).

➢ Based on the overall universe of OneCare Connect claims for CalOptima's health networks for May 2021, CalOptima's health networks received the overall compliance scores:

a\ "N/A" indicates that the category is not applicable to that file type. "Nothing to Report" indicates that there were no files submitted for review for that file type.

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- 98.60% for non-contracted and contracted clean claims paid or denied within 30 calendar days of receipt
- 95.03% for non-contracted and contracted unclean claims paid or denied within 60 calendar days of receipt
- 99.89%% for non-contracted and contracted clean claims paid or denied within 90 calendar days of receipt

- CalOptima's claims management department issued requests for corrective action plans (CAPs) or Pre-CAP to all health networks with deficiencies identified during the review of claims processing for timeliness and accuracy. The claims department continues to work with each health network to remediate the deficiencies by identifying accurate root causes and implementing quality controls, such as, but not limited to, staff training, process development, system enhancements, ongoing inline monitoring, and policy revisions to ensure timely and accurate processing of claims within regulatory requirements.

a\ "N/A" indicates that the category is not applicable to that file type. "Nothing to Report" indicates that there were no files submitted for review for that file type.

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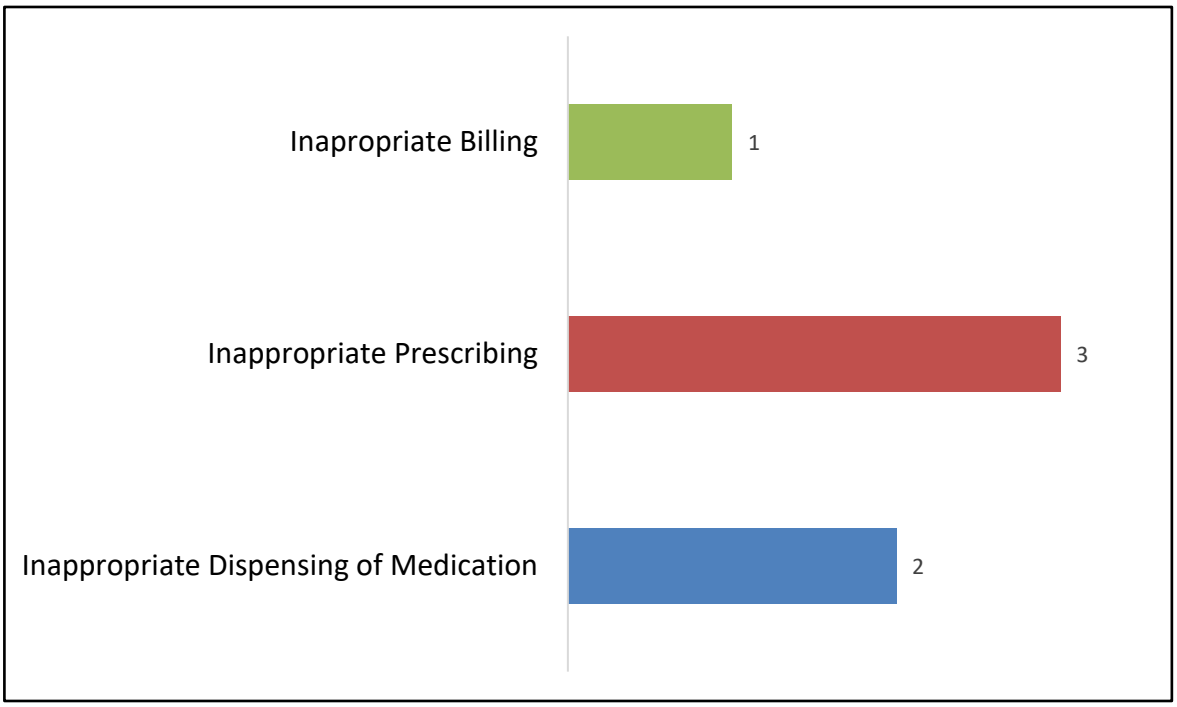
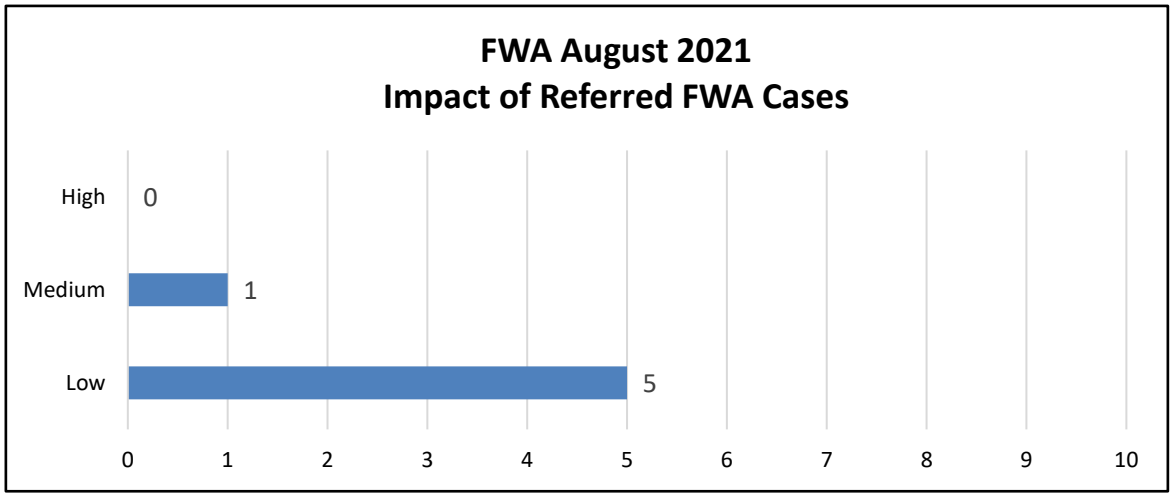
D. Fraud, Waste & Abuse (FWA) Investigations

Types of FWA Cases: (Referred in August 2021)





Total Number of New Cases Referred to DHCS (State)	5
Total Number of Closed Cases Referred to I-MEDIC (CMS)	1
Total Number of Referrals Reported	**6**

a\ "N/A" indicates that the category is not applicable to that file type. "Nothing to Report" indicates that there were no files submitted for review for that file type.

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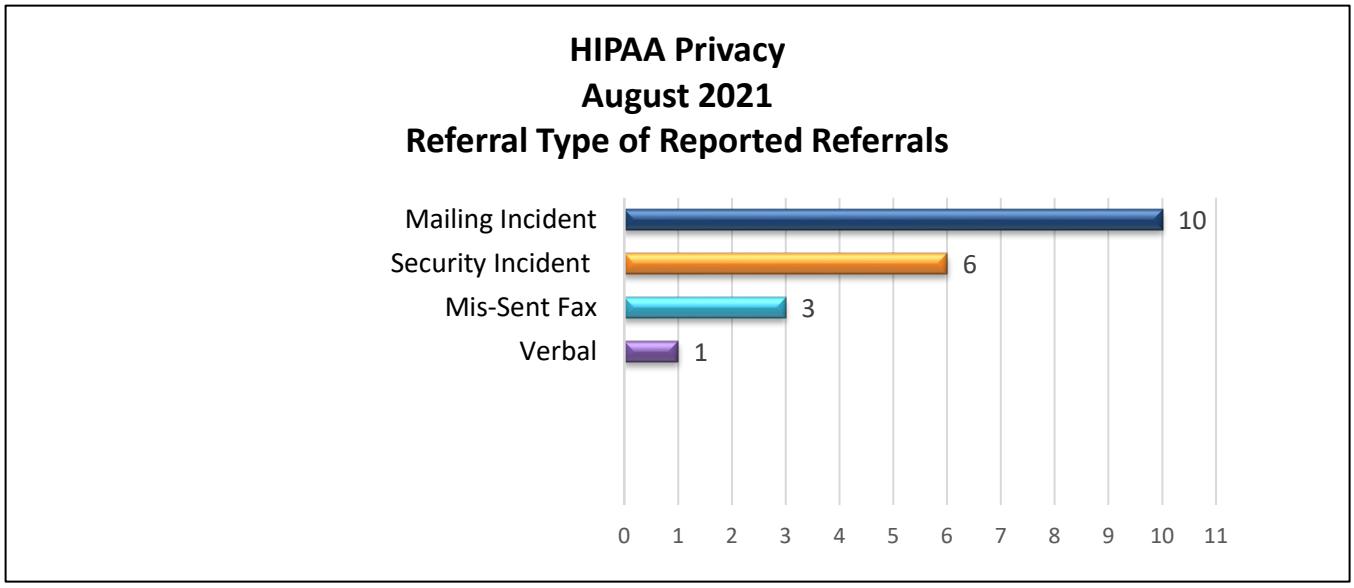
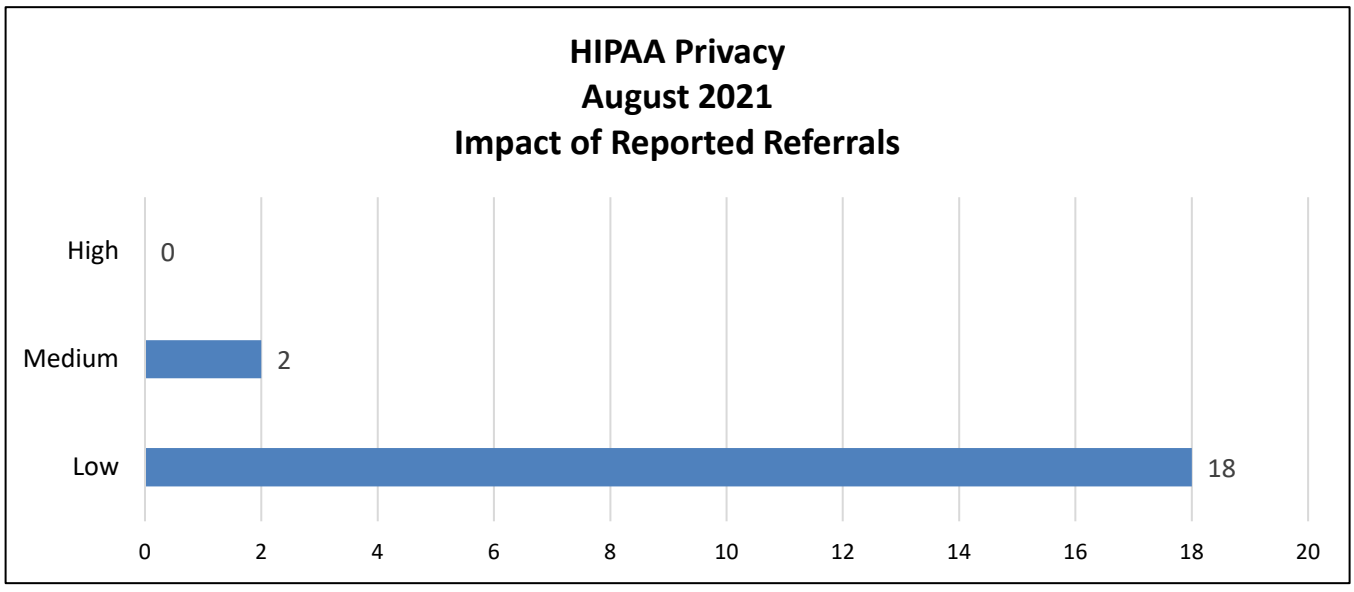
E. Privacy Update: (August 2021)

On August 16, 2021, CalOptima Privacy received a notification from a Member of a missent mail containing a COVID-19 vaccine gift card and letter. The mail contained PHI of another CalOptima Member: Member's name, health plan name, and vaccine status.

On August 19, 2021, it was discovered that the COVID-19 vaccine gift card and letter was mailed to approximately 4,000+ individuals in error. The reason was due to a data warehouse address mismatch during the mass mailing of these letters.

DHCS has determined this to be a State and Federal breach. CalOptima Privacy is working with business areas to meet the required actions, such as issuing a breach notification letter to the affected Members, reporting the incident to the Office of Civil Rights, and issuing a media notice.





a\ "N/A" indicates that the category is not applicable to that file type. "Nothing to Report" indicates that there were no files submitted for review for that file type.

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Total Number of Referrals Reported to DHCS (State)	20
Total Number of Referrals / Breaches Reported to DHCS and Office for Civil Rights (OCR)	0
Total Number of Referrals Reported	**20**

a\ "N/A" indicates that the category is not applicable to that file type. "Nothing to Report" indicates that there were no files submitted for review for that file type.

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POTOMAC PARTNERS DC

STRATEGIC HEALTH CARE

M E M O R A N D U M

September 10, 2021

To: CalOptima

From: Potomac Partners DC & Strategic Health Care

Re: September Board of Directors Report

The House and Senate were in recess for most of the month of August and early September. Despite the planned recess, on August 24th the House briefly convened to pass a $3.5 trillion budget framework by a vote of 220-212 following 24 hours of negotiations and debate in the Democratic caucus. The vote on the budget was in jeopardy after a group of 10 moderate House Democrats vowed to oppose the budget without first passing the Senate's bipartisan infrastructure proposal (H.R. 3684). As part of the compromise to pass the budget, Speaker Pelosi (D-CA) committed to passing the bipartisan infrastructure bill by September 27th.

EXECUTIVE ACTIONS ON MANDATORY VACCINES

On Thursday, September 9th, President Biden signed an Executive Order mandating that all Federal employees be vaccinated, with exceptions only as required by law. Each agency will need to implement the requirement for their vaccine program and report guidance no later than September 16th. President Biden cited the spread of Covid-19 and the "Delta Variant", recommending the use of Pfizer-BioNTech, Moderna, and Janssen Covid vaccines. The Executive Order can be found here.

At the signing, President Biden also announced that he will direct the Department of Labor's Occupational Safety and Health Administration (OSHA) to develop a temporary emergency standard requiring companies with more than 100 employees to mandate vaccination for workers, conduct weekly testing, or be fined $14,000 per violation. This temporary rule is expected to use an expedited review process and be in effect for six months while OSHA develops a final rule.

FISCAL YEAR 2022 (FY22) APPROPRIATIONS & BUDGET RECONCILIATION

Passing the budget resolution is just the first step in the budget reconciliation process. The budget resolution includes instructions to the House and Senate Committees to draft the legislative text for new spending under their jurisdiction, which could mean that a full budget reconciliation package will not be ready until late September, at the earliest. A topline summary of the House committee allocations is included below:

- **House Education & Labor Committee:** $779.5 billion
- **House Energy & Commerce Committee:** $486.5 billion

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- **House Financial Services Committee:** $339 billion
- **House Judiciary Committee:** $107.5 billion
- **House Agriculture Committee:** $89.1 billion
- **House Transportation & Infrastructure Committee:** $60 billion
- **House Science, Space & Technology Committee:** $45.51 billion
- **House Natural Resources Committee:** $25.6 billion
- **House Veterans' Affairs Committee:** $18 billion
- **House Small Business Committee:** $17.5 billion
- **House Oversight & Reform Committee:** $7.5 billion
- **House Homeland Security Committee:** $500 million
- **House Ways & Means Committee:** -$1 billion

The full Senate summary can be found HERE. The House Budget Committee summary can be found HERE. A summary of how budget reconciliation process works is HERE.

Here is the tentative schedule for the House Committee markups for budget Reconciliation:

Thursday, September 2nd
- Natural Resources (11 a.m., Remote)
- Oversight (11 a.m.)

Thursday, September 9th
- Education and Labor (12 p.m., Remote)
- Science, Space and Technology (Remote)
- Small Business (10 a.m., Hybrid)
- Veterans Affairs (2 p.m.)
- Ways and Means

Friday, September 10th
- Ways and Means
- Agriculture (Hybrid)
- Homeland Security (Remote)

Monday, September 13th
- Ways and Means
- Energy and Commerce *(Notable Items Outlined Below)*
    - Committee Documents and Subtitle Text can be found here.
    - Sec. 30711 (Pg. 24) Expands access to Medicaid Home and Community-Based Services, including PACE.
    - Sec. 30712 (Pg. 30) HCBS Improvement Planning Grants, $120 million for FY22 grants which may be used for addressing social determinants of health (SDOH).
    - Sec. 31003 (Pg. 8) would appropriate $10 billion for FQHC grants for capital projects to renovate, remodel, expand, construct, or make other facility alterations at qualifying FQHCs.

    - Sec. 31041 (Pg. 29) would appropriate $175 million to award grants to community-based organizations addressing social determinants of maternal health.
- Financial Services (10 a.m.)
- Judiciary

Tuesday, September 14th

- Ways and Means
- Transportation and Infrastructure (10 a.m., Hybrid)

If the House passes the legislative text prepared by the committees above, it will be sent to the Senate where negotiations on final text will likely take place at the leadership level in coordination with the White House.

The Senate Appropriations Committee began work on its FY22 spending bills this month, marking up the Agriculture (bill text here; report here; summary here), Energy & Water (bill text here; report here; summary here), and Military Construction-Veterans Affairs (bill text here; report here; summary here) spending bills, all of which were advanced by votes of 25-5.

The FY22 Agriculture bill also includes $700 million for the ReConnect program to expand broadband access, and $6.278 billion for the Supplemental Nutrition Program for Women, Infants, and Children (WIC). Senate Appropriations Committee leaders have been continuing negotiations on Subcommittee spending allocations during the recess period, which also involves broader negotiations over increases to defense and non-defense discretionary spending. The Senate will resume work on the remaining 9 spending bills in September.

Even if the spending level and policy rider issues are resolved in the coming weeks, there are a limited number of days available for floor consideration of any agreed-upon spending bill(s) (or minibus packages with multiple spending bills), before the September 30th deadline. At this point, it is likely that Congress will need to rely on a Continuing Resolution (CR) to avoid a government shutdown and fund the federal government beyond the end of the fiscal year.

TELEHEALTH

On August 18th, the Health Resources and Services Administration (HRSA) announced $19 million in funding through four programs to support and expand telehealth:

1. Telehealth Technology-Enabled Learning Program (TTELP): Approximately $4.28 million is being awarded to 9 health organizations to build sustainable tele-mentoring programs and networks in rural and medically underserved communities. The funding will help specialists at academic medical centers provide training and support to primary care providers in rural, frontier, and other underserved areas to help treat patients with complex conditions ranging from long COVID to substance use disorders in their communities.

2. Telehealth Resource Centers (TRCs): $4.55 million is being awarded to 12 regional and 2 national Telehealth Resource Centers. TRCs provide information, assistance, and education on telehealth to organizations and individuals who are actively providing or want to provide

telehealth services to patients. Each regional TRC will offer a wide range of assistance targeted to local community needs. The two national TRCs will provide expert resources on telehealth policy (such as reimbursement, licensing, and privacy) and telehealth technology (such as equipment, cybersecurity, and integration with other systems).

3. Evidence-Based Direct to Consumer Telehealth Network Program (EB TNP): Approximately $3.85 million is being awarded to 11 organizations to help health networks increase access to telehealth services and to assess the effectiveness of telehealth care for patients, providers, and payers. The EB TNP program will expand access to health services in primary care, acute care, and behavioral health care.

4. Telehealth Centers of Excellence (COE) program: $6.5 million is being awarded to 2 organizations to assess telehealth strategies and services to improve health care in rural medically underserved areas that have high chronic disease prevalence and high poverty rates. The Telehealth COEs will be located in academic medical centers and will serve as telehealth incubators to pilot new telehealth services, track outcomes, and publish telehealth research. The COEs will establish an evidence-base for telehealth programs and a framework for future telehealth programs.

The Department of Health and Human Services also announced that "a booster shot will be needed to maximize vaccine-induced protection and prolong its durability" in protecting individuals from COVID-19 and its variants. The full press release can be found here.

PROVIDER RELIEF FUND

Senators Susan Collins (R-ME) and Jeanne Shaheen (D-NH) led a bipartisan group of 41 Senators in a letter on August 26th to HHS Secretary Xavier Becerra urging release of the funds remaining in the Provider Relief Fund (PRF) and other health care relief programs. The Senators point to a recent Government Accountability Office (GAO) report that at least 25% of the funding designated for health care providers goes unspent. The letter was sent as news comes that HHS has hired multiple outside contractors to audit the billions of dollars in emergency relief funding it sent to hospitals and other health care providers during the pandemic. The letter and participating Senators can be found here.

On September 10th, the Biden Administration announced plans to release more than $25 billion in relief funding for health organizations. According to initial reports by the Wall Street Journal, the funding would include $8.5 billion from the American Rescue Plan Act (ARPA) for providers who serve patients in rural areas and are covered by federal programs (Medicare & Medicaid), and an additional $17 billion will be targeted at a broad range of providers. These providers will need to document revenue loss and expenses related to the pandemic. Furthermore, another $7 billion will be used to cover claims for uninsured patients suffering from COVID-19. More details are expected to become available in the coming weeks.

EVICTION MORATORIUM

On August 25th, the US Department of the Treasury revised their Emergency Rental Assistance (ERAP) FAQ, found here. The revised guidance was released in response to a Supreme Court

decision halting the CDC's eviction moratorium, citing an overreach of authority and the need for Congressional action to extend the moratorium, highlighted below:

> "And careful review of that record makes clear that the applicants are virtually certain to succeed on the merits of their argument that the CDC has exceeded its authority. It would be one thing if Congress had specifically authorized the action that the CDC has taken. But that has not happened. Instead, the CDC has imposed a nationwide moratorium on evictions in reliance on a decades-old statute that authorizes it to implement measures like fumigation and pest extermination."

Congress has been reluctant to use their legislative authority to extend the eviction moratorium, instead pushing the expedited use of the ERAP program. Under intense pressure from Congress, Treasury's new polices for using ERAP include self-attestation of household eligibility, estimated delinquent rent payments to landlords, partnerships with local nonprofits, and other improvements.

FDA Approves Pfizer's COVID-19 Vaccine

The FDA has granted full approval to the Pfizer-BioNTech COVID-19 vaccine for people 16 and older, making it the first vaccine against the virus to earn that status in the United States. The vaccine, which will now be marketed as Comirnaty, has already been issued to over 92 million people in the US. Full FDA approval paves the way for the Department of Defense to issue a mandatory vaccine mandate, something that was not legally possible as long as the vaccine was operating under an emergency use authorization. The FDA has not ruled on the effectiveness or use of booster shots yet, despite statements from HHS that boosters may be necessary if data continues to show a decline in vaccine efficacy over time.

Medicare & Social Security Annual Report

On August 31st, the Board of Trustees for Medicare submitted their annual report on the financial health of Medicare to Congress. The report states that in 2020 Medicare covered 62.6 million people, with expenditures totaling $925.8 billion, and a total income of $899.9 billion. The report states that the Hospital Insurance Trust Fund will be depleted by 2026. The report also estimates that the COVID-19 pandemic will have significant effects on the short-term financing and Medicare spending, and that expenditures will increase faster than worker earnings or the economy overall. The full report can be found here. The Social Security/Medicare report can be found here. The summary can be found here.

Supreme Court Rules on Texas Abortion Law

On September 2nd, the Supreme Court ruled in an unsigned 5-4 decision to allow the state of Texas's new abortion law to go into effect. The Texas law will allow civil lawsuits to be filed on anyone who aids and abets, but not the patient, an abortion after the first 6 weeks of pregnancy. The decision states that the parties who presented the case to the Supreme Court have failed to "carry their burden" to address how the applicant will be "irreparably injured absent a stay", nor have they answered some of the cases complex and procedural questions. Furthermore, because the State of Texas has not said they will enforce the law, the ruling states that the criteria

to merit a stay or injunction has not been met. The State defendants argue that they cannot be restrained from enforcing their rules because they do not enforce them in the first place, having placed the burden of enforcement on the general population as a whole through the use of civil suits. This ruling comes ahead of the next Supreme Court term in October, when the Court will hear a challenge on whether Roe V. Wade should be overruled in a case from Mississippi. The full September 2nd ruling on the Texas law can be found here.

On September 9th, the Department of Justice filed a federal lawsuit in Texas asking a federal judge to declare the law invalid, with Attorney General Merrick Garland saying that the law is "clearly unconstitutional". Renae Eze, a spokesperson for Texas Governor Greg Abbott, said his office was confident the courts would uphold the law.

EDELSTEIN GILBERT ROBSON & SMITH LLC

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September 14, 2021

LEGISLATIVE UPDATE

Edelstein Gilbert Robson & Smith LLC

General Update

Friday, September 10, marked the last day of the first year of the 2021-22 Legislative Session. The Legislature spent the last two weeks in Floor Session, passing the remaining viable bills out of both houses. In total, the Legislature passed roughly 800 bills, each of which will be considered by the Governor for his signature. The Governor has until October 10 to sign or veto the bills on his desk.

The Legislature will remain on interim recess until 2022. When they return in January, legislators will introduce new bills and continuing work on two-year bills.

Legislation of Interest

AB 342 (Gipson) - Coverage of Colorectal Screening. This bill requires health plans to cover colorectal cancer screening without cost sharing as well as the colonoscopy that is required after a positive result. The California Health Benefits Review Program (CHBRP) indicates that this will cover 3.8 million enrollees statewide and result in a net increase in expenditures of 0.001%.

Patient advocacy and life science organizations supported the bill and health plans opposed. The bill passed out of the Legislature without any No votes and will make its way to the Governor for his consideration.

AB 361 (R. Rivas) – Open Meetings: Teleconference. This bill would require a local agency to use teleconferencing without complying with the Brown Act when holding a meeting to declare or ratify a local emergency when state/local health officials have required or recommended social distancing. The bill would require that teleconferenced meetings provide notice of the meeting, post agendas, and means for public comment. Further, the bill prohibits local bodies from requiring public comment in advance of the meeting and requires the body to make a series of findings related to the emergency 30 days after each meeting and every 30 days thereafter.

Recent amendments add an urgency clause so that the bill would go into effect immediately after signature and propose changes to the statute governing state-level legislative bodies.

The bill passed out of the Senate 28-7 and Assembly --66-4 and will be sent to the Governor's desk.

AB 369 (Kamlager) - Medi-Cal for Persons Experiencing Homelessness. This measure requires the Department of Health Care Services (DHCS) to implement a Medi-Cal presumptive

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eligibility (PE) enrollment process for persons experiencing homelessness (PEH). The program establishes a single streamlined paper and electronic application for Medi-Cal and Covered California to indicate if applicants are experiencing homelessness. Medi-Cal fee-for-service (FFS) and a Medi-Cal managed care (MCMC) plan are mandated to reimburse Medi-Cal providers for providing covered services that are otherwise reimbursable to the Medi-Cal provider, but that are provided off the premises of the Medi-Cal provider's office. Medi-Cal providers are authorized to issue a temporary Medi-Cal benefits identification card to a PEH who is a Medi-Cal beneficiary.

AB 369 passed the Legislature without any No votes and awaiting action from the Governor.

AB 523 (Nazarian) - PACE. This bill requires DHCS to make permanent changes in the PACE program that DHCS instituted, on or before January 1, 2021, in response to COVID-19. The changes include:

- Authorizing PACE organizations to use telehealth to conduct eligibility assessments for enrollment in the PACE program or for service modifications.
- Requiring PACE organizations to collect and document a verbal agreement of enrollment in lieu of the participant signature. Requires PACE organizations to document the verbal agreement and obtain a written signature within 14 days of submitting the enrollment agreement.
- Prohibiting a PACE organization that exclusively serves PACE participants from being required to provide all nursing services at the PACE center.
- Requiring the PACE organizations to have the flexibility to determine how to provide nursing services to participants
- Authorizing services to be provided via telehealth or other remote methods.
- Requiring PACE organizations to have the flexibility to use a broker for marketing, in accordance with existing federal regulations. Also, authorizes PACE organizations to use individuals and entities to market on their behalf if they have been trained
- Authorizing a discharge planner at a PACE referral source to ask the patient or patient representative if they would prefer to be contacted by a PACE organization.
- Requiring a discharge planner to document if a patient or patient representative consents to being contacted by a PACE organization. Also, authorizes a discharge planner to notify the PACE organization the patient or patient consents to being contacted.

This bill passed with a unanimous vote of the Legislature and is on the Governor’s desk.

SB 221 (Wiener) - Timely Access to Care. This bill codifies existing timely access to care standards for health plans and health insurers and applies these requirements to Medi-Cal managed care plans. In addition, the bill adds a standard for non-urgent follow-up appointments for nonphysician mental health care or substance use disorder providers that is within 10 business days of the prior appointment. Finally, the bill prohibits contracting providers and employees from being disciplined for informing patients about timely access standards.

SB 221 passed 76-0 in the Assembly and 35-1 in the Senate. The bill is awaiting action from the Governor.

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SB 365 (Cabellero) - E-Consult Service. This measure requires an e-consult service to be reimbursable under the Medi-Cal program for an enrolled provider, including a federally qualified health center (FQHC) or rural health clinic (RHC). An "e-consult service" means an interprofessional health record assessment and management service initiated by a treating or requesting provider and delivered by a consultative provider, including a written report to the patient's treating or requesting provider.

This received a unanimous vote in the Legislature and is on the Governor's desk.

SB 510 (Pan) - COVID-19 Cost Sharing. This bill would require health care service plans and disability insurers to cover, without prior approval or cost sharing, the costs for COVID-19 testing and health care services related to the testing for COVID-19, or a future disease when declared a public health emergency by the Governor.

The bill had an urgency clause (2/3 vote) when it came up for a vote on the Assembly floor in the last week of session and failed to garner the 54 votes needed to pass. Because of this, the author removed the urgency clause, and when the bill was brought up again on a majority vote, it reached 55 votes. The bill then passed out of the Senate on a concurrence vote and is on the Governor's desk.

Other Updates

During the last week of the Legislative session, the Governor announced that he has appointed a new Director of the Department of Health Care Services (DHCS). Director Lightbourne is stepping down and will be replaced by Michelle Baass. Ms. Baass currently serves as the Health and Human Services undersecretary. Previously, she worked for many years as a Senate Budget Consultant, where our firm established an exceptionally good working relationship with her.

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Donald B. Gilbert Michael R. Robson Trent E. Smith Jason D. Ikerd Associate Bridget E. McGowan Associate

September 3, 2021

LEGISLATIVE UPDATE
Edelstein Gilbert Robson & Smith LLC

The Legislature has just one week before adjourning the 2021 session on September 10. Governor Newsom will have until October 10 to act on the hundreds of bills that are making their way to his desk this week and next. As we've reported previously, we expect that the Governor will defer much of this work until after his September 14 recall election.

For the first time in several months, the Governor has received some good news on that front. Nevertheless, he must continue to work hard to defeat the recall and retain office.

PPIC Poll Shows the Governor in Better Shape
As we reported previously, polls released in July showed that voters were near evenly split on whether Governor Newsom should be recalled. To say that is not ideal for the Governor would be a serious understatement.

On Thursday, the highly respected Public Policy Institute of California released new polls which showed that only 39% of likely voters support the recall and 58% oppose. It is possible that the positive news for the Newsom campaign has as much to do with Newsom's potential replacements as anything else. Only 44% of voters reported that they were satisfied with the replacement candidates and 49% say they are undecided on who to support or will not vote on a replacement for the Governor. 41% of voters believe the state would be worse off if Governor Newsom's potential replacements are elected and only 31% believe the state would be better.

Early Turnout Shows More Democrats Voting
4.7 million Californians have already returned their ballots by mail. 2.5 million of those are Democrats and 1.1 million are Republicans. While it's impossible to know with certainty how voters cast their ballots, polling and common sense dictates that those Democrats voted overwhelmingly against the recall.

No doubt these statistics are as welcome to the Governor as the new polling results. However, the statistics also reveal a few vulnerabilities. In particular young and Latino voters, an essential part of the Democratic coalition, are not turning out. 40% of the ballots returned so far have been from seniors, who are only 23% of the electorate. Meanwhile, while Latinos make up a quarter of the electorate, they represent less than a fifth of the votes cast so far.

The Governor will need to continue focusing on motivating Democrats to turnout. While the numbers are in his favor today, many more ballots remain to be returned and to date, returned ballots have come disproportionately from liberal areas of the state like

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the Bay Area. Los Angeles County and San Francisco sent their ballots out earlier than the rest of the state. Further, consistent with national trends Republicans are expected to turnout in higher numbers to drop off their ballots in person on election day.

Recognizing their significance in the election, both Governor Newsom and his opponent Larry Elder have invested in Spanish language ads in an attempt to turnout and court Latino voters.

Focusing on COVID-19

In addition to attending an unmasked gathering at the state's most expensive restaurant last fall, the Governor's proactive response to the pandemic was a large driver of the recall effort. It may be surprising therefore that the Governor is beginning to focus on his response to the pandemic and willingness to wield his executive authority to impose mandates as a reason that voters should keep him in office.

To date, Governor Newsom has instead focused on the connections between recall proponents and former President Donald Trump. The anti-recall campaign has hit the airwaves with ads featuring nationally recognized Democrats such as Bernie Sanders and Elizabeth Warren imploring California Democrats to reject a Republican power grab.

However, Governor Newsom has recently shifted to emphasizing his willingness to respond to the pandemic. In public speaking engagements, this week has turned the debate on his recall into a question of public health, noting the contrast between himself and his opponents. Recent ads from the anti-recall campaign have highlighted the same thing noting that the recall decision is "a matter of life and death."

It may seem a little counterintuitive, but the choice makes sense. The Governor's Republican opponents have handed him the talking point by making it clear that they all oppose any efforts to mandate masking or vaccination. At the same time, those voters who are willing to unseat the Governor based on his willingness to impose vaccine mandates are likely already lost to him, making the appeal to those who disagree an obvious choice.

Smooth Sailing?

The Governor is by no means out of the woods. Poor turnout among Democrats is a serious risk.

At the same time, there are serious issues looming over the state. Fair or not, the Governor will be judged on his response and the situation is fraught with risk for him.

The severe drought throughout the Western United States is just one example. Parts of the state are already facing water supply problems, others will be in the near term if the drought continues into another year. The Governor and the Legislature have no ability legislate a more resilient water supply into existence before September 14. Instead, if

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conditions continue to be dry, they will be forced to consider draconian measures to reduce water use.

While it is unlikely that the Governor will pull that trigger prior to September 14, his opponents are eager to raise the specter of drought response. Social media sponsored by pro-recall groups have advertised about the risk of water shut offs and curtailment in the water starved Central Valley already.

We will keep you apprised of further developments.

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2021–22 Legislative Tracking Matrix

COVID-19 (CORONAVIRUS)

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes*
H.R. 4735 Axne **S. 2493 Bennet**	**Provider Relief Fund Deadline Extension Act:** Would delay the deadline by which providers must spend any funds received from the Provider Relief Fund — created in response to the COVID-19 pandemic — until the end of 2021 or the end of the COVID-19 public health emergency, whichever occurs later. Funds that are unspent by any deadline must be repaid to the U.S. Department of Health and Human Services (HHS). ***Potential CalOptima Impact:*** *Increased financial stability for CalOptima's contracted providers.*	**07/28/2021** Introduced; referred to committees	CalOptima: Watch
SB 510 Pan	**Disease Testing and Vaccination Coverage:** Would require a health plan to cover COVID-19 diagnostic and screening testing as well as vaccinations provided by an in-network or out-of-network provider, without cost sharing or prior authorization requirements, during a public health emergency. This bill would also apply these requirements retroactively from the beginning of the COVID-19 public health emergency as well as to any future diseases causing a public health emergency. ***Potential CalOptima Impact:*** *Reimbursement for all in-network and out-of-network provider claims for testing and vaccinations related to a disease causing a public health emergency.*	**09/10/2021** Enrolled to the Governor	CalOptima: Watch CAHP: Oppose Unless Amended LHPC: Oppose

BEHAVIORAL HEALTH

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes*
H.R. 1914 DeFazio **S. 764 Wyden**	**Crisis Assistance Helping Out On The Streets (CAHOOTS) Act:** Would allow State Medicaid programs to provide 24/7 community-based mobile crisis intervention services — under a State Plan Amendment or waiver — for those experiencing a mental health or substance use disorder crisis. Would provide states a 95% Federal Medical Assistance Percentage (FMAP) to cover such services for three years as well as a total of $25 million in planning grants. ***Potential CalOptima Impact:*** *Subject to further action by the California Department of Health Care Services (DHCS), increased behavioral health and substance use disorder services to CalOptima's Medi-Cal members.*	**03/16/2021** Introduced; referred to committees	**08/05/2021** CalOptima: Support

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes*
SB 221 Wiener	**Timely Access to Behavioral Health Follow-Up Care:** Would codify current timely access standards requiring health plans to ensure that contracted providers and health networks schedule initial appointments within specified time frames of a beneficiary's request. Beginning July 1, 2022, would expand current standards to also require follow-up appointments with a non-physician mental health or substance use disorder provider to be scheduled within 10 business days of a previous appointment related to an ongoing course of treatment — in alignment with the current time frame for the initial appointment. ***Potential CalOptima Impact:*** *Increased monitoring of behavioral health appointments; arrangement and payment of out-of-network coverage when timely access is not ensured; additional contracting with behavioral health providers.*	**09/09/2021** Enrolled to the Governor	CalOptima: Watch

BUDGET[1,2]

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes*
AB 128 Ting **AB 161 Ting** **AB 164 Ting** **SB 129 Skinner**	**Budget Act of 2021:** Makes appropriations for the government of the State of California for Fiscal Year (FY) 2021–22. Total spending is $262.6 billion, of which $196.4 billion is from the General Fund. Key initiatives related to health care include: ■ Behavioral health services for youth ■ California Advancing and Innovating Medi-Cal (CalAIM) ■ COVID-19 response ■ Homelessness ■ Medi-Cal eligibility expansion to adults ages 50 years and older, regardless of immigration status ■ Medi-Cal Rx ■ New and reinstated Medi-Cal covered benefits ■ Telehealth	**07/16/2021** Signed into law	CalOptima: Watch
AB 133 Committee on Budget	**Health Trailer Bill I:** Consolidates and enacts certain trailer bill language to implement health-related policies funded by the FY 2021–22 state budget. Key initiatives include: ■ Behavioral health services for youth ■ CalAIM ■ Elimination of asset consideration for Medi-Cal eligibility ■ Health information exchange framework ■ Medi-Cal eligibility expansion to adults ages 50 years and older, regardless of immigration status ■ Medi-Cal eligibility extension for postpartum individuals ■ New and reinstated Medi-Cal covered benefits ■ Proposition 56 supplemental payments ■ Telehealth	**07/27/2021** Signed into law	CalOptima: Watch

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes*
SB 171 Committee on Budget and Fiscal Review	**Health Trailer Bill II:** Would extend current network adequacy requirements for Medi-Cal managed care plans, including time and distance standards, from January 1, 2022, to January 1, 2023. Would also require DHCS to complete an analysis by January 1, 2024, to determine whether there is sufficient network adequacy to add housing support services as a covered Medi-Cal benefit. Finally, would require DHCS to expand Medi-Cal home- and community-based services (HCBS), authorized by CMS under the American Rescue Plan Act of 2021, to include the following new initiatives: ■ Housing and Homelessness Incentive Program ■ Community Based Residential Continuum Pilots ■ CalAIM funds for HCBS and homeless providers	**09/09/2021** Enrolled to the Governor	CalOptima: Watch

[1] The potential CalOptima impacts of budget legislation are included in the Analysis of the Enacted Budget that follows the Legislative Tracking Matrix.

[2] Because the CalAIM initiative was included in budget legislation, separate CalAIM policy bills are no longer required.

COVERED BENEFITS

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes*
H.R. 56 Biggs	**Patient Access to Medical Foods Act:** Would expand the federal definition of medical foods to include food prescribed as a therapeutic option when traditional therapies have been exhausted or may cause adverse outcomes. Effective January 1, 2022, medical foods, as defined, would be covered by private health insurance providers and federal public health programs, including Medicare, TRICARE, Children's Health Insurance Program (CHIP) and Medicaid, as a mandatory benefit. ***Potential CalOptima Impact:*** *New covered benefit for CalOptima's lines of business.*	**01/04/2021** Introduced; referred to committees	CalOptima: Watch
H.R. 1118 Dingell	**Medicare Hearing Aid Coverage Act of 2021:** Effective January 1, 2022, would require Medicare Part B coverage of hearing aids and related examinations. ***Potential CalOptima Impact:*** *New covered benefit for CalOptima OneCare, OneCare Connect and Program of All-Inclusive Care for the Elderly (PACE).*	**02/18/2021** Introduced; referred to committees	CalOptima: Watch
AB 342 Gipson	**Colorectal Cancer Screenings and Colonoscopies:** Effective January 1, 2022, would require health plans to provide no-cost coverage for a colorectal cancer screening recommended by the U.S. Preventive Services Task Force and Medicare. Additionally, when such a test produces a positive result, health plans would be required to provide no-cost coverage for a colonoscopy. Health plans would not be required to comply with these provisions when the service was delivered by an out-of-network provider. ***Potential CalOptima Impact:*** *New Medi-Cal covered benefit.*	**09/10/2021** Enrolled to the Governor	CalOptima: Watch

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes*
SB 48 Limón	**Annual Cognitive Health Assessment:** Would add annual cognitive health assessments as a covered Medi-Cal benefit for beneficiaries ages 65 or older in order to identify signs of Alzheimer's disease and dementia. Assessments would not be covered for beneficiaries who already receive similar assessments as part of an annual wellness visit covered by Medicare. ***Potential CalOptima Impact:*** *New Medi-Cal covered benefit.*	**09/09/2021** Enrolled to the Governor	CalOptima: Watch
SB 65 Skinner	**California Momnibus Act:** No later than April 1, 2022, would require DHCS to convene a workgroup to support implementation of the Medi-Cal doula benefit enacted by the FY 2021–22 state budget. The workgroup, consisting of doulas, providers, health plans, counties and advocates, would focus on ensuring beneficiary access and awareness, adequate doula workforce size and training, and timely payment for services. ***Potential CalOptima Impact:*** *Increased guidance and preparation for covering the doula benefit; increased utilization of doula services by CalOptima Medi-Cal members.*	**09/10/2021** Enrolled to the Governor	CalOptima: Watch
SB 306 Pan	**Sexually Transmitted Disease (STD) Home Test Kits:** Would require health plans to provide coverage and reimbursement for at-home STD test kits and any associated laboratory fees. ***Potential CalOptima Impact:*** *New Medi-Cal covered benefit.*	**09/10/2021** Enrolled to the Governor	CalOptima: Watch CAHP: Oppose

MEDI-CAL OPERATIONS AND ADMINISTRATION

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes*
H.R. 1738 Dingell **S. 646 Brown**	**Stabilize Medicaid and CHIP Coverage Act of 2021:** Would provide 12 months of continuous eligibility and coverage for any Medicaid or CHIP beneficiary. ***Potential CalOptima Impact:*** *Increased number of CalOptima's Medi-Cal members.*	**03/10/2021** Introduced; referred to committees	CalOptima: Watch ACAP: Support
AB 361 Rivas	**Extension of Brown Act Flexibilities:** Effective immediately upon the Governor's signature, would extend current temporary Brown Act flexibilities — enacted by the Governor in response to the COVID-19 public health emergency — that allow remote participation in meetings of a local public agency. Currently set to expire on September 30, 2021, these flexibilities would instead be permitted during any state of emergency that threatens the health and safety of meeting attendees. ***Potential CalOptima Impact:*** *Continued ability for members of CalOptima's Board of Directors and advisory committees to participate in meetings by teleconference during the COVID-19 public health emergency.*	**09/10/2021** Enrolled to the Governor	CalOptima: Watch LHPC: Support

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Bill Number (Author)	Bill Summary	Bill Status	Position/Notes*
AB 1082 Waldron	**California Health Benefits Review Program (CHBRP) Extension:** Would extend current authorization for the University of California to administer CHBRP, which provides independent analyses of proposed states legislation regarding new health benefits, from July 1, 2022, until July 1, 2027. To fully fund CHBRP, the bill would also increase the total annual fee charged to health plans and insurers from $2 million to $2.2 million, beginning July 1, 2022. ***Potential CalOptima Impact:*** *Increased annual fee assessed to CalOptima; continued availability of CHBRP analyses.*	**09/10/2021** Enrolled to the Governor	CalOptima: Watch CAHP: Support In Concept

OLDER ADULT SERVICES

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes*
H.R. 1868 Yarmuth	**Extension of Medicare Sequestration Moratorium:** Extends the moratorium on automatic, across-the-board 2% spending cuts to Medicare payments. The moratorium, which was set to expire on March 31, 2021, now ends on December 31, 2021. ***CalOptima Impact:*** *Continued federal capitation payments to CalOptima OneCare, OneCare Connect and PACE.*	**04/14/2021** Signed into law	CalOptima: Watch
H.R. 4131 Dingell **S. 2210 Casey**	**Better Jobs Better Care Act:** Would make permanent the enhanced 10% FMAP for Medicaid HCBS enacted by the American Rescue Plan Act of 2021. Would also provide states with $100 million in planning grants to develop HCBS infrastructure and workforces. Additionally, would make permanent spousal impoverishment protections for those receiving HCBS. ***Potential CalOptima Impact:*** *Continuation of current federal funding rate for HCBS; expansion of HCBS opportunities.*	**06/24/2021** Introduced; referred to committees	CalOptima: Watch NPA: Support
H.R. 4941 Blumenauer	**PACE Part D Choice Act of 2021:** Would allow a Medicare-only PACE participant to opt out of drug coverage provided by the PACE program and instead enroll in a standalone Medicare Part D prescription drug plan that results in equal or lesser out-of-pocket costs. PACE programs would be required to educate their participants about this option. ***Potential CalOptima Impact:*** *Increased enrollment into CalOptima PACE by Medicare-only beneficiaries due to decreased out-of-pocket costs.*	**08/06/2021** Introduced; referred to committees	CalOptima: Watch NPA: Support
S. 1162 Casey	**PACE Plus Act:** Would increase the number of PACE programs nationally by making it easier for states to adopt PACE as a model of care and providing grants to organizations to start PACE centers or expand existing PACE centers. Would incentivize states to expand the number of seniors and people with disabilities eligible to receive PACE services beyond those deemed to require a nursing home level of care. Would provide states a 90% FMAP to cover the expanded eligibility. ***Potential CalOptima Impact:*** *Subject to further DHCS authorization, expanded eligibility for CalOptima PACE; additional federal funding to expand the service area of a current PACE center or to establish a new PACE center(s).*	**04/15/2021** Introduced; referred to committee	CalOptima: Watch CalPACE: Support NPA: Support

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes*
AB 523 Nazarian	**Permanent PACE Flexibilities:** Would permanently extend most flexibilities granted to PACE organizations during the COVID-19 public health emergency. This includes flexibilities relating to telehealth services, verbal agreements followed with in-person signatures, Adult Day Health Center home-based services and discharge planning. ***Potential CalOptima Impact:*** *Continuation of most flexibilities adopted by CalOptima PACE during the COVID-19 pandemic.*	**09/09/2021** Enrolled to the Governor	**06/03/2021** CalOptima: Support CalPACE: Support/ Sponsor

PROVIDERS

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes*
SB 365 Caballero	**Medi-Cal Provider Electronic Consultation (E-Consult) Service:** Would allow provider-to-provider e-consult services to be reimbursable to all requesting and consulting Medi-Cal providers, including Federally Qualified Health Center (FQHC) and Rural Health Center (RHC) providers. The e-consult may include assessing health records, providing feedback and/or recommending a further course of action. ***Potential CalOptima Impact:*** *Expanded reimbursable service for all Medi-Cal providers and FQHC providers.*	**09/09/2021** Enrolled to the Governor	CalOptima: Watch LHPC: Support

SOCIAL DETERMINANTS OF HEALTH

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes*
H.R. 379 Barragan **S. 104 Smith**	**Improving Social Determinants of Health Act of 2021:** Would require the Centers for Disease Control and Prevention (CDC) to establish a social determinants of health (SDOH) program to coordinate activities to improve health outcomes and reduce health inequities. CDC would be required to consider SDOH in all relevant grant awards and other activities, as well as issue new grants of up to $50 million to health agencies, nonprofit organizations and/or institutions of higher education to address or study SDOH. ***Potential CalOptima Impact:*** *Increased availability of federal grants to address SDOH.*	**01/21/2021** Introduced; referred to committees	CalOptima: Watch
H.R. 943 McBath **S. 851 Blumenthal**	**Social Determinants for Moms Act:** Would require HHS to convene a task force to coordinate federal efforts on social determinants of maternal health as well as award grants to address SDOH, eliminate disparities in maternal health and expand access to free childcare during pregnancy-related appointments. Would also extend postpartum eligibility for the Special Supplemental Nutrition Program for Women, Infants, and Children from six months postpartum to two years postpartum. ***Potential CalOptima Impact:*** *Additional federal guidance or requirements as well as increased availability of federal grants to address social factors affecting maternal health.*	**02/08/2021** Introduced; referred to committees	CalOptima: Watch

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes*
H.R. 2503 Bustos	**Social Determinants Accelerator Act of 2021:** Would establish the Social Determinants Accelerator Interagency Council to award state and local health agencies up to 25 competitive grants totaling no more than $25 million, as well as provide technical assistance to improve coordination of medical and non-medical services to a targeted population of high-need Medicaid beneficiaries. ***Potential CalOptima Impact:*** *Increased availability of federal grants to address the SDOH of members with complex needs.*	**07/15/2021** Passed House Energy and Commerce Committee's Subcommittee on Health; referred to full Committee	CalOptima: Watch
H.R. 3894 Blunt Rochester	**Collecting and Analyzing Resources Integral and Necessary for Guidance (CARING) for Social Determinants Act of 2021:** Would require the Centers for Medicare & Medicaid Services (CMS) to update guidance at least once every three years to help states address SDOH in Medicaid and CHIP programs. ***Potential CalOptima Impact:*** *Increased opportunities for CalOptima to address SDOH.*	**07/21/2021** Passed House Energy and Commerce Committee; referred to House floor	CalOptima: Watch
H.R. 4026 Burgess	**Social Determinants of Health Data Analysis Act of 2021:** Would require the Comptroller General of the United States to submit a report to Congress outlining the actions taken by HHS to address SDOH. The report would include an analysis of interagency efforts, barriers and potential duplication of efforts as well as recommendations on how to foster private-public partnerships to address SDOH. ***Potential CalOptima Impact:*** *Increased opportunities for CalOptima to address SDOH.*	**07/21/2021** Passed House Energy and Commerce Committee; referred to House floor	CalOptima: Watch
AB 369 Kamlager	**Presumptive Eligibility and Street Medicine for Homeless Individuals:** Would apply presumptive Medi-Cal eligibility — with full-scope benefits and without share of cost — to individuals experiencing homelessness. Would allow any Medi-Cal provider to determine presumptive eligibility and issue a temporary Medi-Cal card. Would add a field on the Medi-Cal application to indicate homelessness. Would also allow Medi-Cal providers to deliver any covered Medi-Cal benefit to a homeless individual outside of a medical facility, including primary, specialist and laboratory services, without a referral or prior authorization. Finally, would require DHCS to deduct capitation payments if a plan does not provide services to a person indicating homelessness within the first 60 days of Medi-Cal enrollment ***Potential CalOptima Impact:*** *Increased number of CalOptima's Medi-Cal members; increased access to services for homeless members but may negatively impact care coordination; increased payments to providers; implementation of modified utilization management procedures for homeless members.*	**09/10/2021** Enrolled to the Governor	CalOptima: Watch LHPC: Oppose Unless Amended

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TELEHEALTH

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes*
H.R. 366 Thompson (CA)	**Protecting Access to Post-COVID-19 Telehealth Act of 2021:** Would allow HHS to waive or modify any telehealth service requirements in the Medicare program during a national disaster or public health emergency and for 90 days after one is terminated. Would also permit Medicare reimbursement for telehealth services provided by an FQHC or RHC, as well as allow patients to receive telehealth services in the home without restrictions. ***Potential CalOptima Impact:*** *Continuation and expansion of certain telehealth flexibilities allowed during the COVID-19 pandemic for CalOptima OneCare, OneCare Connect and PACE.*	**01/19/2021** Introduced; referred to committees	CalOptima: Watch
H.R. 2166 Sewell	**Ensuring Parity in MA and PACE for Audio-Only Telehealth Act of 2021:** Would require CMS to include audio-only telehealth diagnoses in the determination of risk adjustment payments for Medicare Advantage (MA) and PACE plans during the COVID-19 public health emergency. ***Potential CalOptima Impact:*** *For CalOptima OneCare, OneCare Connect and PACE, members' risk scores and risk adjustment payments would accurately reflect diagnoses.*	**03/23/2021** Introduced; referred to committees	**08/05/2021** CalOptima: Support ACAP: Support NPA: Support
H.R. 2903 Thompson (CA) **S. 1512 Schatz**	**Creating Opportunities Now for Necessary and Effective Care Technologies (CONNECT) for Health Act of 2021:** Would expand telehealth services for those receiving Medicare benefits and remove restrictions in the Medicare program that prevent physicians from using telehealth technology. Specifically, would: ■ Remove all geographic restrictions for telehealth services ■ Allow beneficiaries to receive telehealth in their own homes, in addition to other locations determined by HHS ■ Remove restrictions on the use of telehealth in emergency medical care ■ Allow FQHCs and RHCs to provide telehealth services ***Potential CalOptima Impact:*** *Continuation and expansion of telehealth flexibilities for CalOptima OneCare, OneCare Connect and PACE.*	**04/28/2021** Introduced; referred to committees	CalOptima: Watch
H.R. 3447 Smith (MO)	**Permanency for Audio-Only Telehealth Act:** Would permanently extend the following current flexibilities, which have been temporarily authorized by CMS during the COVID-19 public health emergency: ■ Medicare providers may be reimbursed for providing certain services via audio-only telehealth, including evaluation and management, behavioral health and substance use disorder services, or any other service specified by HHS. ■ Medicare beneficiaries may receive telehealth services at any location, including their homes. ***Potential CalOptima Impact:*** *Permanent continuation of certain telehealth flexibilities for CalOptima OneCare, OneCare Connect and PACE.*	**05/20/2021** Introduced; referred to committees	CalOptima: Watch

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Bill Number (Author)	Bill Summary	Bill Status	Position/Notes*
H.R. 4058 Matsui **S. 2061 Cassidy**	**Telemental Health Care Access Act of 2021:** Would remove the requirement that Medicare beneficiaries be seen in-person within six months of being treated for behavioral health services via telehealth. ***Potential CalOptima Impact:*** *For CalOptima OneCare and OneCare Connect, decreased in-person behavioral health encounters and increased telehealth behavioral health encounters.*	**06/22/2021** Introduced; referred to committees	CalOptima: Watch
S. 150 Cortez Masto	**Ensuring Parity in MA for Audio-Only Telehealth Act of 2021:** Would require CMS to include audio-only telehealth diagnoses in the determination of risk adjustment payments for MA plans during the COVID-19 public health emergency ***Potential CalOptima Impact:*** *For CalOptima OneCare and OneCare Connect, members' risk scores and risk adjustment payments would accurately reflect diagnoses.*	**02/02/2021** Introduced; referred to committee	CalOptima: Watch ACAP: Support NPA: Support

YOUTH SERVICES

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes*
H.R. 66 Buchanan	**Comprehensive Access to Robust Insurance Now Guaranteed (CARING) for Kids Act:** Would permanently extend authorization and funding of CHIP and associated programs, including the Medicaid and CHIP express lane eligibility option, which enables states to expedite eligibility determinations by referencing enrollment in other public programs. ***Potential CalOptima Impact:*** *Continuation of current federal funding and eligibility requirements for CalOptima's Medi-Cal members eligible under CHIP.*	**01/04/2021** Introduced; referred to committee	CalOptima: Watch
H.R. 1390 Wild **S. 453 Casey**	**Children's Health Insurance Program Pandemic Enhancement and Relief (CHIPPER) Act:** Would retroactively extend CHIP's temporary 11.5% FMAP increase, enacted by the HEALTHY KIDS Act (2018), from September 30, 2020, until September 30, 2022, to meet increased health care needs during the COVID-19 public health emergency. ***Potential CalOptima Impact:*** *Increased federal funds for CalOptima's Medi-Cal members eligible under CHIP.*	**02/25/2021** Introduced; referred to committees	CalOptima: Watch
SB 682 Rubio	**Childhood Chronic Health Conditions:** Would require the California Health and Human Services Agency to convene an advisory workgroup to develop and implement a plan that reduces racial disparities in children with chronic health conditions by 50% by 2030. Chronic conditions may include asthma, diabetes, depression and vaping-related diseases. ***Potential CalOptima Impact:*** *New interventions, quality measures and/or reporting requirements required by DHCS.*	**09/09/2021** Enrolled to the Governor	CalOptima: Watch

Two-Year Bills

The following bills did not meet the deadline to be passed by both houses of the Legislature. These are now considered two-year bills and are eligible for reconsideration in 2022:

- AB 4 (Arambula)
- AB 32 (Aguiar-Curry)
- AB 58 (Salas)
- AB 71 (Rivas, Luz)
- AB 112 (Holden)
- AB 114 (Maienschein)
- AB 393 (Reyes)
- AB 454 (Rodriguez)
- AB 470 (Carrillo)
- AB 540 (Petrie-Norris)
- AB 552 (Quirk-Silva)
- AB 563 (Berman)
- AB 586 (O'Donnell)
- AB 671 (Wood)
- AB 685 (Maienschein)
- AB 797 (Wicks)
- AB 822 (Rodriguez)
- AB 862 (Chen)
- AB 875 (Wood)
- AB 882 (Gray)
- AB 935 (Maienschein)
- AB 942 (Wood)
- AB 1050 (Gray)
- AB 1083 (Nazarian)
- AB 1107 (Boerner Horvath)
- AB 1117 (Wicks)
- AB 1131 (Wood)
- AB 1132 (Wood)
- AB 1160 (Rubio)
- AB 1162 (Villapadua)
- AB 1254 (Gipson)
- AB 1372 (Muratsuchi)
- AB 1400 (Kalra, Lee, Santiago)
- SB 17 (Pan)
- SB 56 (Pan)
- SB 245 (Gonzalez)
- SB 250 (Pan)
- SB 256 (Pan)
- SB 279 (Pan)
- SB 293 (Limon)
- SB 316 (Eggman)
- SB 371 (Caballero)
- SB 508 (Stern)
- SB 523 (Leyva)
- SB 562 (Portantino)
- SB 773 (Roth)

*Information in this document is subject to change as bills proceed through the legislative process.

ACAP: Association for Community Affiliated Plans
CAHP: California Association of Health Plans
CalPACE: California PACE Association
LHPC: Local Health Plans of California
NPA: National PACE Association

Last Updated: September 13, 2021

2021 Federal Legislative Dates

January 3	117th Congress, First Session convenes
March 29–April 9	Spring recess
August 2–27	Summer recess for House
August 9–September 10	Summer recess for Senate
December 10	First Session adjourns

2021 State Legislative Dates*

**Due to COVID-19, 2021 State Legislative dates have been modified*

January 11	Legislature reconvenes
February 19	Last day for legislation to be introduced
March 25–April 4	Spring recess
April 30	Last day for policy committees to hear and report to fiscal committees any fiscal bills introduced in their house
May 7	Last day for policy committees to hear and report to the floor any non-fiscal bills introduced in their house
May 21	Last day for fiscal committees to hear and report to the floor any bills introduced in their house
June 1–4	Floor session only
June 4	Last day for each house to pass bills introduced in that house
June 15	Budget bill must be passed by midnight
July 14	Last day for policy committees to hear and report bills to fiscal committees or the floor
July 16–August 15	Summer recess
August 27	Last day for fiscal committees to report bills to the floor
August 30–September 10	Floor session only
September 3	Last day to amend bills on the floor
September 10	Last day for bills to be passed; final recess begins upon adjournment
October 10	Last day for Governor to sign or veto bills passed by the Legislature

Sources: 2021 State Legislative Deadlines, California State Assembly: http://assembly.ca.gov/legislativedeadlines

About CalOptima

CalOptima is a county organized health system that administers health insurance programs for low-income children, adults, seniors and people with disabilities. As Orange County's community health plan, our mission is to provide members with access to quality health care services delivered in a cost-effective and compassionate manner. We provide coverage through four major programs: Medi-Cal, OneCare Connect Cal MediConnect Plan (Medicare-Medicaid Plan), OneCare (Medicare Advantage Special Needs Plan) and the Program of All-Inclusive Care for the Elderly (PACE).

FY 2021–22 California State Budget: Analysis of the Enacted Budget

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Overview

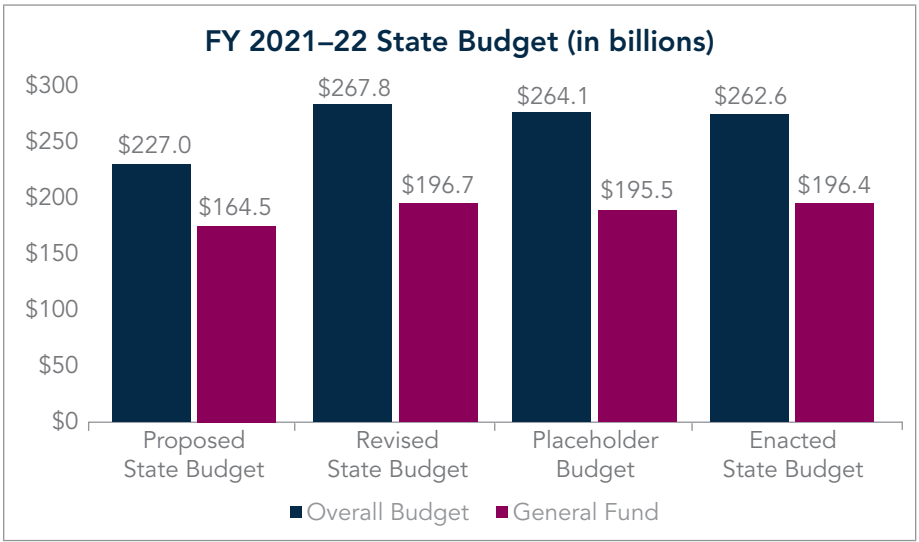
On January 8, 2021, Gov. Gavin Newsom released the Fiscal Year (FY) 2021–22 Proposed State Budget of $227 billion, including $164.5 billion General Fund (GF).[1] After experiencing a $54 billion budget shortfall in the Enacted FY 2020–21 State Budget, the proposed budget estimated $34 billion in budget resiliency, including a $12 billion surplus and $22 billion in budget reserves.

On May 14, 2021, Gov. Newsom announced the Revised State Budget (May Revise) for FY 2021–22. The May Revise proposed a state budget of $267.8 billion, including $196.7 billion GF.[2] With the economy beginning to recover from the COVID-19 pandemic, the May Revise included the *California Comeback Plan*, a budget surplus of $100 billion for the next FY.

To meet the constitutionally obligated deadline to pass a balanced budget, on June 14, 2021, the Senate and Assembly passed the Budget Act of 2021, Assembly Bill (AB) 128, a preliminary state budget for FY 2021–22. The Legislature's Budget includes a spending plan of $264.1 billion, including $195.5 billion GF. This reflects a $3.7 billion decrease in overall spending from the May Revise.

Following negotiations with the Legislature, on June 28, 2021, Gov. Newsom signed into law AB 128 and, on July 12, 2021, Senate Bill 129 followed by AB 133 on July 27. Together, these bills represent the Enacted Budget for FY 2021–22.

Table 1. California State Budget



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Enacted Budget & Key Impacts

The Enacted Budget reflects a total spending plan of $262.6 billion ($196.4 billion GF) for FY 2021–22.

Medi-Cal Budget

The spending plan also increases funding for Medi-Cal and assumes total Medi-Cal enrollment will reach 14.5 million by 2022.

The overall caseload is influenced by the suspension of Medi-Cal eligibility redeterminations, the COVID-19-driven recession and additional data on actual caseload growth.

Key budget initiatives related to health care with a significant impact to CalOptima include:

- Behavioral health services for youth
- California Advancing and Innovating Medi-Cal (CalAIM) proposal
- Medi-Cal eligibility for older adults ages 50 and older, regardless of immigration status

Behavioral Health for Youth

In response to the ongoing COVID-19 pandemic, the Administration and State Legislature have prioritized behavioral health (BH) services for youth ages 25 and younger. The Enacted Budget includes nearly $4.4 billion in funding over five years with several initiatives focusing on care coordination, prevention and access.[4] This includes implementing a $400 million one-time funding incentive plan through Medi-Cal managed care plans (MCPs) to increase the number of preschool and TK-12 students receiving preventive and early intervention BH services at school, beginning no sooner than January 1, 2022.

During calendar year (CY) 2020, **more than 40,000 CalOptima members under the age of 19 utilized BH services** — half of which were diagnosed with severe mental illness and received care through the Orange County Health Care Agency (HCA). If CalOptima opts into the BH incentive program, CalOptima will need to establish the infrastructure to administer Medi-Cal-reimbursable services to students. CalOptima does not currently contract with schools or school districts. This could result in significant administrative changes for CalOptima by requiring increased staff time to administer incentive payments and implement interventions with one or more school districts.

Of note, CalOptima already has an existing MOU with HCA for BH services. It is unknown if a new MOU would need to be established and at what level schools would be integrated into the incentive program. Pending guidance from DHCS, the program may lead to confusion regarding where the member can access services (e.g., school, MCP or HCA), who is responsible for that member, and what role each provider would play. With key details still missing from this proposal, including the allocation of funds, the exact degree of impact remains unclear.

Other funding directed for innovative and preventive youth BH services includes:

- $1.4 billion ($1 billion GF, $100 million Coronavirus Fiscal Recovery Fund, $222 million federal funds, and $105 million Mental Health Services Fund) in 2021-22
- $1.5 billion ($1.4 billion GF and $124 million federal funds) in 2022-23
- $431 million ($300 million GF and $131 million federal funds) in 2023-24 and ongoing[3]

CalAIM

The CalAIM initiative received full funding in the Enacted Budget, with $1.6 billion total funds ($650.7 million GF) for FY 2021–22, $1.5 billion total funds ($812.5million GF) for FY 2023–24, decreasing to $900 million ($480 million GF) by FY 2024-25, ongoing.[4] When compared with the January Proposed Budget, this reflects an increase of $5 billion for FY 2021–22.

Table 2. CalAIM Funding

Cost Category	Enacted Budget
Behavioral Health	$21.8 million
Dental	$113.5 million
Enhanced Care Management	$187.5 million
Incentives	$300 million
In Lieu of Services	$47.9 million
Medically Tailored Meals	$9.3 million
Multipurpose Senior Services Program Carve-out	$1.6 million
Organ Transplant Carve-In	$4.7 million
Population Health Management (PHM)	$315 million
Providing Access and Transforming Health (PATH)	$200 million
Specialty Mental Health Services Carve-Out	-$4.8 million
State Operations Funding	$38.9 million
Transitioning Populations	$401.6 million

Of the CalAIM initiatives, ECM, ILOS and operating a Dual Eligible Special Needs Plan (D-SNP) are projected to have direct impacts to CalOptima, with details to follow.

ECM and ILOS

Building upon the existing Health Homes Program (HHP) delivery system infrastructure, ECM is designed to meet clinical and nonclinical needs of the highest-cost and/or highest-need beneficiaries. This includes members experiencing homelessness, members with complex medical conditions, members unable to self-manage health successfully and may include those enrolled in HHP or Whole Person Care (WPC). ILOS, which is optional for MCPs to offer, also builds upon both HHP and WPC infrastructures as a way to provide flexible wrap-around services as substitutes for other covered services, such as emergency department visits or skilled nursing facility admissions. DHCS has proposed 14 ILOS options, four of which CalOptima will implement in Phase 1. CalOptima has not yet determined which of the remaining ILOS options will be included in Phase 2 and beyond. Of note, CalOptima has begun discussions with HCA and its current ECM providers (health networks) to coordinate implementation efforts and ensure no gaps in services.

Table 2. Phase 1 ILOS Programs (No Sooner Than January 1, 2022)

Housing Transition Navigation Services	Housing Tenancy and Sustaining Services
Housing Deposits	Recuperative Care (Medical Respite)

Table 3. Pending Future ILOS Programs (No Sooner Than July 1, 2022)

Short-Term Post-Hospitalization Housing	Personal Care and Homemaker Services
Respite Services	Environmental Accessibility Adaptations (Home Modifications)
Day Habilitation Programs	Meals/Medically Tailored Meals
Nursing Facility Transition/Diversion to Assisted Living Facilities	Sobering Centers
Community Transition Services/Nursing Facility Transition to a Home	Asthma Remediation

As of June 2021, there are approximately 790 CalOptima members participating in HHP and nearly 5,000 members in WPC. Based on current populations identified in May 2021, **CalOptima projects approximately 34,000 members may be eligible for ECM and/or ILOS**. Additional population projections will be available in the future, pending guidance from DHCS. Of note, recent DHCS guidance directs counties managing a WPC pilot to determine which members should transition to ECM, ILOS or both. If a member is not deemed appropriate for ECM, ILOS or both, that county will continue to manage that individual's care until referred to another service.

With ECM reimbursement rates and the cost of providing ILOS still pending due to unknown utilization levels, CalOptima has budgeted approximately $16 million for FY 2022 in Medi-Cal revenue and expenses for ECM and ILOS. ECM and ILOS are scheduled to be implemented no sooner than January 1, 2022.

D-SNP

To standardize comprehensive care coordination, the Enacted Budget supports the discontinuation of the Cal MediConnect pilot program at the end of CY 2022. DHCS will support mandatory enrollment of dually eligible beneficiaries into managed care and require MCPs to operate a Medicare D-SNP in order to achieve that aligned enrollment.

Therefore, **CalOptima will be required to transition more than 14,000 OneCare Connect members into OneCare, CalOptima's D-SNP,** effective January 1, 2023. Current trends project 250 Orange County residents become dually eligible for Medi-Cal and Medicare each month. Pending further clarification from DHCS, it is unknown how aligned enrollment will be implemented for CalOptima members who become dually eligible on or after January 1, 2023. Of note, there are approximately 75,000 dually eligible seniors in Medicare fee-for-service (FFS) in Orange County. Those individuals will not be required to passively enroll into OneCare and will remain in Medicare FFS unless they elect to enroll in a D-SNP.

Medi-Cal Eligibility Expansion

Older Adults

The Enacted Budget expands Medi-Cal eligibility to those 50 years or older, regardless of immigration status. This was originally proposed in 2019 and paused due to the COVID-19 pandemic. The cost of the expansion is $1.5 billion ($1.3 billion GF) ongoing, including In-Home Supportive Services, effective no sooner than May 1, 2022.[5]

There are an estimated 17,000 Orange County residents ages 55 and older who are undocumented immigrants; another 37,000 are ages 45–54.[6] Of that population, CalOptima staff estimate there are approximately 35,000 individuals ages 50 and older. While those eligible for full-scope Medi-Cal based on federal poverty level (FPL) percentage is unknown, it is estimated that nearly half of those individuals are eligible. Therefore, **CalOptima is projecting approximately 16,000–17,000 new members**.

Pregnant Women and Their Newborn Children

The Enacted Budget includes a 5-year Medi-Cal eligibility expansion program for postpartum individuals and their newborn children, regardless of receiving a formal BH-related diagnosis. This extends eligibility for full-scope Medi-Cal from 60 days to 12 months postpartum and would apply to those with an FPL percentage of 139% to 322%. Effective no sooner than April 1, 2022, the budget includes $90.5 million ($45.3 million GF) in FY 2021–22 and $362.2 million ($181.1 million GF) in FY 2022–23, increasing to $400 million ($200 million GF) until April 2027, to implement the extension.[7]

In 2020, nearly 750 CalOptima members earning 139% to 322% FPL were Medi-Cal-eligible because of their pregnancy. Since this program extends access to full-scope Medi-Cal from 60 days to 12 months postpartum, it is expected that point-in-time membership and utilization of covered services, overall, will increase. However, the total number of unique CalOptima members is projected to remain the same.

Covered Benefits

In addition to introducing the CalAIM proposal, Gov. Newsom proposed that Medi-Cal expand the list of covered benefits and address issues relating to health equity and cultural sensitivity. In response, the Enacted Budget includes three new covered benefits.

- **Continuous Glucose Monitors (CGMs):** $4.9 million ($1.3 million GF) to include CGM devices as a Medi-Cal-covered benefit for those with Type 1 Diabetes, effective January 1, 2022.[8] CalOptima had 6,700 members with Type 1 Diabetes through CY 2020. These members would meet the qualifications to request a CGM device as a new method to manage their Type 1 Diabetes.
- **Doula Care:** $403,000 ($152,000 GF) in FY 2021–22 and approximately $4.4 million ($1.7 million GF) annually to add doula services as a Medi-Cal covered benefit, effective January 1, 2022.[9] While CalOptima is unable to specifically identify members who may become pregnant and use doula services in CY 2021, there were approximately 15,000 members who became pregnant in CY 2020.
- **Dyadic Care:** $800 million to introduce dyadic care as a new statewide Medi-Cal benefit, effective no sooner than July 1, 2022.[10] Similar to Parent-Child Interaction Therapy, currently managed by HCA, dyadic care would provide integrated physical and behavioral health screening and services to the whole family. The goal of providing dyadic care is to improve access to preventive and coordinated care for children, rates of immunization completion, social-emotional health services, developmentally appropriate parenting and maternal mental health. As this is a new covered benefit, CalOptima is unable to determine the exact impact to the plan. However, for CY 2020, 282,000 CalOptima members were 21 years or younger, with approximately 60,000 utilizing BH services. It is projected that children with a BH-related condition may be more likely to use dyadic care.
- **Over the Counter (OTC) Medications:** Reinstates Medi-Cal coverage for adult cold/cough and acetaminophen OTC medications, effective July 1, 2021.[11] Based on utilization prior to being eliminated, reinstating these OTC medications may cost CalOptima approximately $600,000 a year. However, once the pharmacy benefit is carved out of managed care, there will be no cost to CalOptima.

Of note, Proposition 56 directed payments, In-Home Support Services (IHSS) and optional adult Medi-Cal benefits that were scheduled for suspension in 2021 will now receive ongoing funding and have been removed from the suspension list.

COVID-19

California continues to recover from the COVID-19 pandemic-driven recession and public health emergency. As of July 2021, over 3.7 million California residents have contracted COVID-19 and nearly 64,000 people have died.[12] The Enacted Budget highlights the State's ongoing response to the pandemic using state and federal funds, including $27 billion from the American Rescue Plan Act of 2021.

Since the May Revise, the State calculated an additional $122 million in spending related to the vaccine distribution and administration. Therefore, current fiscal impacts to the state include $12.1 billion total costs between FY 2019-20 and 2021–22.[13] This includes costs for contact tracing, testing, vaccine administration and temporary provider reimbursements.

Table 4. COVID-19 Costs to the State[14]

Cost Category	Enacted Budget
Community Engagement	$193.3 million
Contact Tracing and Tracking	$233.1 million
Hospital and Medical Surge	$1.2 billion
Hotels for Health Care Workers	$277.9 million
Housing for the Harvest	$24.2 million
Procurements	$2.9 billion
State Response Operations	$2.3 billion
Statewide Testing	$1.8 billion
Support for Vulnerable Populations	$1.7 billion
Vaccine Distribution and Administration	$1.5 billion

Furthermore, the state will continue to maximize the use of federal funds to support the current public health emergency, currently projected to remain in effect through December 2021. This includes:

- $236.6 billion from the Coronavirus Aid, Relief, and Economic Security Act
- $191.1 billion from the American Rescue Plan Act
- $99.2 billion from the Coronavirus Response and Relief Act
- $74.7 billion from the Paycheck Protection and Health Care Act
- $17.3 billion from the Families First Act
- $8 billion from the Federal Emergency Management Agency (FEMA) Public Assistance Program
- $2.4 billion from the Coronavirus Relief Fund
- $1.6 billion from the Preparedness and Response Act
- $347.7 million from other federal and private funds

Of note, upon the conclusion of the public health emergency, the Enacted Budget includes one-time funding of $73 million ($36.5 million GF) for FY 2021–22 and FY 2022–23 to resume annual Medi-Cal redeterminations.[15]

Homelessness

The State's response with Project Roomkey, and then Project Homekey, was successful at both housing those experiencing homelessness and reducing their risk of contracting COVID-19. The Enacted Budget includes approximately $12 billion for housing and homeless services over the next two FYs, with a goal to end homelessness statewide.[16] This includes $5.8 billion in one-time funds over two years to further support Project Homekey. Initiatives within Project Homekey will also include BH services and housing support for youth, families, and low-income seniors.

It is anticipated that of the 132 units currently available in Orange County through Project Homekey, approximately 80% will house CalOptima members.

Medi-Cal Rx

The Medi-Cal pharmacy (Rx) benefit carve-out will remain carved-in to managed care through the remainder of CY 2021. The Administration anticipates the carve-out will take place no sooner than January 1, 2022. With the current placeholder in the Enacted Budget, the pharmacy carve-out is expected to result in ongoing annual savings of $859 million total funds ($309 million GF). Due to the timing of various Medi-Cal Rx transition impacts, the budget also assumes temporary costs of $32 million total funds ($14 million GF) in FY 2020–21 and $363 million total funds ($134 million GF) in FY 2021–22.[17] The Administration is still discussing an implementation plan and will provide an update within the coming months.

Telehealth

As part of the Administration's proposal, the Enacted Budget includes $151.1 million ($53.3 million GF) for FY 2021–22 to extend telehealth flexibilities implemented during the pandemic.[18] DHCS will consult with stakeholders to establish utilization management protocols for all telehealth services prior to implementation of post-pandemic telehealth services.

Other Medi-Cal Programs

Community Health Workers

$16.3 million ($6.2 million GF), increasing to $201 million ($76 million GF) by FY 2026–27, to add community health workers to the class of health workers who are able to provide services to Medi-Cal beneficiaries, effective January 1, 2022.[19]

Health Information Exchange

$2.5 million GF for the Health and Human Services Agency to lead efforts and stakeholder engagement to build out information exchange capabilities for health and social services programs.[20]

Master Plan for Aging (MPA) Implementation

$3.3 million GF ongoing for the hiring of 20 permanent positions that will provide the Department of Aging with policy, project management and information technology leadership necessary to implement the MPA.[21] Of note, it is still unknown which initiatives will be implemented first.

Regional Center Mobile Crisis Teams

$8 million GF in FY 2021–22, increasing to $11 million GF ongoing in FY 2022–23, for Systemic, Therapeutic, Assessment, Resources and Treatment (START) teams. The START teams provide 24-hour crisis prevention and response services to individuals with intellectual or developmental disabilities.[22]

Next Steps

The Legislature will continue to advance budget trailer bills and policy bills through the legislative process. Bills with funding allocated in the Enacted Budget are likely to be passed and signed into law. The Legislature has until September 10, 2021, to pass legislation, and Gov. Newsom has until October 10, 2021, to either sign or veto that legislation. Additionally, state agencies will begin implementing the policies enacted through the budget, such as CalAIM and the Medi-Cal Rx carve-out. Staff will continue to monitor these polices and provide updates regarding issues that have a significant impact to CalOptima.

About CalOptima

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

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

Endnotes

[1] 2021-22 Governor's Budget: Proposed Budget Detail, January 8, 2021
[2] 2021–22 Governor's May Revise Budget Summary, May 14, 2021, Pg. 13
[3] 2021-22 Governor's Enacted Budget Summary, Pg. 83
[4] California State Assembly Floor Report of the 2021-22 Budget, July 15, 2021, Pg. 9
[5] 2021-22 Governor's Enacted Budget Summary, Pg. 69
[6] Profile of the Unauthorized Population: Orange County, CA, Migration Policy Institute, 2018
[7] 2021-22 Governor's May Revise Budget Summary, May 14, 2021, Pg. 96
[8] 2021-22 Governor's Enacted Budget, Department of Health Care Services Enacted Budget Detail
[9] 2021-22 Governor's Enacted Budget Summary, Pg. 70
[10] California State Assembly Floor Report of the 2021-22 Budget, July 15, 2021, Pg. 16
[11] California State Assembly Floor Report of the 2021-22 Budget, July 15, 2021, Pg. 26
[12] State of California COVID-19 Dashboard, July 19, 2021
[13] 2021-22 Governor's Enacted Budget Summary, Pg. 31
[14] 2021-22 Governor's Enacted Budget Summary, Pg. 32
[15] 2021-22 Governor's Enacted Budget Summary, Pg. 71
[16] 2021-22 Governor's Enacted Budget Summary, Pg. 70
[17] 2021-22 Governor's Enacted Budget, Department of Health Care Services Enacted Budget Detail
[18] 2021-22 Governor's Enacted Budget Summary, Pg. 71
[19] 2021-22 Governor's Enacted Budget Summary, Pg. 70
[20] 2021-22 Governor's Enacted Budget Summary, Pg. 84
[21] 22021-22 Governor's Enacted Budget Summar, Pg. 87
[22] 22021-22 Governor's Enacted Budget Summar, Pg. 81

Board of Directors Meeting
October 7, 2021

CalOptima Community Outreach Summary — September and October 2021

Background
CalOptima is committed to serving our community by sharing information with current and potential members and strengthening relationships with our community partners. CalOptima accomplishes this by participating in community coalitions, collaborative meetings and advisory groups, supporting our community partners' public activities and sharing information with current and potential members.

CalOptima's participation in public activities supports:

- Member interaction/enrollment in a CalOptima program
- Branding that promotes community awareness of CalOptima
- Partnerships that increase positive visibility and relationships with community organizations

CalOptima is reviewing recent updates to local, state and federal guidelines to prevent the spread of COVID-19. In the interim, CalOptima continues to participate in public activities via virtual meetings and virtual and limited in-person events, providing CalOptima Medi-Cal educational materials and, if criteria are met, providing financial support and/or CalOptima-branded items. (Some exceptions may apply.)

CalOptima Highlight
In alignment with CalOptima's Strategic Plan, CalOptima hosted two events to engage with stakeholders on initiatives taking place in Orange County.

On September 14, 2021, CalOptima hosted a virtual Community Alliances Forum on "Community Efforts to Strengthen Health Equity in Orange County." The purpose of the event was to share information about CalOptima and the County's role in improving access to health and innovative strategies taking place in Orange County to increase health equity for vulnerable population and for people with disabilities. Guest speakers included Maria Jeannis, Executive Director of Quality and Population Health Management at CalOptima, Hieu Nguyen, Director of Population Health and Equity at Orange County Health Care Agency, Joe Perez, Community Services Superintendent at the city of Anaheim, and Larry Wanger, Executive Director at The Dayle McIntosh Center.

On September 22, 2021, CalOptima also hosted a California Advancing and Innovating Medi-Cal (CalAIM) Delivery System Stakeholder Meeting, in a hybrid format. The purpose of the event was to obtain input about the CalAIM delivery system for Enhance Care Management and In Lieu of Services. The event included a CalAIM overview presentation by CalOptima leaders and seven breakout sessions to discuss best practices for serving three populations of focus, including members who are experiencing homelessness, adult high utilizers, or members with serious mental illness/substance use disorder. Select community partners serving members within those populations were invited to share their knowledge and discuss best practices in preparation for the January 2022 CalAIM launch.

CalOptima recognizes the value that comes from collaboration and is committed to keeping our community stakeholders informed and providing opportunities for feedback.

For additional information or questions, please contact CalOptima Community Relations Manager Tiffany Kaaiakamanu at **657-235-6872** or tkaaiakamanu@caloptima.org.

* CalOptima Hosted
† Exhibitor/Attendee

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Summary of Public Activities
As of August 18, 2021, CalOptima plans to participate in, organize, or convene 68 public activities in September and October. For September, this includes 35 public activities: 25 virtual community/collaborative meetings; 5 community events; 3 community-based organization presentations; 1 Community Alliance Forum; and 1 Health Network Forum. For October, this includes 33 public activities: 28 virtual community/collaborative meetings; 1 community-based organization presentation; 2 community events; 1 Cafecito; and 1 Health Network Forum.

CalOptima's participation in community meetings throughout Orange County can be found at: https://www.caloptima.org/en/About/CommunityRelations/UpcomingEventsAndMeetings.aspx.

Below are more details about CalOptima's participation in these community events hosted by community partners and CalOptima-hosted events and meetings:

September 2021			
Date/Time	**Event Title/Location**	**Expected Staff/Volunteer/ Financial Participation**	**Event Type/Audience**
9/9 10 a.m.–11 a.m.	**CalOptima Medi-Cal Presentation for Buena Park Collaborative** Virtual	1 staff member presented.	• Community-based organization presentation • Open to collaborative members
9/10 8 a.m.–12 p.m.	**32nd Annual SoCal Alzheimer's Disease Research Conference hosted by UCI MIND†** Virtual	At least 2 staff members attended. Sponsorship fee: $250, included recognition of CalOptima on event website, event e-communications, event social media posts and rotating slides during the live virtual event.	• Conference • Open to the public
9/11 9 a.m.–1 p.m.	**Annual Back-to-School Event hosted by the Boys & Girls Clubs of Garden Grove†** The Boys & Girls Clubs of Garden Grove 10540 Chapman Ave., Garden Grove, CA	At least 2 staff members attended (in person). Sponsorship fee: $1,000 included a resource table, agency's banner displayed at event site and agency's logo shared on event's social media pages.	• Health/resource fair • Open to the public
9/14 9 a.m.–11 a.m.	**Community Alliance Forum – Community Efforts to Strengthen Health Equity in Orange County*** Virtual	At least 4 staff members attended and 1 presented.	• Forum • Open to health and human service providers
9/16 9 a.m.–11 a.m.	**Health Network Forum*** Virtual	At least 10 staff members attended.	• Forum • Open to health and human service providers
9/20 9 a.m.–10 a.m.	**CalOptima Medi-Cal Spanish Presentation for Willard Intermediate School** Virtual	1 staff presented.	• Community-based organization presentation • Open to staff and parents
9/22 9 a.m.–12 p.m.	**CalAIM Stakeholder Event*** Hybrid	At least 10 staff members attended.	• Provider and community-based organization presentation • By invitation only

* CalOptima Hosted
† Exhibitor/Attendee

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9/24 8:30 a.m.–12 p.m.	**Turning Silver into Gold Conference hosted by Alzheimer's OC†** Virtual	At least 2 staff members attended. Sponsorship fee: $1,000, included logo placement on promotional materials, exhibit tables at two of the senior center in-person sites of choice on a first-confirmed basis, and a recorded 30 second commercial to be played on a loop before and during conference breaks.	• Health/resource fair • Open to the public
9/24 3 p.m.–4:30 p.m.	**CalOptima Medi-Cal Presentation for BPSOS Center for Community Advancement, Inc.** Virtual	1 staff presented.	• Community-based organization presentation • Open to staff and parents
9/25 9 a.m.–4 p.m.	**Recovery Connection Rally hosted by The Purpose of Recovery Inc.†** KiwanisLand 9840 Larson Ave., Garden Grove, CA	At least 1 staff member attended (in person)Sponsorship fee: $250 included a half-page ad in the event program, 30 second speaking opportunity on stage and a resource table at the event.	• Health/resource fair • Open to the public
9/25 10 a.m.–2 p.m.	**Together Again Resource Fair hosted by Huntington Beach Senior Center†** Senior Center in Central Park 18041 Goldenwest St., Huntington Beach, CA	At least 1 staff member attended (in person) Sponsorship fee: $1,000 included logo placement on all event materials, CalOptima's website link on Huntington Beach Council on Aging's website for three months, a quarter-page ad in the event program and directory, an opportunity to host a 30-minute workshop and a resource table during the event.	• Health/resource fair • Open to the public
October 2021			
10/1 9 a.m.–10 a.m.	**CalOptima Medi-Cal Spanish Presentation for Willard Intermediate School** Virtual	1 staff member to present.	• Community-based organization presentation • Open to staff and parents
10/6 11 a.m.–3 p.m.	**Fall Festival Resource Fair hosted by Eli Home†** The Eli Home 1175 N. East St. Anaheim, CA	1 staff member to attend (in person).	• Health/resource fair • Open to the public
10/9 8:30 a.m.–1 p.m.	**3rd Annual Together4Teens Conference and Resource Fair hosted by the Wellness and Prevention Coalition†** Capistrano Valley High School 26301 Via Escolar, Mission Viejo, CA	1 staff member to attend (in person). Sponsorship fee: $1,000 includes mention in press release, newsletter, and social media. Logo on all promotional items, promotional item in resource bag, 2 reserved seats for keynote, vendor booth and half page program ad.	• Health/resource fair • Open to the public
10/21 9 a.m.–11 a.m.	**Health Network Forum*** Virtual	At least 10 staff members to attend.	• Forum • Open to health and human service providers
10/27 9 a.m.–10:30 a.m.	**Cafecito Meeting*** Virtual	At least 3 staff members to attend.	• Steering committee meeting • Open to collaborative members

* CalOptima Hosted
† Exhibitor/Attendee

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These sponsorship request(s) and community event(s) meet the requirements of CalOptima Policy AA.1223: Participation in Community Events Involving External Entities. More information about our policy requirements can be found at: https://www.caloptima.org/en/About/CommunityRelations/CommunityOutreach.aspx.

Endorsements
CalOptima provided one endorsement since the last reporting period (e.g., letters of support, program/public activity events with support or use of name/logo). These endorsement requests meet the requirements of CalOptima Policy AA.1214: Guidelines for Endorsements by CalOptima, for Letters of Support and Use of CalOptima Name and Logo. More information about our policy requirements can be found at: https://www.caloptima.org/en/About/CommunityRelations/CommunityOutreach.aspx.

1. Provide a Letter of Support for University of California, Irvine's funding application under the Public Health Informatics and Technology Workforce Development Program to develop a program to prepare the next general informatics and technology savvy public health workers.

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken October 7, 2021
Regular Meeting of the CalOptima Board of Directors

Report Item

12. Consider Authorizing Contract with Health Management Associates for Consulting Services to Assist in Preparation for the Department of Health Care Services Routine Medical Audit Scheduled for January 2022, and Authorize Expenditures from Existing Reserves for Such Services

Contacts

Carmen Dobry, Executive Director, Compliance, (657) 235-6997
Richard Sanchez, Chief Executive Officer, (657) 900-1481

Recommended Actions

1. Authorize the Chief Executive Officer (CEO), with the assistance of Legal Counsel, to execute a contract with HMA for consulting services to prepare for the Department of Health Care Services (DHCS) medical audit, and assist with addressing subsequent findings and corrective actions, as necessary; and
2. Authorize unbudgeted expenditures in an amount up to $250,000 from existing reserves to fund this contract through June 30, 2022.

Background

The Department of Health Care Services (DHCS) routinely conducts audits of CalOptima's Medi-Cal program and plans to conduct a routine medical audit in January 2022. The audit can consist of, but is not limited to, an evaluation of CalOptima's compliance with its DHCS contracts and regulations in the areas of utilization management, case management and coordination of care, availability and accessibility, member rights, quality management, and administrative and organizational capacity.

The medical survey is comprised of the following activities:

- Reviewing CalOptima's policies for providing services,
- Reviewing the procedures used to implement CalOptima's policies,
- Verifying the implementation and effectiveness of the policies through file reviews,
- Interviewing CalOptima's administrators, staff, and delegated entities, and
- Conducting Facility (Provider) Site Visits and Medical Record Reviews.

Around late January 2022, CalOptima will be formally engaged for the annual DHCS Medical Survey covering the lookback period of February 1, 2020 – current. It is important to note the lookback period is longer than the normal annual review period due to the delay that COVID has caused. The scope of the DHCS Medical Survey may include the following categories:

Audit Scope
Utilization Management
Case Management and Coordination of Care • Behavioral Health Treatment

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Access and Availability • Claims
Member Rights • Grievances • Appeals
Quality Improvement • Potential Quality Issues (PQI)
Administrative and Organizational Capacity • FWA • HIPAA
State Supported Service

When DHCS formally engages CalOptima, the following actions occur:

- Reviewing the pre-audit information, received by DHCS, and developing a workplan following the referencing system, and submitting the documentation responses and attachments to DHCS within thirty (30) days of receipt.
    - The pre-audit information request includes, but is not limited to, the following for all requested categories:
        - Policies and Procedures
        - Program Descriptions/Program Evaluations
        - Universe requests
        - Organizational Charts
        - Questionnaires
        - Delegated Activities
- DHCS provides Verification Studies (file reviews) to CalOptima. CalOptima has approximately two (2) weeks to submit the numerous verification studies back to DHCS.
    - The verification studies include the review and development of multiple case files across multiple disciplines within CalOptima.
- DHCS begins their designated onsite portion of the audit (Due to COVID this portion will be via webinar). This portion is scheduled for a **two (2) week period** in which the following activities occur:
    - Scheduled interviews
    - Ad-hoc interviews
    - File review
    - Additional onsite (ad-hoc) document requests
- At the close of the audit, DHCS will provide a draft audit report. The draft audit report includes the potential findings and recommendations discovered during the audit period. CalOptima has fifteen calendar (15) days to review the draft audit report and provide a rebuttal, including additional supporting documentation.

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- DHCS will review the rebuttal and submit a final audit report to CalOptima. At that time, CalOptima will have thirty calendar (30) days to review the final audit report and provide a detailed Corrective Action Plan (CAP) for each recommendation noted within the final report.

Discussion

In preparation for the upcoming DHCS medical audit, the Board Ad Hoc Committee comprised of Chair Andrew Do, Vice Chair Clayton Corwin, Director Scott Schoeffel and Director Clayton Chau, M.D selected HMA as a vendor partner to serve as an adjunct to CalOptima's Compliance Department and directed staff to negotiate a contract with HMA to assist with the Department of Health Care Services annual medical audit.

Project Description

The engagement will include:

- Pre-audit preparation – HMA shall be available in-person and remotely via videoconference, email, and/or telephone to provide guidance and to assist in reviewing reports, data sets, and other documents requested by the regulatory entity;
- Onsite support during audit readiness activities- HMA shall be available in-person to conduct audit readiness activities including but not limited to reviewing data sets, reports, clinical-focused file selections and other documents as deemed necessary in preparation for the regulatory audit;
- Onsite support during Audit (as-needed) - HMA shall be available to support the organization and assist in preparing, compiling, and reviewing requested documents during the onsite visit;
- Areas of focus for the audit readiness activities and regulatory audit may include at least the following, but may be expanded upon pursuant to agreement between CalOptima and HMA:
    - Claims;
    - Language Assistance Program;
    - Access to Emergency Room and Payment;
    - Member Rights;
    - Access and Availability;
    - Grievance and Appeals;
    - Utilization Management;
    - Post-Stabilization Authorizations;
    - Provider Training; and
    - Quality Improvement

Post- audit Corrective Actions (as-needed) - HMA shall be available to:

- Assist CalOptima in responding to regulatory audit findings, as needed;
- Assist CalOptima in developing any remedial work plan(s), as needed;
- Assist CalOptima in identifying resources necessary from Plan or delegate(s) to assure task completion; and

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- Assist CalOptima in developing or improving a program to oversight first tier, downstream and related entities related to audit findings or other issues or concerns identified by CalOptima or the regulatory entity.

Project Milestones (Proposed)

- Audit Readiness Activities - October 2021 to TBD
- Assistance in preparing pre-audit documents - November 2021 to TBD
- Assistance in preparing for the audit - December 2021/January 2022 to TBD
- Post visit corrective actions – February 2022 to TBD

Fiscal Impact

The recommended action is unbudgeted. An allocation of up to $250,000 from existing reserves will fund this action through June 30, 2022.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. Entities Covered by this Recommended Action

/s/ Richard Sanchez *09/30/2021*
Authorized Signature **Date**

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ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
Health Management Associates	120 North Washington Square, Suite 705, Lansing	Lansing	MI	48933

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken October 7, 2021
Regular Meeting of the CalOptima Board of Directors

Report Item

13. Consider Ratifying Salary Schedule Adopted on September 2, 2021 and Actions to Amend the Chief Executive Officer's Employment Agreement and Adjust the Base Salaries of Executive Level Positions to at Least the Minimums of the New Salary Ranges included in Salary Schedule

Contact

Brigette Hoey, Executive Director, Human Resources, (714) 246-8405

Recommended Actions

Ratify:

1. Approval and Implementation of Salary Schedule Presented to the Board on September 2, 2021, effective September 12, 2021:
2. Actions to amend the Chief Executive Officer's (CEO) employment agreement to increase his annual base salary to $560,000, the minimum of the salary range for the CEO position; and
3. Adjustments to the annual base salaries of executive level positions to at least the minimum of the new salary ranges consistent with the attached Salary Schedule in the amounts of $433,000 for the Chief Operating Officer; $368,000 for the Chief Counsel, Chief Financial Officer, and Chief Medical Officer; $313,000 for the Chief Information Officer, Deputy Chief Counsel, and Deputy Chief Medical Officer; and $226,000 for the Chief of Staff and Executive Directors of Behavioral Health Integration, Clinical Operations, Compliance, Finance, Human Resources, Network Operations, Operations, Program Implementation, Public Affairs, and Quality & Population Health Management.

Background/Discussion

Pursuant to the California Code of Regulations Title 2, section 570.5, CalOptima is required to adopt a publicly available pay schedule that meets the requirements set forth by the California Public Employees Retirement System (CalPERS) to reflect changes, including the addition or deletion of classifications and revisions to pay grades. Any adjustment to the salary schedule requires Board of Directors approval. At its September 2, 2021, meeting, the Board of Directors authorized updates to CalOptima's salary schedule, which included increases to the salary ranges for all executive positions.

California Government Code section 54953, subdivision (c)(3) requires the Board, prior to taking final action, to provide an oral summary of a recommendation for a final action on the salaries, salary schedules or compensation paid in the form of fringe benefits of a local agency executive, during the regular open meeting in which the final action is to be taken. While the Board voted generally to approve the salary schedule updates, authorize the Chair to amend the CEO employment agreement, and authorize the CEO to administer CalOptima compensation practices in accordance with CalOptima policies, the required oral summary was not first read into the record. To address this oversight, staff recommends that the actions above be presented orally for Board consideration, with the same implementation date corresponding with the Salary Schedule approved on September 2, 2021.

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As listed in the recommended actions and detailed in the attached schedule, the minimum of the salary ranges for all executive level positions were increased. Similarly, the salary range minimum for the Medical Director position was increased to $266,000. In accordance with CalOptima policy GA.8057 Compensation Program and Attachment A Compensation Administration Guidelines, all employees should have a pay rate equal to or greater than at least the pay range minimum.

Fiscal Impact

The recommended action will not have an additional fiscal impact. A previous Board action on September 2, 2021, authorized funds from existing reserves to fund this action through June 30, 2022.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. California Code of Regulations Title 2, Section 570.5
2. September 2 2021 Report Item 12 - CalOptima Board Action Agenda Referral and Attachments
3. GA.8057 Compensation Program and Attachment A Compensation Administration Guidelines
4. Government Code section 54953
5. Amendment I to CEO Employment Agreement dated September 2, 2021

/s/ Richard Sanchez — **Authorized Signature**

09/30/2021 — **Date**

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Barclays Official California Code of Regulations Currentness
Title 2. Administration
Division 1. Administrative Personnel
Chapter 2. Board of Administration of Public Employees' Retirement System
Subchapter 1. Employees' Retirement System Regulations
Article 4. Contracts

2 CCR § 570.5

§ 570.5. Requirement for a Publicly Available Pay Schedule.

(a) For purposes of determining the amount of "compensation earnable" pursuant to Government Code Sections 20630, 20636, and 20636.1, payrate shall be limited to the amount listed on a pay schedule that meets all of the following requirements:

(1) Has been duly approved and adopted by the employer's governing body in accordance with requirements of applicable public meetings laws;

(2) Identifies the position title for every employee position;

(3) Shows the payrate for each identified position, which may be stated as a single amount or as multiple amounts within a range;

(4) Indicates the time base, including, but not limited to, whether the time base is hourly, daily, bi-weekly, monthly, bi-monthly, or annually;

(5) Is posted at the office of the employer or immediately accessible and available for public review from the employer during normal business hours or posted on the employer's internet website;

(6) Indicates an effective date and date of any revisions;

(7) Is retained by the employer and available for public inspection for not less than five years; and

(8) Does not reference another document in lieu of disclosing the payrate.

(b) Whenever an employer fails to meet the requirements of subdivision (a) above, the Board, in its sole discretion, may determine an amount that will be considered to be payrate, taking into consideration all information it deems relevant including, but not limited to, the following:

(1) Documents approved by the employer's governing body in accordance with requirements of public meetings laws and maintained by the employer;

(2) Last payrate listed on a pay schedule that conforms to the requirements of subdivision (a) with the same employer for the position at issue;

(3) Last payrate for the member that is listed on a pay schedule that conforms with the requirements of subdivision (a) with the same employer for a different position;

(4) Last payrate for the member in a position that was held by the member and that is listed on a pay schedule that conforms with the requirements of subdivision (a) of a former CalPERS employer.

Note: Authority cited: Sections 20120 and 20121, Government Code. Reference: Sections 20630, 20636 and 20636.1, Government Code.

HISTORY

1. New section filed 7-11-2011; operative 8-10-2011 (Register 2011, No. 28).

2 CCR § 570.5, 2 CA ADC § 570.5

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken September 2, 2021
Regular Meeting of the CalOptima Board of Directors

Report Item

12. Consider Adoption of Resolution Approving and Adopting Updated CalOptima Policy GA.8058: Salary Schedule; Appropriation of Funds and Authorization of Unbudgeted Expenditures and Other Actions as Necessary to Implement Updated Compensation Practices and Proposed Salary and Salary Range Changes, Including Authorizing an Amendment to the Chief Executive Officer's Employment Contract; and Authorization of Independent Employee Compensation Study

Contacts

Richard Sanchez, Chief Executive Officer, (657) 900-1481
Brigette Hoey, Executive Director, Human Resources, (714) 246-8405

Recommended Actions

1. Adopt Resolution Approving Updated CalOptima Policy GA.8058: Salary Schedule and Attachment A;
2. Authorize the Board Chair to execute an amendment to the Chief Executive Officer (CEO) employment agreement to increase his base salary to at least the minimum of the proposed salary range and authorize unbudgeted expenditure in an amount up to $177,000 from existing reserves for this purpose through June 30, 2022;
3. Authorize the CEO to administer CalOptima compensation practices in accordance with CalOptima policies and authorize unbudgeted expenditures in an amount up to $189,000 from existing reserves to fund moving affected employees to the minimum of the proposed salary range through June 30, 2022;
4. Authorize the CEO to administer CalOptima compensation practices in accordance with CalOptima policies and authorize unbudgeted expenditures in an amount up to $1,500,000 from existing reserves for market adjustments in Fiscal Year (FY) 2021-22;
5. Appropriate funds and authorize unbudgeted expenditures in an amount up to $476,000 from existing reserves to fund the salaries and benefits for the upgrade of Executive Director Behavioral Health Integration and new Executive Director Finance positions through June 30, 2022; and
6. Appropriate funds and authorize unbudgeted expenditures of up to $500,000 from existing reserves to fund a comprehensive independent compensation study of CalOptima's pay policies, practices, and market competitiveness.

Background

Near CalOptima's inception, the Board of Directors delegated authority to the CEO to develop and implement employee policies and procedures, and to amend them as appropriate from time to time, subject to annual updates to the Board, with emphasis on changes. CalOptima'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.

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Based on this framework, the Board has adopted Compensation Administration Guidelines that are memorialized in CalOptima Policy GA. 8057: Compensation Program. This policy specifies that CalOptima's salary structure is to be reviewed on a regular basis, either annually or every other year, to ensure that CalOptima's pay policies and practices reflect market competitiveness. At its March 4, 2021, meeting, the Board of Directors authorized updates to CalOptima's Salary Schedule. Those updates were based upon data from a compensation study completed in 2018 by an independent compensation consultant, Grant Thornton. The March 2021 revised pay grades factored incentive pay into the base salary for all classifications, except those at the executive level.

CalOptima has continued to experience turnover and vacancies at the executive level and difficulty recruiting to fill key executive positions, such as the Chief Information Officer and Deputy Chief Medical Officer, even after the March 2021 salary schedule was updated. In order to attract more qualified individuals to fill executive positions by offering salaries and incentive packages that are competitive in the industry, which includes private health plans, staff proposes to update the salary structure and salary schedule recommendations to include salary ranges for the executive level pay grades in consideration of "total cash compensation" (base salary plus annual incentives), calculated by staff using the market data collected by Grant Thornton in their study.

In addition, recruitment efforts to fill three (3) of seven (7) Medical Director positions remain challenging. Medical Director positions are critical in meeting CalOptima's compliance and regulatory requirements and in ensuring that members have access to the health care they need; however, vacancies have existed in this classification for over two (2) years. Since the Medical Director salary range was increased in March 2021, one (1) vacancy was filled, but CalOptima lost three (3) qualified candidates who declined job offers for salary-related reasons. In addition, seven (7) candidates withdrew from the selection process, mostly for similar salary-related reasons. In order to attract more qualified individuals to fill the three (3) vacant Medical Director positions by offering salaries that are competitive in the industry, including private health plans, the salary schedule recommendations have been further refined to include "total cash compensation" salary ranges for the Medical Director pay grade.

Pursuant to the California Code of Regulations, Title 2, Section 570.5, CalOptima is required to adopt a publicly available pay schedule that meets the requirements set forth by the California Public Employees' Retirement System (CalPERS) to reflect recent changes, including the addition or deletion of positions and revisions to wage grades for certain positions.

Discussion

Update to GA.8058: Salary Schedule and Attachment A

The following table lists the existing CalOptima policy that has been updated and is being presented for review and approval.

Policy No./Name	Summary of Changes	Reason for Change	Impact
A.8058: Salary Schedule	• This policy focuses solely on CalOptima's Salary Schedule and requirements under CalPERS regulations. • Attachment A – Salary Schedule has been revised to include one (1) change in pay grade assignment, the addition of one (1) new executive job title, and six (6) pay grade adjustments of job titles based on a review of total cash compensation market data. • A summary of the changes to the Salary Schedule Attachment A is included for reference.	• Pursuant to CalPERS requirement, 2 CCR §570.5 • CalOptima periodically updates the salary schedule to reflect current job titles and pay grades for each classification. • New Position: Creation of a new job title due to the addition of a new level in a job family.	Meets CalPERS requirements, 2 CCR §570.5 The salary range and pay grade adjustments will more closely bring the affected job titles to market competitiveness to enhance recruitment and retention efforts The addition of one (1) new job title will allow for job progression in the finance job family

Proposed revisions to Attachment A of CalOptima Policy GA.8058: Salary Schedule include:

- Salary range adjustments to Medical Director and executive level job titles
- The addition of one (1) new job title:
  - Executive Director Finance; and
- Pay grade change for one (1) job title:
  - Chief Operating Officer

Employees whose salaries fall below the proposed minimum of the pay grade for their positions will be moved to the approved minimum of the applicable pay grades, per current policy. Staff recommends the Board authorize the Board Chair to execute an amendment to the employment agreement with the CEO to bring the CEO's base pay up to at least the minimum of the proposed pay grade for his classification.

Salary and Market Adjustments
GA.8057 Compensation Program Policy establishes a compensation program within clearly defined guidelines that promote consistent, competitive, and equitable pay practices. Attachment A of the Policy – Compensation Administration Guidelines provides the CEO with authority to provide market adjustments within the approved Salary Schedule pay ranges. In addition to job-related experience and external market, the Compensation Guidelines require consideration of internal equity when determining an appropriate pay level for a new hire. Where internal compensation has not kept pace with market competitiveness, the ability to offer competitive compensation packages to new hires is limited and negatively impacting recruitment results. To address internal equity issues, Staff recommends the following:

- Authorize the Board Chair to amend the CEO employment agreement to increase the base salary to at least the minimum of the proposed salary range. The annual fiscal impact is approximately $221,000. The FY 2021-22 fiscal impact is approximately $177,000 for the period of September 12, 2021, through June 30, 2022.
- Authorize the CEO to move employees below the proposed pay grade minimums to the proposed pay grade minimums. The annual fiscal impact is approximately $235,000. The FY 2021-22 fiscal impact is approximately $189,000 for the period of September 12, 2021, through June 30, 2022.
- Authorize the CEO to fund market adjustments to address internal equity issues during FY 2021-22. The fiscal impact is approximately $1.5 million through June 30, 2022.

Position Adjustments
Two unfunded position requests are also included for Board consideration. Staff requests that one (1) of two (2) of the Behavioral Health Integration Director positions be upgraded to the position of Executive Director of Behavioral Health Integration. This new executive position will be crucial in leading the planning and implementation of new programs, or pilots that will improve integration of physical and behavioral health care services. This position will have the expertise to represent CalOptima on various community planning bodies and workgroups at the local, state, and national level. The Executive Director of Behavioral Health will foster collaborative relationships with the County of Orange, Providers, Health Networks, community-based organizations, and other key stakeholders to work on CalAIM implementation.

On January 1, 2018, CalOptima transitioned Behavioral Health Services for the Medi-Cal line of business to a nondelegated model directly managing in-house. This resulted in increased staffing for the day-to-day operations of managing the CalOptima Behavioral Health line call center and utilization management activities (e.g., authorizations for Behavioral Health Treatment and psychological testing, and oversight of outpatient utilization). On January 1, 2020, CalOptima transitioned Behavioral Health Services OneCare/OneCare Connect lines of business in-house. The Executive Director of Behavioral Health Integration is already included in the current salary schedule; however, the position has been unfunded and vacant.

The proposed Executive Director of Finance is a new executive level position intended to lead company-wide support of financial reporting and all other analytics related tasks. Healthcare is an information-intensive sector where data plays a crucial role in CalOptima's organizational and operational decisions. With the increasing needs in new program implementation and provider contract development, CalOptima needs this executive-level position to direct the delivery of complex analysis and collaborate with department leaders and executives to develop targeted business intelligence products. This position will serve as the key role to utilize data analytics and industry knowledge to support CalOptima's mission, vision, strategies, and other business priorities.

The annual fiscal impact to upgrade the Director of Behavioral Health Integration to the Executive Director of Behavioral health Integration position and fund the new Executive Director of Finance position is $595,000. The FY 2021-22 fiscal impact is approximately $476,000 for the period of September 12, 2021, through June 30, 2022.

Compensation Study Funding

Finally, the Compensation Administration Guidelines indicate that CalOptima's salary structure should be reviewed at least every other year to continue to reflect market competitiveness. Although a revised salary structure was adopted in March 2021, the recommendations were based on market data from 2018. This was due to the length of time it took the compensation consultant to finalize and present their recommendations to the Board Ad-Hoc Committee, and for staff to present the recommendations multiple times to the Board. Staff is recommending another compensation study immediately follow a job classification study. The purpose of the job classification study is to reduce the number of classifications by combining job titles of similar positions, create job progression within job families, create consistency in job duties and minimum qualifications where appropriate, identify feasibility for telework, designate Fair Labor Standards Act (FLSA) exemption status, and most importantly, provide accurate data for the subsequent compensation study. The CalOptima FY 2021-22 Operating Budget included $200,000 for the job classification study. Staff is requesting an additional $500,000 to fund the independent compensation study and designation of FLSA exemption status. If approved, staff will initiate the request for proposals process to select a compensation consultant. Of note, changes in FLSA exemption status from non-exempt to exempt may results in salary savings in reduced overtime

Fiscal Impact

The recommended actions are unbudgeted, with an annualized fiscal impact of approximately $3.1 million. An allocation of up to $2.842 million will fund these actions for the period of September 12, 2021, through June 30, 2022.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. Resolution No. 21-0902-001, Approve Updated Human Resources Policy
2. Revised CalOptima Policy GA.8058: Salary Schedule (redlined and clean copies) with revised Attachment A
3. Summary of Changes to Salary Schedule
4. GA.8047 Compensation Program
   a. Attachment A Compensation Administration Guidelines
5. Grant Thornton CalOptima Compensation and Benefits Analysis Reports July 9, 2019 and May 21, 2020

/s/ Richard Sanchez — **Authorized Signature**

08/26/2021 — **Date**

RESOLUTION NO. 21-0902-001

RESOLUTION OF THE BOARD OF DIRECTORS ORANGE COUNTY HEALTH AUTHORITY
d.b.a. CalOptima

APPROVE UPDATED CALOPTIMA POLICY GA 8058: SALARY SCHEDULE

WHEREAS, section 13.1 of the Bylaws of the Orange County Health Authority, dba CalOptima, provide that the Board of Directors shall adopt by resolution, and may from time to time amend, procedures, practices and policies for, inter alia, hiring employees, and managing personnel; and

WHEREAS, in 1994, the Board of Directors designated the Chief Executive Officer as the Appointing Authority with full power to hire and terminate CalOptima employees at will, to set compensation within the boundaries of the budget limits set by the Board, to promulgate employee policies and procedures, and to amend said policies and procedures from time to time, subject to annual review by the Board of Directors, or a committee appointed by the Board for that purpose; and

WHEREAS, California Code of Regulations, Title 2, Section 570.5, requires CalOptima to adopt a publicly available pay schedule that identifies the position title and pay rate for every employee position, and CalOptima regularly reviews CalOptima's salary schedule accordingly.

NOW, THEREFORE, BE IT RESOLVED:

Section 1. That the Board of Directors hereby approves and adopts the attached updated CalOptima Policy:

a. GA.8058: Salary Schedule with Attachment to be Implemented September 12, 2021

APPROVED AND ADOPTED by the Board of Directors of the Orange County Health Authority, d.b.a., CalOptima this September 2, 2021.

AYES: Becerra, Chaffee, Corwin, Do, Giammona, Schoeffel, Shivers, Tran
NOES: None
ABSENT: None
ABSTAIN: None

/s/ _____
Title: Chair, Board of Directors
Printed Name and Title: Andrew Do, Chair, CalOptima Board of Directors

Attest:
/s/ _____
Sharon Dwiers, Clerk of the Board

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Policy:	GA.8058
Title:	**Salary Schedule**
Department:	CalOptima Administrative
Section:	Human Resources
CEO Approval:	*/s/*
Effective Date:	05/01/2014
Revised Date:	09/02/2021
Applicable to:	☐ Medi-Cal ☐ OneCare ☐ OneCare Connect ☐ PACE ☒ Administrative

I. PURPOSE

A. This policy maintains a CalOptima Salary Schedule that lists all active job classifications including job title, salary grade, and salary ranges (minimum, midpoint, and maximum pay rate amounts).

B. This policy ensures the salary schedule is publicly available pursuant to the requirements of Title 2, California Code of Regulations (CCR) §570.5 so that employees who are members of the California Public Employees Retirement System (CalPERS) have their compensation considered qualified for pension calculation under CalPERS regulations.

II. POLICY

A. Pursuant to the requirements under Title 2, California Code of Regulations (CCR) §570.5, CalOptima has established the attached salary schedule for each CalOptima job position. In order for CalPERS member's pay rates to be credited by CalPERS, the Human Resources Department (HR) shall maintain a salary schedule that meets the following eight (8) separate criteria:

1. Approval and adoption by the governing body in accordance with requirements applicable to public meetings laws;

2. Identification of position titles for every employee position;

3. Listing of pay rate for each identified position, which may be stated as a single amount or as multiple amounts with a range;

4. Specifies the time base, including, but not limited to, whether the time base is hourly, daily, bi-weekly, monthly, bi-monthly, or annually;

5. Posted at the employer's office or immediately accessible and available for public review from the employer during normal business hours or posted on the employer's internet website;

6. Indicates the effective date and date of any revisions;

7. Retained by the employer and available for public inspection for not less than five (5) years; and

8. Does not reference another document in lieu of disclosing the pay rate.

B. The Chief Executive Officer (CEO) is authorized and directed to take all steps necessary and proper to implement the salary schedule for all other employees not inconsistent therewith.

III. PROCEDURE

A. The Human Resources Department (HR) will ensure that the salary schedule meets the requirements above and is available at CalOptima's offices, immediately accessible for public review during normal business hours and posted on CalOptima's internal and external websites.

B. HR shall retain the salary schedule for not less than five (5) years.

C. HR shall review the salary schedule and provide recommendations to maintain the competitiveness of the salary schedule to market pay levels.

D. Any adjustments to the salary schedule will require the Executive Director of HR to make a recommendation to the CEO for approval, with the CEO taking the recommendation to the CalOptima Board of Directors for final approval. No changes to the salary schedule, or CEO compensation, shall be effective unless and until approved by the CalOptima Board of Directors.

IV. ATTACHMENT(S)

A. CalOptima - Salary Schedule (Revised as of ~~08/05~~09/02/2021)

V. REFERENCE(S)

A. Title 2, California Code of Regulations, §570.5

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

Date	Meeting
05/01/2014	Regular Meeting of the CalOptima Board of Directors
08/07/2014	Regular Meeting of the CalOptima Board of Directors
11/06/2014	Regular Meeting of the CalOptima Board of Directors
12/04/2014	Regular Meeting of the CalOptima Board of Directors
03/05/2015	Regular Meeting of the CalOptima Board of Directors
06/04/2015	Regular Meeting of the CalOptima Board of Directors
10/01/2015	Regular Meeting of the CalOptima Board of Directors
12/03/2015	Regular Meeting of the CalOptima Board of Directors
03/03/2016	Regular Meeting of the CalOptima Board of Directors
06/02/2016	Regular Meeting of the CalOptima Board of Directors
08/04/2016	Regular Meeting of the CalOptima Board of Directors
09/01/2016	Regular Meeting of the CalOptima Board of Directors
10/06/2016	Regular Meeting of the CalOptima Board of Directors
11/03/2016	Regular Meeting of the CalOptima Board of Directors

Date	Meeting
12/01/2016	Regular Meeting of the CalOptima Board of Directors
03/02/2017	Regular Meeting of the CalOptima Board of Directors
05/04/2017	Regular Meeting of the CalOptima Board of Directors
06/01/2017	Regular Meeting of the CalOptima Board of Directors
08/03/2017	Regular Meeting of the CalOptima Board of Directors
09/07/2017	Regular Meeting of the CalOptima Board of Directors
11/02/2017	Regular Meeting of the CalOptima Board of Directors
02/01/2018	Regular Meeting of the CalOptima Board of Directors
09/06/2018	Regular Meeting of the CalOptima Board of Directors
10/04/2018	Regular Meeting of the CalOptima Board of Directors
02/07/2019	Regular Meeting of the CalOptima Board of Directors
08/01/2019	Regular Meeting of the CalOptima Board of Directors
09/03/2020	Regular Meeting of the CalOptima Board of Directors
03/04/2021	Regular Meeting of the CalOptima Board of Directors
08/05/2021	Regular Meeting of the CalOptima Board of Directors
09/02/2021	Regular Meeting of the CalOptima Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	05/01/2014	GA.8057	Compensation Program and Salary Schedule	Administrative
Revised	08/07/2014	GA.8057	Compensation Program and Salary Schedule	Administrative
Revised	11/06/2014	GA.8057	Compensation Program and Salary Schedule	Administrative
Revised	12/04/2014	GA.8057	Compensation Program and Salary Schedule	Administrative
Revised	03/05/2015	GA.8057	Compensation Program and Salary Schedule	Administrative
Revised	06/04/2015	GA.8058	Salary Schedule	Administrative
Revised	10/01/2015	GA.8058	Salary Schedule	Administrative
Revised	12/03/2015	GA.8058	Salary Schedule	Administrative
Revised	03/03/2016	GA.8058	Salary Schedule	Administrative
Revised	06/02/2016	GA.8058	Salary Schedule	Administrative
Revised	08/04/2016	GA.8058	Salary Schedule	Administrative
Revised	09/01/2016	GA.8058	Salary Schedule	Administrative
Revised	10/06/2016	GA.8058	Salary Schedule	Administrative
Revised	11/03/2016	GA.8058	Salary Schedule	Administrative
Revised	12/01/2016	GA.8058	Salary Schedule	Administrative
Revised	03/02/2017	GA.8058	Salary Schedule	Administrative
Revised	05/04/2017	GA.8058	Salary Schedule	Administrative
Revised	06/01/2017	GA.8058	Salary Schedule	Administrative
Revised	08/03/2017	GA.8058	Salary Schedule	Administrative
Revised	09/07/2017	GA.8058	Salary Schedule	Administrative

Action	Date	Policy	Policy Title	Program(s)
Revised	11/02/2017	GA.8058	Salary Schedule	Administrative
Revised	02/01/2018	GA.8058	Salary Schedule	Administrative
Revised	09/06/2018	GA.8058	Salary Schedule	Administrative
Revised	10/04/2018	GA.8058	Salary Schedule	Administrative
Revised	02/07/2019	GA.8058	Salary Schedule	Administrative
Revised	08/01/2019	GA.8058	Salary Schedule	Administrative
Revised	09/03/2020	GA.8058	Salary Schedule	Administrative
Revised	03/04/2021	GA.8058	Salary Schedule	Administrative
Revised	08/05/2021	GA.8058	Salary Schedule	Administrative
Revised	09/02/2021	GA.8058	Salary Schedule	Administrative

GLOSSARY

Not Applicable

Policy:	GA.8058
Title:	**Salary Schedule**
Department:	CalOptima Administrative
Section:	Human Resources
CEO Approval:	*/s/*
Effective Date:	05/01/2014
Revised Date:	09/02/2021
Applicable to:	☐ Medi-Cal ☐ OneCare ☐ OneCare Connect ☐ PACE ☒ Administrative

I. PURPOSE

A. This policy maintains a CalOptima Salary Schedule that lists all active job classifications including job title, salary grade, and salary ranges (minimum, midpoint, and maximum pay rate amounts).

B. This policy ensures the salary schedule is publicly available pursuant to the requirements of Title 2, California Code of Regulations (CCR) §570.5 so that employees who are members of the California Public Employees Retirement System (CalPERS) have their compensation considered qualified for pension calculation under CalPERS regulations.

II. POLICY

A. Pursuant to the requirements under Title 2, California Code of Regulations (CCR) §570.5, CalOptima has established the attached salary schedule for each CalOptima job position. In order for CalPERS member's pay rates to be credited by CalPERS, the Human Resources Department (HR) shall maintain a salary schedule that meets the following eight (8) separate criteria:

1. Approval and adoption by the governing body in accordance with requirements applicable to public meetings laws;

2. Identification of position titles for every employee position;

3. Listing of pay rate for each identified position, which may be stated as a single amount or as multiple amounts with a range;

4. Specifies the time base, including, but not limited to, whether the time base is hourly, daily, bi-weekly, monthly, bi-monthly, or annually;

5. Posted at the employer's office or immediately accessible and available for public review from the employer during normal business hours or posted on the employer's internet website;

6. Indicates the effective date and date of any revisions;

7. Retained by the employer and available for public inspection for not less than five (5) years; and

8. Does not reference another document in lieu of disclosing the pay rate.

B. The Chief Executive Officer (CEO) is authorized and directed to take all steps necessary and proper to implement the salary schedule for all other employees not inconsistent therewith.

III. PROCEDURE

A. The Human Resources Department (HR) will ensure that the salary schedule meets the requirements above and is available at CalOptima's offices, immediately accessible for public review during normal business hours and posted on CalOptima's internal and external websites.

B. HR shall retain the salary schedule for not less than five (5) years.

C. HR shall review the salary schedule and provide recommendations to maintain the competitiveness of the salary schedule to market pay levels.

D. Any adjustments to the salary schedule will require the Executive Director of HR to make a recommendation to the CEO for approval, with the CEO taking the recommendation to the CalOptima Board of Directors for final approval. No changes to the salary schedule, or CEO compensation, shall be effective unless and until approved by the CalOptima Board of Directors.

IV. ATTACHMENT(S)

A. CalOptima - Salary Schedule (Revised as of 09/02/2021)

V. REFERENCE(S)

A. Title 2, California Code of Regulations, §570.5

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

Date	Meeting
05/01/2014	Regular Meeting of the CalOptima Board of Directors
08/07/2014	Regular Meeting of the CalOptima Board of Directors
11/06/2014	Regular Meeting of the CalOptima Board of Directors
12/04/2014	Regular Meeting of the CalOptima Board of Directors
03/05/2015	Regular Meeting of the CalOptima Board of Directors
06/04/2015	Regular Meeting of the CalOptima Board of Directors
10/01/2015	Regular Meeting of the CalOptima Board of Directors
12/03/2015	Regular Meeting of the CalOptima Board of Directors
03/03/2016	Regular Meeting of the CalOptima Board of Directors
06/02/2016	Regular Meeting of the CalOptima Board of Directors
08/04/2016	Regular Meeting of the CalOptima Board of Directors
09/01/2016	Regular Meeting of the CalOptima Board of Directors
10/06/2016	Regular Meeting of the CalOptima Board of Directors
11/03/2016	Regular Meeting of the CalOptima Board of Directors

Date	Meeting
12/01/2016	Regular Meeting of the CalOptima Board of Directors
03/02/2017	Regular Meeting of the CalOptima Board of Directors
05/04/2017	Regular Meeting of the CalOptima Board of Directors
06/01/2017	Regular Meeting of the CalOptima Board of Directors
08/03/2017	Regular Meeting of the CalOptima Board of Directors
09/07/2017	Regular Meeting of the CalOptima Board of Directors
11/02/2017	Regular Meeting of the CalOptima Board of Directors
02/01/2018	Regular Meeting of the CalOptima Board of Directors
09/06/2018	Regular Meeting of the CalOptima Board of Directors
10/04/2018	Regular Meeting of the CalOptima Board of Directors
02/07/2019	Regular Meeting of the CalOptima Board of Directors
08/01/2019	Regular Meeting of the CalOptima Board of Directors
09/03/2020	Regular Meeting of the CalOptima Board of Directors
03/04/2021	Regular Meeting of the CalOptima Board of Directors
08/05/2021	Regular Meeting of the CalOptima Board of Directors
09/02/2021	Regular Meeting of the CalOptima Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	05/01/2014	GA.8057	Compensation Program and Salary Schedule	Administrative
Revised	08/07/2014	GA.8057	Compensation Program and Salary Schedule	Administrative
Revised	11/06/2014	GA.8057	Compensation Program and Salary Schedule	Administrative
Revised	12/04/2014	GA.8057	Compensation Program and Salary Schedule	Administrative
Revised	03/05/2015	GA.8057	Compensation Program and Salary Schedule	Administrative
Revised	06/04/2015	GA.8058	Salary Schedule	Administrative
Revised	10/01/2015	GA.8058	Salary Schedule	Administrative
Revised	12/03/2015	GA.8058	Salary Schedule	Administrative
Revised	03/03/2016	GA.8058	Salary Schedule	Administrative
Revised	06/02/2016	GA.8058	Salary Schedule	Administrative
Revised	08/04/2016	GA.8058	Salary Schedule	Administrative
Revised	09/01/2016	GA.8058	Salary Schedule	Administrative
Revised	10/06/2016	GA.8058	Salary Schedule	Administrative
Revised	11/03/2016	GA.8058	Salary Schedule	Administrative
Revised	12/01/2016	GA.8058	Salary Schedule	Administrative
Revised	03/02/2017	GA.8058	Salary Schedule	Administrative
Revised	05/04/2017	GA.8058	Salary Schedule	Administrative
Revised	06/01/2017	GA.8058	Salary Schedule	Administrative
Revised	08/03/2017	GA.8058	Salary Schedule	Administrative
Revised	09/07/2017	GA.8058	Salary Schedule	Administrative

Action	Date	Policy	Policy Title	Program(s)
Revised	11/02/2017	GA.8058	Salary Schedule	Administrative
Revised	02/01/2018	GA.8058	Salary Schedule	Administrative
Revised	09/06/2018	GA.8058	Salary Schedule	Administrative
Revised	10/04/2018	GA.8058	Salary Schedule	Administrative
Revised	02/07/2019	GA.8058	Salary Schedule	Administrative
Revised	08/01/2019	GA.8058	Salary Schedule	Administrative
Revised	09/03/2020	GA.8058	Salary Schedule	Administrative
Revised	03/04/2021	GA.8058	Salary Schedule	Administrative
Revised	08/05/2021	GA.8058	Salary Schedule	Administrative
Revised	09/02/2021	GA.8058	Salary Schedule	Administrative

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GLOSSARY

Not Applicable

CalOptima - Annual Base Salary Schedule - Revised ~~August 05, 2021~~September 2, 2021

To be Implemented ~~August 05, 2021~~ September 12, 2021

Effective as of May 01, 2014

	Job Title	Pay Grade	Job Code	Min	Mid	Max
	Accountant	H	39	$59,000	$68,000	$77,000
	Accountant Int	I	634	$61,000	$73,000	$85,000
	Accountant Sr	K	68	$70,000	$84,000	$98,000
	Accounting Clerk	D	334	$44,000	$51,000	$58,000
	Accounting Clerk Sr	E	680	$48,000	$55,000	$62,000
	Activity Coordinator (PACE)	E	681	$48,000	$55,000	$62,000
	Actuarial Analyst	I	558	$61,000	$73,000	$85,000
	Actuarial Analyst Sr	L	559	$77,000	$93,000	$109,000
	Actuary	O	357	$105,000	$127,000	$149,000
	Administrative Assistant	D	19	$44,000	$51,000	$58,000
	Analyst	H	562	$59,000	$68,000	$77,000
	Analyst Int	I	563	$61,000	$73,000	$85,000
	Analyst Sr	J	564	$65,000	$78,000	$91,000
	Applications Analyst	I	232	$61,000	$73,000	$85,000
	Applications Analyst Int	J	233	$65,000	$78,000	$91,000
	Applications Analyst Sr	L	298	$77,000	$93,000	$109,000
	Associate Director	P	682	$117,000	$141,000	$165,000
	Associate Director Customer Service	P	593	$117,000	$141,000	$165,000
	Associate Director Grievance & Appeals	P	TBD	$117,000	$141,000	$165,000
	Associate Director Information Services	Q	557	$130,000	$157,000	$184,000
	Auditor	I	565	$61,000	$73,000	$85,000
	Auditor Sr	J	566	$65,000	$78,000	$91,000
	Behavioral Health Manager	M	383	$85,000	$103,000	$121,000
	Biostatistics Manager	M	418	$85,000	$103,000	$121,000
	Board Services Specialist	E	435	$48,000	$55,000	$62,000
	Business Analyst	J	40	$65,000	$78,000	$91,000
	Business Analyst Sr	L	611	$77,000	$93,000	$109,000
	Business Systems Analyst Sr	K	69	$70,000	$84,000	$98,000
	Buyer	G	29	$55,000	$63,000	$71,000
	Buyer Int	H	49	$59,000	$68,000	$77,000
	Buyer Sr	I	67	$61,000	$73,000	$85,000
	Care Manager	K	657	$70,000	$84,000	$98,000
	Care Transition Intervention Coach (RN)	L	417	$77,000	$93,000	$109,000
	Certified Coder	H	399	$59,000	$68,000	$77,000
	Certified Coding Specialist	H	639	$59,000	$68,000	$77,000
	Certified Coding Specialist Sr	J	640	$65,000	$78,000	$91,000
	Change Control Administrator	I	499	$61,000	$73,000	$85,000
	Change Control Administrator Int	J	500	$65,000	$78,000	$91,000
**	Chief Counsel	X	132	$368,000 ~~$289,000~~	$460,000 ~~$361,000~~	$552,000 ~~$433,000~~
**	Chief Executive Officer	Z	138	$560,000 ~~$400,000~~	$625,000 ~~$500,000~~	$765,000 ~~$600,000~~
**	Chief Financial Officer	X	134	$368,000 ~~$289,000~~	$460,000 ~~$361,000~~	$552,000 ~~$433,000~~
**	Chief Information Officer	W	131	$313,000 ~~$246,000~~	$391,000 ~~$307,000~~	$469,000 ~~$368,000~~
**	Chief of Staff	U	TBD	$226,000 ~~$209,000~~	$282,000 ~~$261,000~~	$338,000 ~~$313,000~~

CalOptima - Annual Base Salary Schedule - Revised ~~August 05, 2021~~September 2, 2021

To be Implemented ~~August 05, 2021~~ September 12, 2021

Effective as of May 01, 2014

	Job Title	Pay Grade	Job Code	Min	Mid	Max
**	Chief Medical Officer	X	137	$368,000 ~~$289,000~~	$460,000 ~~$361,000~~	$552,000 ~~$433,000~~
**	Chief Operating Officer	Y ~~X~~	136	$433,000 ~~$289,000~~	$540,909 ~~$361,000~~	$649,000 ~~$433,000~~
	Claims - Lead	G	574	$55,000	$63,000	$71,000
	Claims Examiner	C	9	$41,000	$47,000	$53,000
	Claims Examiner - Lead	F	236	$51,000	$59,000	$67,000
	Claims Examiner Sr	E	20	$48,000	$55,000	$62,000
	Claims QA Analyst	E	28	$48,000	$55,000	$62,000
	Claims QA Analyst Sr	F	540	$51,000	$59,000	$67,000
	Claims Recovery Specialist	F	283	$51,000	$59,000	$67,000
	Claims Resolution Specialist	F	262	$51,000	$59,000	$67,000
	Clerk of the Board	O	59	$105,000	$127,000	$149,000
	Clinical Auditor	L	567	$77,000	$93,000	$109,000
	Clinical Auditor Sr	M	568	$85,000	$103,000	$121,000
	Clinical Documentation Specialist (RN)	M	641	$85,000	$103,000	$121,000
	Clinical Pharmacist	P	297	$117,000	$141,000	$165,000
	Clinical Systems Administrator	K	607	$70,000	$84,000	$98,000
	Clinician (Behavioral Health)	K	513	$70,000	$84,000	$98,000
	Communications Specialist	G	188	$55,000	$63,000	$71,000
	Communications Specialist Sr	H	TBD	$59,000	$68,000	$77,000
	Communications Specialist - Lead	J	TBD	$65,000	$78,000	$91,000
	Community Partner	G	575	$55,000	$63,000	$71,000
	Community Partner Sr	H	612	$59,000	$68,000	$77,000
	Community Relations Specialist	G	288	$55,000	$63,000	$71,000
	Community Relations Specialist Sr	I	646	$61,000	$73,000	$85,000
	Compliance Claims Auditor	G	222	$55,000	$63,000	$71,000
	Compliance Claims Auditor Sr	H	279	$59,000	$68,000	$77,000
	Contract Administrator	K	385	$70,000	$84,000	$98,000
	Contracts Manager	M	207	$85,000	$103,000	$121,000
	Contracts Manager Sr	N	683	$95,000	$114,000	$133,000
	Contracts Specialist	I	257	$61,000	$73,000	$85,000
	Contracts Specialist Int	J	469	$65,000	$78,000	$91,000
	Contracts Specialist Sr	K	331	$70,000	$84,000	$98,000
*	Controller	T	464	$182,000	$227,000	$272,000
	Credentialing Coordinator	E	41	$48,000	$55,000	$62,000
	Credentialing Coordinator - Lead	F	510	$51,000	$59,000	$67,000
	Customer Service Coordinator	E	182	$48,000	$55,000	$62,000
	Customer Service Rep	C	5	$41,000	$47,000	$53,000
	Customer Service Rep - Lead	E	482	$48,000	$55,000	$62,000
	Customer Service Rep Sr	D	481	$44,000	$51,000	$58,000
	Data Analyst	J	337	$65,000	$78,000	$91,000
	Data Analyst Int	K	341	$70,000	$84,000	$98,000
	Data Analyst Sr	L	342	$77,000	$93,000	$109,000
	Data and Reporting Analyst - Lead	M	654	$85,000	$103,000	$121,000
	Data Entry Tech	A	3	$36,000	$41,000	$46,000
	Data Warehouse Architect	N	363	$95,000	$114,000	$133,000

CalOptima - Annual Base Salary Schedule - Revised ~~August 05, 2021~~September 2, 2021

To be Implemented ~~August 05, 2021~~ September 12, 2021

Effective as of May 01, 2014

	Job Title	Pay Grade	Job Code	Min	Mid	Max
	Data Warehouse Programmer/Analyst	N	364	$95,000	$114,000	$133,000
	Data Warehouse Reporting Analyst	M	412	$85,000	$103,000	$121,000
	Data Warehouse Reporting Analyst Sr	N	522	$95,000	$114,000	$133,000
	Database Administrator	L	90	$77,000	$93,000	$109,000
	Database Administrator Sr	N	179	$95,000	$114,000	$133,000
**	Deputy Chief Counsel	W	160	$313,000 ~~$246,000~~	$391,000 ~~$307,000~~	$469,000 ~~$368,000~~
**	Deputy Chief Medical Officer	W	561	$313,000 ~~$246,000~~	$391,000 ~~$307,000~~	$469,000 ~~$368,000~~
	Deputy Clerk of the Board	K	684	$70,000	$84,000	$98,000
*	Director Audit & Oversight	R	546	$144,000	$174,000	$204,000
*	Director Behavioral Health Services	S	392	$154,000	$193,000	$232,000
*	Director Budget and Procurement	S	527	$154,000	$193,000	$232,000
*	Director Case Management	S	318	$154,000	$193,000	$232,000
*	Director Claims Administration	R	112	$144,000	$174,000	$204,000
*	Director Clinical Pharmacy	T	129	$182,000	$227,000	$272,000
*	Director Coding Initiatives	S	375	$154,000	$193,000	$232,000
*	Director Communications	R	361	$144,000	$174,000	$204,000
*	Director Community Relations	R	TBD	$144,000	$174,000	$204,000
*	Director Contracting	R	184	$144,000	$174,000	$204,000
*	Director Customer Service	R	118	$144,000	$174,000	$204,000
*	Director Data Management Services	Q	TBD	$130,000	$157,000	$184,000
*	Director Enterprise Analytics	R	520	$144,000	$174,000	$204,000
*	Director Facilities	Q	428	$130,000	$157,000	$184,000
*	Director Financial Analysis	T	374	$182,000	$227,000	$272,000
*	Director Financial Compliance	R	460	$144,000	$174,000	$204,000
*	Director Fraud Waste & Abuse and Privacy	R	581	$144,000	$174,000	$204,000
*	Director Government Affairs	R	277	$144,000	$174,000	$204,000
*	Director Grievance & Appeals	R	528	$144,000	$174,000	$204,000
*	Director Human Resources	S	322	$154,000	$193,000	$232,000
*	Director Information Services	T	547	$182,000	$227,000	$272,000
*	Director Long Term Support Services	S	128	$154,000	$193,000	$232,000
*	Director Network Management	R	125	$144,000	$174,000	$204,000
*	Director PACE Program	S	449	$154,000	$193,000	$232,000
*	Director Population Health Management	R	675	$144,000	$174,000	$204,000
*	Director Process Excellence	R	447	$144,000	$174,000	$204,000
*	Director Program Implementation	R	489	$144,000	$174,000	$204,000
*	Director Purchasing	Q	TBD	$130,000	$157,000	$184,000
*	Director Quality Analytics	R	591	$144,000	$174,000	$204,000
*	Director Quality Improvement	R	172	$144,000	$174,000	$204,000
*	Director Regulatory Affairs and Compliance	R	625	$144,000	$174,000	$204,000
*	Director Strategic Development	R	121	$144,000	$174,000	$204,000
*	Director Utilization Management	S	265	$154,000	$193,000	$232,000
*	Director Vendor Management	Q	685	$130,000	$157,000	$184,000
	Enrollment Coordinator (PACE)	F	441	$51,000	$59,000	$67,000
	Enterprise Analytics Manager	O	582	$105,000	$127,000	$149,000
	Executive Administrative Services Manager	J	661	$65,000	$78,000	$91,000

CalOptima - Annual Base Salary Schedule - Revised ~~August 05, 2021~~September 2, 2021

To be Implemented ~~August 05, 2021~~ September 12, 2021

Effective as of May 01, 2014

	Job Title	Pay Grade	Job Code	Min	Mid	Max
	Executive Assistant	G	339	$55,000	$63,000	$71,000
	Executive Assistant to CEO	I	261	$61,000	$73,000	$85,000
**	Executive Director Behavioral Health Integration	U	614	$226,000 ~~$209,000~~	$282,000 ~~$261,000~~	$338,000 ~~$313,000~~
**	Executive Director Clinical Operations	U	501	$226,000 ~~$209,000~~	$282,000 ~~$261,000~~	$338,000 ~~$313,000~~
**	Executive Director Compliance	U	493	$226,000 ~~$209,000~~	$282,000 ~~$261,000~~	$338,000 ~~$313,000~~
**	Executive Director Finance	U	TBD	$226,000	$282,000	$338,000
**	Executive Director Human Resources	U	494	$226,000 ~~$209,000~~	$282,000 ~~$261,000~~	$338,000 ~~$313,000~~
**	Executive Director Network Operations	U	632	$226,000 ~~$209,000~~	$282,000 ~~$261,000~~	$338,000 ~~$313,000~~
**	Executive Director Operations	U	276	$226,000 ~~$209,000~~	$282,000 ~~$261,000~~	$338,000 ~~$313,000~~
**	Executive Director Program Implementation	U	490	$226,000 ~~$209,000~~	$282,000 ~~$261,000~~	$338,000 ~~$313,000~~
**	Executive Director Public Affairs	U	290	$226,000 ~~$209,000~~	$282,000 ~~$261,000~~	$338,000 ~~$313,000~~
**	Executive Director Quality & Population Health Management	U	676	$226,000 ~~$209,000~~	$282,000 ~~$261,000~~	$338,000 ~~$313,000~~
	Facilities & Support Services Coord - Lead	G	631	$55,000	$63,000	$71,000
	Facilities & Support Services Coordinator	E	10	$48,000	$55,000	$62,000
	Facilities & Support Services Coordinator Sr	F	511	$51,000	$59,000	$67,000
	Facilities Coordinator	E	438	$48,000	$55,000	$62,000
	Financial Analyst	J	51	$65,000	$78,000	$91,000
	Financial Analyst Sr	L	84	$77,000	$93,000	$109,000
	Financial Reporting Analyst	I	475	$61,000	$73,000	$85,000
	Graphic Designer	K	387	$70,000	$84,000	$98,000
	Graphic Designer Sr	L	TBD	$77,000	$93,000	$109,000
	Grievance & Appeals Nurse Specialist	M	226	$85,000	$103,000	$121,000
	Grievance Resolution Specialist	F	42	$51,000	$59,000	$67,000
	Grievance Resolution Specialist - Lead	I	590	$61,000	$73,000	$85,000
	Grievance Resolution Specialist Sr	H	589	$59,000	$68,000	$77,000
	Health Coach	K	556	$70,000	$84,000	$98,000
	Health Educator	H	47	$59,000	$68,000	$77,000
	Health Educator Sr	I	355	$61,000	$73,000	$85,000
	Health Network Liaison Specialist (RN)	L	524	$77,000	$93,000	$109,000
	Health Network Oversight Specialist	K	323	$70,000	$84,000	$98,000
	HEDIS Case Manager	M	443	$85,000	$103,000	$121,000
	Help Desk Technician	E	571	$48,000	$55,000	$62,000
	Help Desk Technician Sr	F	573	$51,000	$59,000	$67,000
	HR Assistant	D	181	$44,000	$51,000	$58,000
	HR Business Partner	M	584	$85,000	$103,000	$121,000
	HR Coordinator	F	316	$51,000	$59,000	$67,000
	HR Representative	J	278	$65,000	$78,000	$91,000
	HR Representative Sr	L	350	$77,000	$93,000	$109,000
	HR Specialist	G	505	$55,000	$63,000	$71,000
	HR Specialist Sr	H	608	$59,000	$68,000	$77,000
	Infrastructure Systems Administrator	F	541	$51,000	$59,000	$67,000
	Infrastructure Systems Administrator Int	G	542	$55,000	$63,000	$71,000

CalOptima - Annual Base Salary Schedule - Revised ~~August 05, 2021~~September 2, 2021
To be Implemented ~~August 05, 2021~~ September 12, 2021
Effective as of May 01, 2014

Job Title	Pay Grade	Job Code	Min	Mid	Max
Inpatient Quality Coding Auditor	I	642	$61,000	$73,000	$85,000
Intern	A	237	$36,000	$41,000	$46,000
Investigator Sr	I	553	$61,000	$73,000	$85,000
IS Coordinator	E	365	$48,000	$55,000	$62,000
IS Project Manager	N	424	$95,000	$114,000	$133,000
IS Project Manager Sr	O	509	$105,000	$127,000	$149,000
IS Project Specialist	K	549	$70,000	$84,000	$98,000
IS Project Specialist Sr	L	550	$77,000	$93,000	$109,000
Kitchen Assistant	A	585	$36,000	$41,000	$46,000
Licensed Clinical Social Worker	J	598	$65,000	$78,000	$91,000
Litigation Support Specialist	K	588	$70,000	$84,000	$98,000
LVN (PACE)	K	533	$70,000	$84,000	$98,000
LVN Specialist	K	686	$70,000	$84,000	$98,000
Mailroom Clerk	A	1	$36,000	$41,000	$46,000
Manager Accounting	O	98	$105,000	$127,000	$149,000
Manager Actuary	Q	453	$130,000	$157,000	$184,000
Manager Audit & Oversight	O	539	$105,000	$127,000	$149,000
Manager Behavioral Health	O	633	$105,000	$127,000	$149,000
Manager Business Integration	O	544	$105,000	$127,000	$149,000
Manager Case Management	P	270	$117,000	$141,000	$165,000
Manager Claims	O	92	$105,000	$127,000	$149,000
Manager Clinic Operations	N	551	$95,000	$114,000	$133,000
Manager Clinical Pharmacist	R	296	$144,000	$174,000	$204,000
Manager Coding Quality	N	382	$95,000	$114,000	$133,000
Manager Communications	N	398	$95,000	$114,000	$133,000
Manager Community Relations	N	384	$95,000	$114,000	$133,000
Manager Contracting	O	329	$105,000	$127,000	$149,000
Manager Creative Branding	M	430	$85,000	$103,000	$121,000
Manager Cultural & Linguistic	M	349	$85,000	$103,000	$121,000
Manager Customer Service	M	94	$85,000	$103,000	$121,000
Manager Electronic Business	N	422	$95,000	$114,000	$133,000
Manager Encounters	M	516	$85,000	$103,000	$121,000
Manager Environmental Health & Safety	N	495	$95,000	$114,000	$133,000
Manager Finance	O	148	$105,000	$127,000	$149,000
Manager Financial Analysis	P	356	$117,000	$141,000	$165,000
Manager Government Affairs	N	437	$95,000	$114,000	$133,000
Manager Grievance & Appeals	O	426	$105,000	$127,000	$149,000
Manager Human Resources	O	526	$105,000	$127,000	$149,000
Manager Information Services	P	560	$117,000	$141,000	$165,000
Manager Long Term Support Services	O	200	$105,000	$127,000	$149,000
Manager Marketing & Enrollment (PACE)	N	414	$95,000	$114,000	$133,000
Manager Marketing & Outreach	M	687	$85,000	$103,000	$121,000
Manager Member Liaison Program	M	354	$85,000	$103,000	$121,000
Manager Member Outreach & Education	M	616	$85,000	$103,000	$121,000
Manager MSSP	O	393	$105,000	$127,000	$149,000
Manager OneCare Clinical	P	359	$117,000	$141,000	$165,000

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	Job Title	Pay Grade	Job Code	Min	Mid	Max
	Manager OneCare Customer Service	M	429	$85,000	$103,000	$121,000
	Manager Outreach & Enrollment	M	477	$85,000	$103,000	$121,000
	Manager PACE Center	N	432	$95,000	$114,000	$133,000
	Manager Population Health Management	N	674	$95,000	$114,000	$133,000
	Manager Process Excellence	O	622	$105,000	$127,000	$149,000
	Manager Program Implementation	N	488	$95,000	$114,000	$133,000
	Manager Provider Data Management Services	M	653	$85,000	$103,000	$121,000
	Manager Provider Network	O	191	$105,000	$127,000	$149,000
	Manager Provider Relations	M	171	$85,000	$103,000	$121,000
	Manager Purchasing	O	275	$105,000	$127,000	$149,000
	Manager QI Initiatives	M	433	$85,000	$103,000	$121,000
	Manager Quality Analytics	N	617	$95,000	$114,000	$133,000
	Manager Quality Improvement	N	104	$95,000	$114,000	$133,000
	Manager Regulatory Affairs and Compliance	O	626	$105,000	$127,000	$149,000
	Manager Reporting & Financial Compliance	O	572	$105,000	$127,000	$149,000
	Manager Strategic Development	O	603	$105,000	$127,000	$149,000
	Manager Utilization Management	P	250	$117,000	$141,000	$165,000
	Marketing and Outreach Specialist	F	496	$51,000	$59,000	$67,000
	Medical Assistant	C	535	$41,000	$47,000	$53,000
	Medical Authorization Asst	C	11	$41,000	$47,000	$53,000
	Medical Case Manager	L	72	$77,000	$93,000	$109,000
	Medical Case Manager (LVN)	K	444	$70,000	$84,000	$98,000
*	Medical Director	V	306	$266,000 ~~$221,400~~	$332,000 ~~$276,300~~	$398,000 ~~$331,200~~
	Medical Records & Health Plan Assistant	B	548	$38,000	$44,000	$50,000
	Medical Records Clerk	B	523	$38,000	$44,000	$50,000
	Medical Services Case Manager	G	54	$55,000	$63,000	$71,000
	Member Liaison Specialist	C	353	$41,000	$47,000	$53,000
	MMS Program Coordinator	G	360	$55,000	$63,000	$71,000
	Nurse Practitioner (PACE)	O	635	$105,000	$127,000	$149,000
	Occupational Therapist	L	531	$77,000	$93,000	$109,000
	Occupational Therapist Assistant	H	623	$59,000	$68,000	$77,000
	Office Clerk	A	335	$36,000	$41,000	$46,000
	OneCare Operations Manager	N	461	$95,000	$114,000	$133,000
	OneCare Partner - Sales	F	230	$51,000	$59,000	$67,000
	OneCare Partner - Sales (Lead)	G	537	$55,000	$63,000	$71,000
	OneCare Partner - Service	C	231	$41,000	$47,000	$53,000
	OneCare Partner (Inside Sales)	E	371	$48,000	$55,000	$62,000
	Outreach Specialist	C	218	$41,000	$47,000	$53,000
	Paralegal/Legal Secretary	I	376	$61,000	$73,000	$85,000
	Payroll Specialist	E	554	$48,000	$55,000	$62,000
	Payroll Specialist Sr	G	688	$55,000	$63,000	$71,000
	Performance Analyst	I	538	$61,000	$73,000	$85,000
	Personal Care Attendant	A	485	$36,000	$41,000	$46,000
	Personal Care Attendant - Lead	B	498	$38,000	$44,000	$50,000
	Personal Care Coordinator	C	525	$41,000	$47,000	$53,000

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Personal Care Coordinator Sr	D	689	$44,000	$51,000	$58,000
Pharmacy Resident	G	379	$55,000	$63,000	$71,000
Pharmacy Services Specialist	C	23	$41,000	$47,000	$53,000
Pharmacy Services Specialist Int	D	35	$44,000	$51,000	$58,000
Pharmacy Services Specialist Sr	E	507	$48,000	$55,000	$62,000
Physical Therapist	L	530	$77,000	$93,000	$109,000
Physical Therapist Assistant	H	624	$59,000	$68,000	$77,000
Policy Advisor Sr	M	580	$85,000	$103,000	$121,000
Privacy Manager	N	536	$95,000	$114,000	$133,000
Privacy Officer	O	648	$105,000	$127,000	$149,000
Process Excellence Manager	N	529	$95,000	$114,000	$133,000
Program Assistant	C	24	$41,000	$47,000	$53,000
Program Coordinator	C	284	$41,000	$47,000	$53,000
Program Development Analyst Sr	K	492	$70,000	$84,000	$98,000
Program Manager	L	421	$77,000	$93,000	$109,000
Program Manager Sr	M	594	$85,000	$103,000	$121,000
Program Specialist	E	36	$48,000	$55,000	$62,000
Program Specialist Int	G	61	$55,000	$63,000	$71,000
Program Specialist Sr	I	508	$61,000	$73,000	$85,000
Program/Policy Analyst	I	56	$61,000	$73,000	$85,000
Program/Policy Analyst Sr	K	85	$70,000	$84,000	$98,000
Programmer	K	43	$70,000	$84,000	$98,000
Programmer Int	M	74	$85,000	$103,000	$121,000
Programmer Sr	N	80	$95,000	$114,000	$133,000
Project Manager	L	81	$77,000	$93,000	$109,000
Project Manager - Lead	M	467	$85,000	$103,000	$121,000
Project Manager Sr	N	105	$95,000	$114,000	$133,000
Project Specialist	E	291	$48,000	$55,000	$62,000
Project Specialist Sr	I	503	$61,000	$73,000	$85,000
Projects Analyst	G	254	$55,000	$63,000	$71,000
Provider Data Management Services Coordinator	D	12	$44,000	$51,000	$58,000
Provider Data Management Services Coordinator Sr	F	586	$51,000	$59,000	$67,000
Provider Enrollment Manager	G	190	$55,000	$63,000	$71,000
Provider Network Rep Sr	I	391	$61,000	$73,000	$85,000
Provider Network Specialist	H	44	$59,000	$68,000	$77,000
Provider Network Specialist Sr	J	595	$65,000	$78,000	$91,000
Provider Office Education Manager	I	300	$61,000	$73,000	$85,000
Provider Relations Rep	G	205	$55,000	$63,000	$71,000
Provider Relations Rep Sr	I	285	$61,000	$73,000	$85,000
Publications Coordinator	G	293	$55,000	$63,000	$71,000
QA Analyst	I	486	$61,000	$73,000	$85,000
QA Analyst Sr	L	380	$77,000	$93,000	$109,000
QI Nurse Specialist	M	82	$85,000	$103,000	$121,000
QI Nurse Specialist (LVN)	L	445	$77,000	$93,000	$109,000
Receptionist	B	140	$38,000	$44,000	$50,000
Records Manager	Q	TBD	$130,000	$157,000	$184,000

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	Job Title	Pay Grade	Job Code	Min	Mid	Max
	Recreational Therapist	H	487	$59,000	$68,000	$77,000
	Registered Dietitian	I	57	$61,000	$73,000	$85,000
	Regulatory Affairs and Compliance Analyst	I	628	$61,000	$73,000	$85,000
	Regulatory Affairs and Compliance Analyst Sr	K	629	$70,000	$84,000	$98,000
	Regulatory Affairs and Compliance - Lead	L	630	$77,000	$93,000	$109,000
	RN (PACE)	M	480	$85,000	$103,000	$121,000
	Security Analyst Int	M	534	$85,000	$103,000	$121,000
	Security Analyst Sr	N	474	$95,000	$114,000	$133,000
	Security Officer	B	311	$38,000	$44,000	$50,000
	SharePoint Developer/Administrator Sr	N	397	$95,000	$114,000	$133,000
	Social Worker	J	463	$65,000	$78,000	$91,000
	Social Worker Sr	K	690	$70,000	$84,000	$98,000
*	Special Counsel	T	317	$182,000	$227,000	$272,000
	Sr Manager Financial Analysis	Q	660	$130,000	$157,000	$184,000
	Sr Manager Human Resources	P	649	$117,000	$141,000	$165,000
	Sr Manager Information Services	Q	650	$130,000	$157,000	$184,000
	Staff Attorney	P	195	$117,000	$141,000	$165,000
	Staff Attorney Sr	R	691	$144,000	$174,000	$204,000
	Supervisor Accounting	M	434	$85,000	$103,000	$121,000
	Supervisor Audit and Oversight	M	618	$85,000	$103,000	$121,000
	Supervisor Behavioral Health	M	659	$85,000	$103,000	$121,000
	Supervisor Budgeting	N	466	$95,000	$114,000	$133,000
	Supervisor Case Management	M	86	$85,000	$103,000	$121,000
	Supervisor Claims	I	219	$61,000	$73,000	$85,000
	Supervisor Coding Initiatives	M	502	$85,000	$103,000	$121,000
	Supervisor Credentialing	I	671	$61,000	$73,000	$85,000
	Supervisor Customer Service	I	34	$61,000	$73,000	$85,000
	Supervisor Data Entry	H	192	$59,000	$68,000	$77,000
	Supervisor Day Center (PACE)	H	619	$59,000	$68,000	$77,000
	Supervisor Dietary Services (PACE)	J	643	$65,000	$78,000	$91,000
	Supervisor Encounters	I	253	$61,000	$73,000	$85,000
	Supervisor Facilities	J	162	$65,000	$78,000	$91,000
	Supervisor Finance	M	419	$85,000	$103,000	$121,000
	Supervisor Grievance and Appeals	L	620	$77,000	$93,000	$109,000
	Supervisor Information Services	N	457	$95,000	$114,000	$133,000
	Supervisor Long Term Support Services	M	587	$85,000	$103,000	$121,000
	Supervisor Member Outreach and Education	K	592	$70,000	$84,000	$98,000
	Supervisor MSSP	M	348	$85,000	$103,000	$121,000
	Supervisor Nursing Services (PACE)	M	662	$85,000	$103,000	$121,000
	Supervisor OneCare Customer Service	I	408	$61,000	$73,000	$85,000
	Supervisor Payroll	M	517	$85,000	$103,000	$121,000
	Supervisor Pharmacist	Q	610	$130,000	$157,000	$184,000
	Supervisor Population Health Management	M	673	$85,000	$103,000	$121,000
	Supervisor Provider Data Management Services	K	439	$70,000	$84,000	$98,000
	Supervisor Provider Relations	L	652	$77,000	$93,000	$109,000
	Supervisor Quality Analytics	M	609	$85,000	$103,000	$121,000

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Supervisor Quality Improvement	M	600	$85,000	$103,000	$121,000
Supervisor Regulatory Affairs and Compliance	M	627	$85,000	$103,000	$121,000
Supervisor Social Work (PACE)	J	636	$65,000	$78,000	$91,000
Supervisor Therapy Services (PACE)	M	645	$85,000	$103,000	$121,000
Supervisor Utilization Management	M	637	$85,000	$103,000	$121,000
Systems Network Administrator Int	L	63	$77,000	$93,000	$109,000
Systems Network Administrator Sr	M	89	$85,000	$103,000	$121,000
Systems Operations Analyst	F	32	$51,000	$59,000	$67,000
Systems Operations Analyst Int	G	45	$55,000	$63,000	$71,000
Technical Analyst Int	J	64	$65,000	$78,000	$91,000
Technical Analyst Sr	L	75	$77,000	$93,000	$109,000
Therapy Aide	E	521	$48,000	$55,000	$62,000
Training Administrator	I	621	$61,000	$73,000	$85,000
Training Program Coordinator	H	471	$59,000	$68,000	$77,000
Translation Specialist	B	241	$38,000	$44,000	$50,000
Web Architect	N	366	$95,000	$114,000	$133,000

* These positions are identified for the purposes of CalOptima Policy GA. 8042: Supplemental Compensation as Director level and above positions for which eligible employees may qualify for Employer-Paid Member Contribution.

** These positions are identified for the purposes of CalOptima Policy GA. 8042: Supplemental Compensation as Director level and above positions for which eligible employees may qualify for Employer-Paid Member Contribution and are also Chief or Executive Director level positions.

Revised ~~08/05/2021~~ 09/02/2021

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	Job Title	Pay Grade	Job Code	Min	Mid	Max
	Accountant	H	39	$59,000	$68,000	$77,000
	Accountant Int	I	634	$61,000	$73,000	$85,000
	Accountant Sr	K	68	$70,000	$84,000	$98,000
	Accounting Clerk	D	334	$44,000	$51,000	$58,000
	Accounting Clerk Sr	E	680	$48,000	$55,000	$62,000
	Activity Coordinator (PACE)	E	681	$48,000	$55,000	$62,000
	Actuarial Analyst	I	558	$61,000	$73,000	$85,000
	Actuarial Analyst Sr	L	559	$77,000	$93,000	$109,000
	Actuary	O	357	$105,000	$127,000	$149,000
	Administrative Assistant	D	19	$44,000	$51,000	$58,000
	Analyst	H	562	$59,000	$68,000	$77,000
	Analyst Int	I	563	$61,000	$73,000	$85,000
	Analyst Sr	J	564	$65,000	$78,000	$91,000
	Applications Analyst	I	232	$61,000	$73,000	$85,000
	Applications Analyst Int	J	233	$65,000	$78,000	$91,000
	Applications Analyst Sr	L	298	$77,000	$93,000	$109,000
	Associate Director	P	682	$117,000	$141,000	$165,000
	Associate Director Customer Service	P	593	$117,000	$141,000	$165,000
	Associate Director Grievance & Appeals	P	TBD	$117,000	$141,000	$165,000
	Associate Director Information Services	Q	557	$130,000	$157,000	$184,000
	Auditor	I	565	$61,000	$73,000	$85,000
	Auditor Sr	J	566	$65,000	$78,000	$91,000
	Behavioral Health Manager	M	383	$85,000	$103,000	$121,000
	Biostatistics Manager	M	418	$85,000	$103,000	$121,000
	Board Services Specialist	E	435	$48,000	$55,000	$62,000
	Business Analyst	J	40	$65,000	$78,000	$91,000
	Business Analyst Sr	L	611	$77,000	$93,000	$109,000
	Business Systems Analyst Sr	K	69	$70,000	$84,000	$98,000
	Buyer	G	29	$55,000	$63,000	$71,000
	Buyer Int	H	49	$59,000	$68,000	$77,000
	Buyer Sr	I	67	$61,000	$73,000	$85,000
	Care Manager	K	657	$70,000	$84,000	$98,000
	Care Transition Intervention Coach (RN)	L	417	$77,000	$93,000	$109,000
	Certified Coder	H	399	$59,000	$68,000	$77,000
	Certified Coding Specialist	H	639	$59,000	$68,000	$77,000
	Certified Coding Specialist Sr	J	640	$65,000	$78,000	$91,000
	Change Control Administrator	I	499	$61,000	$73,000	$85,000
	Change Control Administrator Int	J	500	$65,000	$78,000	$91,000
**	Chief Counsel	X	132	$368,000	$460,000	$552,000
**	Chief Executive Officer	Z	138	$560,000	$625,000	$765,000
**	Chief Financial Officer	X	134	$368,000	$460,000	$552,000
**	Chief Information Officer	W	131	$313,000	$391,000	$469,000
**	Chief of Staff	U	TBD	$226,000	$282,000	$338,000
**	Chief Medical Officer	X	137	$368,000	$460,000	$552,000
**	Chief Operating Officer	Y	136	$433,000	$540,909	$649,000
	Claims - Lead	G	574	$55,000	$63,000	$71,000

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	Job Title	Pay Grade	Job Code	Min	Mid	Max
	Claims Examiner	C	9	$41,000	$47,000	$53,000
	Claims Examiner - Lead	F	236	$51,000	$59,000	$67,000
	Claims Examiner Sr	E	20	$48,000	$55,000	$62,000
	Claims QA Analyst	E	28	$48,000	$55,000	$62,000
	Claims QA Analyst Sr	F	540	$51,000	$59,000	$67,000
	Claims Recovery Specialist	F	283	$51,000	$59,000	$67,000
	Claims Resolution Specialist	F	262	$51,000	$59,000	$67,000
	Clerk of the Board	O	59	$105,000	$127,000	$149,000
	Clinical Auditor	L	567	$77,000	$93,000	$109,000
	Clinical Auditor Sr	M	568	$85,000	$103,000	$121,000
	Clinical Documentation Specialist (RN)	M	641	$85,000	$103,000	$121,000
	Clinical Pharmacist	P	297	$117,000	$141,000	$165,000
	Clinical Systems Administrator	K	607	$70,000	$84,000	$98,000
	Clinician (Behavioral Health)	K	513	$70,000	$84,000	$98,000
	Communications Specialist	G	188	$55,000	$63,000	$71,000
	Communications Specialist Sr	H	TBD	$59,000	$68,000	$77,000
	Communications Specialist - Lead	J	TBD	$65,000	$78,000	$91,000
	Community Partner	G	575	$55,000	$63,000	$71,000
	Community Partner Sr	H	612	$59,000	$68,000	$77,000
	Community Relations Specialist	G	288	$55,000	$63,000	$71,000
	Community Relations Specialist Sr	I	646	$61,000	$73,000	$85,000
	Compliance Claims Auditor	G	222	$55,000	$63,000	$71,000
	Compliance Claims Auditor Sr	H	279	$59,000	$68,000	$77,000
	Contract Administrator	K	385	$70,000	$84,000	$98,000
	Contracts Manager	M	207	$85,000	$103,000	$121,000
	Contracts Manager Sr	N	683	$95,000	$114,000	$133,000
	Contracts Specialist	I	257	$61,000	$73,000	$85,000
	Contracts Specialist Int	J	469	$65,000	$78,000	$91,000
	Contracts Specialist Sr	K	331	$70,000	$84,000	$98,000
*	Controller	T	464	$182,000	$227,000	$272,000
	Credentialing Coordinator	E	41	$48,000	$55,000	$62,000
	Credentialing Coordinator - Lead	F	510	$51,000	$59,000	$67,000
	Customer Service Coordinator	E	182	$48,000	$55,000	$62,000
	Customer Service Rep	C	5	$41,000	$47,000	$53,000
	Customer Service Rep - Lead	E	482	$48,000	$55,000	$62,000
	Customer Service Rep Sr	D	481	$44,000	$51,000	$58,000
	Data Analyst	J	337	$65,000	$78,000	$91,000
	Data Analyst Int	K	341	$70,000	$84,000	$98,000
	Data Analyst Sr	L	342	$77,000	$93,000	$109,000
	Data and Reporting Analyst - Lead	M	654	$85,000	$103,000	$121,000
	Data Entry Tech	A	3	$36,000	$41,000	$46,000
	Data Warehouse Architect	N	363	$95,000	$114,000	$133,000
	Data Warehouse Programmer/Analyst	N	364	$95,000	$114,000	$133,000
	Data Warehouse Reporting Analyst	M	412	$85,000	$103,000	$121,000
	Data Warehouse Reporting Analyst Sr	N	522	$95,000	$114,000	$133,000
	Database Administrator	L	90	$77,000	$93,000	$109,000

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	Database Administrator Sr	N	179	$95,000	$114,000	$133,000
**	Deputy Chief Counsel	W	160	$313,000	$391,000	$469,000
**	Deputy Chief Medical Officer	W	561	$313,000	$391,000	$469,000
	Deputy Clerk of the Board	K	684	$70,000	$84,000	$98,000
*	Director Audit & Oversight	R	546	$144,000	$174,000	$204,000
*	Director Behavioral Health Services	S	392	$154,000	$193,000	$232,000
*	Director Budget and Procurement	S	527	$154,000	$193,000	$232,000
*	Director Case Management	S	318	$154,000	$193,000	$232,000
*	Director Claims Administration	R	112	$144,000	$174,000	$204,000
*	Director Clinical Pharmacy	T	129	$182,000	$227,000	$272,000
*	Director Coding Initiatives	S	375	$154,000	$193,000	$232,000
*	Director Communications	R	361	$144,000	$174,000	$204,000
*	Director Community Relations	R	TBD	$144,000	$174,000	$204,000
*	Director Contracting	R	184	$144,000	$174,000	$204,000
*	Director Customer Service	R	118	$144,000	$174,000	$204,000
*	Director Data Management Services	Q	TBD	$130,000	$157,000	$184,000
*	Director Enterprise Analytics	R	520	$144,000	$174,000	$204,000
*	Director Facilities	Q	428	$130,000	$157,000	$184,000
*	Director Financial Analysis	T	374	$182,000	$227,000	$272,000
*	Director Financial Compliance	R	460	$144,000	$174,000	$204,000
*	Director Fraud Waste & Abuse and Privacy	R	581	$144,000	$174,000	$204,000
*	Director Government Affairs	R	277	$144,000	$174,000	$204,000
*	Director Grievance & Appeals	R	528	$144,000	$174,000	$204,000
*	Director Human Resources	S	322	$154,000	$193,000	$232,000
*	Director Information Services	T	547	$182,000	$227,000	$272,000
*	Director Long Term Support Services	S	128	$154,000	$193,000	$232,000
*	Director Network Management	R	125	$144,000	$174,000	$204,000
*	Director PACE Program	S	449	$154,000	$193,000	$232,000
*	Director Population Health Management	R	675	$144,000	$174,000	$204,000
*	Director Process Excellence	R	447	$144,000	$174,000	$204,000
*	Director Program Implementation	R	489	$144,000	$174,000	$204,000
*	Director Purchasing	Q	TBD	$130,000	$157,000	$184,000
*	Director Quality Analytics	R	591	$144,000	$174,000	$204,000
*	Director Quality Improvement	R	172	$144,000	$174,000	$204,000
*	Director Regulatory Affairs and Compliance	R	625	$144,000	$174,000	$204,000
*	Director Strategic Development	R	121	$144,000	$174,000	$204,000
*	Director Utilization Management	S	265	$154,000	$193,000	$232,000
*	Director Vendor Management	Q	685	$130,000	$157,000	$184,000
	Enrollment Coordinator (PACE)	F	441	$51,000	$59,000	$67,000
	Enterprise Analytics Manager	O	582	$105,000	$127,000	$149,000
	Executive Administrative Services Manager	J	661	$65,000	$78,000	$91,000
	Executive Assistant	G	339	$55,000	$63,000	$71,000
	Executive Assistant to CEO	I	261	$61,000	$73,000	$85,000
**	Executive Director Behavioral Health Integration	U	614	$226,000	$282,000	$338,000
**	Executive Director Clinical Operations	U	501	$226,000	$282,000	$338,000
**	Executive Director Compliance	U	493	$226,000	$282,000	$338,000

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Job Title	Pay Grade	Job Code	Min	Mid	Max
** Executive Director Finance	U	TBD	$226,000	$282,000	$338,000
** Executive Director Human Resources	U	494	$226,000	$282,000	$338,000
** Executive Director Network Operations	U	632	$226,000	$282,000	$338,000
** Executive Director Operations	U	276	$226,000	$282,000	$338,000
** Executive Director Program Implementation	U	490	$226,000	$282,000	$338,000
** Executive Director Public Affairs	U	290	$226,000	$282,000	$338,000
** Executive Director Quality & Population Health Management	U	676	$226,000	$282,000	$338,000
Facilities & Support Services Coord - Lead	G	631	$55,000	$63,000	$71,000
Facilities & Support Services Coordinator	E	10	$48,000	$55,000	$62,000
Facilities & Support Services Coordinator Sr	F	511	$51,000	$59,000	$67,000
Facilities Coordinator	E	438	$48,000	$55,000	$62,000
Financial Analyst	J	51	$65,000	$78,000	$91,000
Financial Analyst Sr	L	84	$77,000	$93,000	$109,000
Financial Reporting Analyst	I	475	$61,000	$73,000	$85,000
Graphic Designer	K	387	$70,000	$84,000	$98,000
Graphic Designer Sr	L	TBD	$77,000	$93,000	$109,000
Grievance & Appeals Nurse Specialist	M	226	$85,000	$103,000	$121,000
Grievance Resolution Specialist	F	42	$51,000	$59,000	$67,000
Grievance Resolution Specialist - Lead	I	590	$61,000	$73,000	$85,000
Grievance Resolution Specialist Sr	H	589	$59,000	$68,000	$77,000
Health Coach	K	556	$70,000	$84,000	$98,000
Health Educator	H	47	$59,000	$68,000	$77,000
Health Educator Sr	I	355	$61,000	$73,000	$85,000
Health Network Liaison Specialist (RN)	L	524	$77,000	$93,000	$109,000
Health Network Oversight Specialist	K	323	$70,000	$84,000	$98,000
HEDIS Case Manager	M	443	$85,000	$103,000	$121,000
Help Desk Technician	E	571	$48,000	$55,000	$62,000
Help Desk Technician Sr	F	573	$51,000	$59,000	$67,000
HR Assistant	D	181	$44,000	$51,000	$58,000
HR Business Partner	M	584	$85,000	$103,000	$121,000
HR Coordinator	F	316	$51,000	$59,000	$67,000
HR Representative	J	278	$65,000	$78,000	$91,000
HR Representative Sr	L	350	$77,000	$93,000	$109,000
HR Specialist	G	505	$55,000	$63,000	$71,000
HR Specialist Sr	H	608	$59,000	$68,000	$77,000
Infrastructure Systems Administrator	F	541	$51,000	$59,000	$67,000
Infrastructure Systems Administrator Int	G	542	$55,000	$63,000	$71,000
Inpatient Quality Coding Auditor	I	642	$61,000	$73,000	$85,000
Intern	A	237	$36,000	$41,000	$46,000
Investigator Sr	I	553	$61,000	$73,000	$85,000
IS Coordinator	E	365	$48,000	$55,000	$62,000
IS Project Manager	N	424	$95,000	$114,000	$133,000
IS Project Manager Sr	O	509	$105,000	$127,000	$149,000
IS Project Specialist	K	549	$70,000	$84,000	$98,000
IS Project Specialist Sr	L	550	$77,000	$93,000	$109,000

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Job Title	Pay Grade	Job Code	Min	Mid	Max
Kitchen Assistant	A	585	$36,000	$41,000	$46,000
Licensed Clinical Social Worker	J	598	$65,000	$78,000	$91,000
Litigation Support Specialist	K	588	$70,000	$84,000	$98,000
LVN (PACE)	K	533	$70,000	$84,000	$98,000
LVN Specialist	K	686	$70,000	$84,000	$98,000
Mailroom Clerk	A	1	$36,000	$41,000	$46,000
Manager Accounting	O	98	$105,000	$127,000	$149,000
Manager Actuary	Q	453	$130,000	$157,000	$184,000
Manager Audit & Oversight	O	539	$105,000	$127,000	$149,000
Manager Behavioral Health	O	633	$105,000	$127,000	$149,000
Manager Business Integration	O	544	$105,000	$127,000	$149,000
Manager Case Management	P	270	$117,000	$141,000	$165,000
Manager Claims	O	92	$105,000	$127,000	$149,000
Manager Clinic Operations	N	551	$95,000	$114,000	$133,000
Manager Clinical Pharmacist	R	296	$144,000	$174,000	$204,000
Manager Coding Quality	N	382	$95,000	$114,000	$133,000
Manager Communications	N	398	$95,000	$114,000	$133,000
Manager Community Relations	N	384	$95,000	$114,000	$133,000
Manager Contracting	O	329	$105,000	$127,000	$149,000
Manager Creative Branding	M	430	$85,000	$103,000	$121,000
Manager Cultural & Linguistic	M	349	$85,000	$103,000	$121,000
Manager Customer Service	M	94	$85,000	$103,000	$121,000
Manager Electronic Business	N	422	$95,000	$114,000	$133,000
Manager Encounters	M	516	$85,000	$103,000	$121,000
Manager Environmental Health & Safety	N	495	$95,000	$114,000	$133,000
Manager Finance	O	148	$105,000	$127,000	$149,000
Manager Financial Analysis	P	356	$117,000	$141,000	$165,000
Manager Government Affairs	N	437	$95,000	$114,000	$133,000
Manager Grievance & Appeals	O	426	$105,000	$127,000	$149,000
Manager Human Resources	O	526	$105,000	$127,000	$149,000
Manager Information Services	P	560	$117,000	$141,000	$165,000
Manager Long Term Support Services	O	200	$105,000	$127,000	$149,000
Manager Marketing & Enrollment (PACE)	N	414	$95,000	$114,000	$133,000
Manager Marketing & Outreach	M	687	$85,000	$103,000	$121,000
Manager Member Liaison Program	M	354	$85,000	$103,000	$121,000
Manager Member Outreach & Education	M	616	$85,000	$103,000	$121,000
Manager MSSP	O	393	$105,000	$127,000	$149,000
Manager OneCare Clinical	P	359	$117,000	$141,000	$165,000
Manager OneCare Customer Service	M	429	$85,000	$103,000	$121,000
Manager Outreach & Enrollment	M	477	$85,000	$103,000	$121,000
Manager PACE Center	N	432	$95,000	$114,000	$133,000
Manager Population Health Management	N	674	$95,000	$114,000	$133,000
Manager Process Excellence	O	622	$105,000	$127,000	$149,000
Manager Program Implementation	N	488	$95,000	$114,000	$133,000
Manager Provider Data Management Services	M	653	$85,000	$103,000	$121,000
Manager Provider Network	O	191	$105,000	$127,000	$149,000

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	Job Title	Pay Grade	Job Code	Min	Mid	Max
	Manager Provider Relations	M	171	$85,000	$103,000	$121,000
	Manager Purchasing	O	275	$105,000	$127,000	$149,000
	Manager QI Initiatives	M	433	$85,000	$103,000	$121,000
	Manager Quality Analytics	N	617	$95,000	$114,000	$133,000
	Manager Quality Improvement	N	104	$95,000	$114,000	$133,000
	Manager Regulatory Affairs and Compliance	O	626	$105,000	$127,000	$149,000
	Manager Reporting & Financial Compliance	O	572	$105,000	$127,000	$149,000
	Manager Strategic Development	O	603	$105,000	$127,000	$149,000
	Manager Utilization Management	P	250	$117,000	$141,000	$165,000
	Marketing and Outreach Specialist	F	496	$51,000	$59,000	$67,000
	Medical Assistant	C	535	$41,000	$47,000	$53,000
	Medical Authorization Asst	C	11	$41,000	$47,000	$53,000
	Medical Case Manager	L	72	$77,000	$93,000	$109,000
	Medical Case Manager (LVN)	K	444	$70,000	$84,000	$98,000
*	Medical Director	V	306	$266,000	$332,000	$398,000
	Medical Records & Health Plan Assistant	B	548	$38,000	$44,000	$50,000
	Medical Records Clerk	B	523	$38,000	$44,000	$50,000
	Medical Services Case Manager	G	54	$55,000	$63,000	$71,000
	Member Liaison Specialist	C	353	$41,000	$47,000	$53,000
	MMS Program Coordinator	G	360	$55,000	$63,000	$71,000
	Nurse Practitioner (PACE)	O	635	$105,000	$127,000	$149,000
	Occupational Therapist	L	531	$77,000	$93,000	$109,000
	Occupational Therapist Assistant	H	623	$59,000	$68,000	$77,000
	Office Clerk	A	335	$36,000	$41,000	$46,000
	OneCare Operations Manager	N	461	$95,000	$114,000	$133,000
	OneCare Partner - Sales	F	230	$51,000	$59,000	$67,000
	OneCare Partner - Sales (Lead)	G	537	$55,000	$63,000	$71,000
	OneCare Partner - Service	C	231	$41,000	$47,000	$53,000
	OneCare Partner (Inside Sales)	E	371	$48,000	$55,000	$62,000
	Outreach Specialist	C	218	$41,000	$47,000	$53,000
	Paralegal/Legal Secretary	I	376	$61,000	$73,000	$85,000
	Payroll Specialist	E	554	$48,000	$55,000	$62,000
	Payroll Specialist Sr	G	688	$55,000	$63,000	$71,000
	Performance Analyst	I	538	$61,000	$73,000	$85,000
	Personal Care Attendant	A	485	$36,000	$41,000	$46,000
	Personal Care Attendant - Lead	B	498	$38,000	$44,000	$50,000
	Personal Care Coordinator	C	525	$41,000	$47,000	$53,000
	Personal Care Coordinator Sr	D	689	$44,000	$51,000	$58,000
	Pharmacy Resident	G	379	$55,000	$63,000	$71,000
	Pharmacy Services Specialist	C	23	$41,000	$47,000	$53,000
	Pharmacy Services Specialist Int	D	35	$44,000	$51,000	$58,000
	Pharmacy Services Specialist Sr	E	507	$48,000	$55,000	$62,000
	Physical Therapist	L	530	$77,000	$93,000	$109,000
	Physical Therapist Assistant	H	624	$59,000	$68,000	$77,000
	Policy Advisor Sr	M	580	$85,000	$103,000	$121,000
	Privacy Manager	N	536	$95,000	$114,000	$133,000

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Privacy Officer	O	648	$105,000	$127,000	$149,000
Process Excellence Manager	N	529	$95,000	$114,000	$133,000
Program Assistant	C	24	$41,000	$47,000	$53,000
Program Coordinator	C	284	$41,000	$47,000	$53,000
Program Development Analyst Sr	K	492	$70,000	$84,000	$98,000
Program Manager	L	421	$77,000	$93,000	$109,000
Program Manager Sr	M	594	$85,000	$103,000	$121,000
Program Specialist	E	36	$48,000	$55,000	$62,000
Program Specialist Int	G	61	$55,000	$63,000	$71,000
Program Specialist Sr	I	508	$61,000	$73,000	$85,000
Program/Policy Analyst	I	56	$61,000	$73,000	$85,000
Program/Policy Analyst Sr	K	85	$70,000	$84,000	$98,000
Programmer	K	43	$70,000	$84,000	$98,000
Programmer Int	M	74	$85,000	$103,000	$121,000
Programmer Sr	N	80	$95,000	$114,000	$133,000
Project Manager	L	81	$77,000	$93,000	$109,000
Project Manager - Lead	M	467	$85,000	$103,000	$121,000
Project Manager Sr	N	105	$95,000	$114,000	$133,000
Project Specialist	E	291	$48,000	$55,000	$62,000
Project Specialist Sr	I	503	$61,000	$73,000	$85,000
Projects Analyst	G	254	$55,000	$63,000	$71,000
Provider Data Management Services Coordinator	D	12	$44,000	$51,000	$58,000
Provider Data Management Services Coordinator Sr	F	586	$51,000	$59,000	$67,000
Provider Enrollment Manager	G	190	$55,000	$63,000	$71,000
Provider Network Rep Sr	I	391	$61,000	$73,000	$85,000
Provider Network Specialist	H	44	$59,000	$68,000	$77,000
Provider Network Specialist Sr	J	595	$65,000	$78,000	$91,000
Provider Office Education Manager	I	300	$61,000	$73,000	$85,000
Provider Relations Rep	G	205	$55,000	$63,000	$71,000
Provider Relations Rep Sr	I	285	$61,000	$73,000	$85,000
Publications Coordinator	G	293	$55,000	$63,000	$71,000
QA Analyst	I	486	$61,000	$73,000	$85,000
QA Analyst Sr	L	380	$77,000	$93,000	$109,000
QI Nurse Specialist	M	82	$85,000	$103,000	$121,000
QI Nurse Specialist (LVN)	L	445	$77,000	$93,000	$109,000
Receptionist	B	140	$38,000	$44,000	$50,000
Records Manager	Q	TBD	$130,000	$157,000	$184,000
Recreational Therapist	H	487	$59,000	$68,000	$77,000
Registered Dietitian	I	57	$61,000	$73,000	$85,000
Regulatory Affairs and Compliance Analyst	I	628	$61,000	$73,000	$85,000
Regulatory Affairs and Compliance Analyst Sr	K	629	$70,000	$84,000	$98,000
Regulatory Affairs and Compliance - Lead	L	630	$77,000	$93,000	$109,000
RN (PACE)	M	480	$85,000	$103,000	$121,000
Security Analyst Int	M	534	$85,000	$103,000	$121,000
Security Analyst Sr	N	474	$95,000	$114,000	$133,000
Security Officer	B	311	$38,000	$44,000	$50,000

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	Job Title	Pay Grade	Job Code	Min	Mid	Max
	SharePoint Developer/Administrator Sr	N	397	$95,000	$114,000	$133,000
	Social Worker	J	463	$65,000	$78,000	$91,000
	Social Worker Sr	K	690	$70,000	$84,000	$98,000
*	Special Counsel	T	317	$182,000	$227,000	$272,000
	Sr Manager Financial Analysis	Q	660	$130,000	$157,000	$184,000
	Sr Manager Human Resources	P	649	$117,000	$141,000	$165,000
	Sr Manager Information Services	Q	650	$130,000	$157,000	$184,000
	Staff Attorney	P	195	$117,000	$141,000	$165,000
	Staff Attorney Sr	R	691	$144,000	$174,000	$204,000
	Supervisor Accounting	M	434	$85,000	$103,000	$121,000
	Supervisor Audit and Oversight	M	618	$85,000	$103,000	$121,000
	Supervisor Behavioral Health	M	659	$85,000	$103,000	$121,000
	Supervisor Budgeting	N	466	$95,000	$114,000	$133,000
	Supervisor Case Management	M	86	$85,000	$103,000	$121,000
	Supervisor Claims	I	219	$61,000	$73,000	$85,000
	Supervisor Coding Initiatives	M	502	$85,000	$103,000	$121,000
	Supervisor Credentialing	I	671	$61,000	$73,000	$85,000
	Supervisor Customer Service	I	34	$61,000	$73,000	$85,000
	Supervisor Data Entry	H	192	$59,000	$68,000	$77,000
	Supervisor Day Center (PACE)	H	619	$59,000	$68,000	$77,000
	Supervisor Dietary Services (PACE)	J	643	$65,000	$78,000	$91,000
	Supervisor Encounters	I	253	$61,000	$73,000	$85,000
	Supervisor Facilities	J	162	$65,000	$78,000	$91,000
	Supervisor Finance	M	419	$85,000	$103,000	$121,000
	Supervisor Grievance and Appeals	L	620	$77,000	$93,000	$109,000
	Supervisor Information Services	N	457	$95,000	$114,000	$133,000
	Supervisor Long Term Support Services	M	587	$85,000	$103,000	$121,000
	Supervisor Member Outreach and Education	K	592	$70,000	$84,000	$98,000
	Supervisor MSSP	M	348	$85,000	$103,000	$121,000
	Supervisor Nursing Services (PACE)	M	662	$85,000	$103,000	$121,000
	Supervisor OneCare Customer Service	I	408	$61,000	$73,000	$85,000
	Supervisor Payroll	M	517	$85,000	$103,000	$121,000
	Supervisor Pharmacist	Q	610	$130,000	$157,000	$184,000
	Supervisor Population Health Management	M	673	$85,000	$103,000	$121,000
	Supervisor Provider Data Management Services	K	439	$70,000	$84,000	$98,000
	Supervisor Provider Relations	L	652	$77,000	$93,000	$109,000
	Supervisor Quality Analytics	M	609	$85,000	$103,000	$121,000
	Supervisor Quality Improvement	M	600	$85,000	$103,000	$121,000
	Supervisor Regulatory Affairs and Compliance	M	627	$85,000	$103,000	$121,000
	Supervisor Social Work (PACE)	J	636	$65,000	$78,000	$91,000
	Supervisor Therapy Services (PACE)	M	645	$85,000	$103,000	$121,000
	Supervisor Utilization Management	M	637	$85,000	$103,000	$121,000
	Systems Network Administrator Int	L	63	$77,000	$93,000	$109,000
	Systems Network Administrator Sr	M	89	$85,000	$103,000	$121,000
	Systems Operations Analyst	F	32	$51,000	$59,000	$67,000
	Systems Operations Analyst Int	G	45	$55,000	$63,000	$71,000

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Technical Analyst Int	J	64	$65,000	$78,000	$91,000
Technical Analyst Sr	L	75	$77,000	$93,000	$109,000
Therapy Aide	E	521	$48,000	$55,000	$62,000
Training Administrator	I	621	$61,000	$73,000	$85,000
Training Program Coordinator	H	471	$59,000	$68,000	$77,000
Translation Specialist	B	241	$38,000	$44,000	$50,000
Web Architect	N	366	$95,000	$114,000	$133,000

* These positions are identified for the purposes of CalOptima Policy GA. 8042: Supplemental Compensation as Director level and above positions for which eligible employees may qualify for Employer-Paid Member Contribution.

** These positions are identified for the purposes of CalOptima Policy GA. 8042: Supplemental Compensation as Director level and above positions for which eligible employees may qualify for Employer-Paid Member Contribution and are also Chief or Executive Director level positions.

Revised 09/02/2021

Summary of Changes to Salary Schedule

For September 2021 Board Meeting

Job Title	Pay Grade	Job Code	Min	Mid	Max	For Approval
** Chief Counsel	X	132	$368,000 ~~$289,000~~	$460,000 ~~$361,000~~	$552,000 ~~$433,000~~	In consideration of Grant Thornton total cash market data and internal evaluation of pay grades.
** Chief Executive Officer	Z	138	$560,000 ~~$400,000~~	$625,000 ~~$500,000~~	$765,000 ~~$600,000~~	In consideration of Grant Thornton total cash market data and internal evaluation of pay grades.
** Chief Financial Officer	X	134	$368,000 ~~$289,000~~	$460,000 ~~$361,000~~	$552,000 ~~$433,000~~	In consideration of Grant Thornton total cash market data and internal evaluation of pay grades.
** Chief Information Officer	W	131	$313,000 ~~$246,000~~	$391,000 ~~$307,000~~	$469,000 ~~$368,000~~	In consideration of Grant Thornton total cash market data and internal evaluation of pay grades.
** Chief of Staff	U	TBD	$226,000 ~~$209,000~~	$282,000 ~~$261,000~~	$338,000 ~~$313,000~~	In consideration of Grant Thornton total cash market data and internal evaluation of pay grades.
** Chief Medical Officer	X	137	$368,000 ~~$289,000~~	$460,000 ~~$361,000~~	$552,000 ~~$433,000~~	In consideration of Grant Thornton total cash market data and internal evaluation of pay grades.
** Chief Operating Officer	Y ~~X~~	136	$433,000 ~~$289,000~~	$540,909 ~~$361,000~~	$649,000 ~~$433,000~~	In consideration of Grant Thornton total cash market data and internal evaluation of pay grades.
** Deputy Chief Counsel	W	160	$313,000 ~~$246,000~~	$391,000 ~~$307,000~~	$469,000 ~~$368,000~~	In consideration of Grant Thornton total cash market data and internal evaluation of pay grades.
** Deputy Chief Medical Officer	W	561	$313,000 ~~$246,000~~	$391,000 ~~$307,000~~	$469,000 ~~$368,000~~	In consideration of Grant Thornton total cash market data and internal evaluation of pay grades.
** Executive Director Behavioral Health Integration	U	614	$226,000 ~~$209,000~~	$282,000 ~~$261,000~~	$338,000 ~~$313,000~~	In consideration of Grant Thornton total cash market data and internal evaluation of pay grades.
** Executive Director Clinical Operations	U	501	$226,000 ~~$209,000~~	$282,000 ~~$261,000~~	$338,000 ~~$313,000~~	In consideration of Grant Thornton total cash market data and internal evaluation of pay grades.
** Executive Director Compliance	U	493	$226,000 ~~$209,000~~	$282,000 ~~$261,000~~	$338,000 ~~$313,000~~	In consideration of Grant Thornton total cash market data and internal evaluation of pay grades.
** Executive Director Finance	U	TBD	$226,000	$282,000	$338,000	New position requires approval as an Executive Director level position in accordance with the Compensation Administration Guidelines.
** Executive Director Human Resources	U	494	$226,000 ~~$209,000~~	$282,000 ~~$261,000~~	$338,000 ~~$313,000~~	In consideration of Grant Thornton total cash market data and internal evaluation of pay grades.
** Executive Director Network Operations	U	632	$226,000 ~~$209,000~~	$282,000 ~~$261,000~~	$338,000 ~~$313,000~~	In consideration of Grant Thornton total cash market data and internal evaluation of pay grades.
** Executive Director Operations	U	276	$226,000 ~~$209,000~~	$282,000 ~~$261,000~~	$338,000 ~~$313,000~~	In consideration of Grant Thornton total cash market data and internal evaluation of pay grades.
** Executive Director Program Implementation	U	490	$226,000 ~~$209,000~~	$282,000 ~~$261,000~~	$338,000 ~~$313,000~~	In consideration of Grant Thornton total cash market data and internal evaluation of pay grades.
** Executive Director Public Affairs	U	290	$226,000 ~~$209,000~~	$282,000 ~~$261,000~~	$338,000 ~~$313,000~~	In consideration of Grant Thornton total cash market data and internal evaluation of pay grades.
** Executive Director Quality & Population Health Management	U	676	$226,000 ~~$209,000~~	$282,000 ~~$261,000~~	$338,000 ~~$313,000~~	In consideration of Grant Thornton total cash market data and internal evaluation of pay grades.
* Medical Director	V	306	$266,000 ~~$221,400~~	$332,000 ~~$276,300~~	$398,000 ~~$331,200~~	In consideration of Grant Thornton total cash market data and internal evaluation of pay grades.

Summary of Changes to Salary Schedule

For September 2021 Board Meeting

Job Title	Pay Grade	Job Code	Min	Mid	Max	For Approval

* These positions are identified for the purposes of CalOptima Policy GA. 8042: Supplemental Compensation as
** These positions are identified for the purposes of CalOptima Policy GA. 8042: Supplemental Compensation as

Revised ~~08/05/2021~~ 09/02/2021

Policy:	GA.8057
Title:	**Compensation Program**
Department:	CalOptima Administrative
Section:	Human Resources
Interim CEO Approval:	*/s/ Richard Sanchez 06/10/2020*
Effective Date:	05/01/2014
Revised Date:	06/04/2020
Applicable to:	☐ Medi-Cal ☐ OneCare ☐ OneCare Connect ☐ PACE ☒ Administrative

I. PURPOSE

This policy establishes a compensation program for CalOptima job classifications within clearly defined guidelines that promote consistent, competitive and equitable pay practices.

II. POLICY

A. CalOptima's compensation program is intended to:

1. Provide fair compensation based on organization and individual performance;
2. Attract, retain, and motivate employees;
3. Balance internal equity and market competitiveness to recruit and retain qualified employees; and
4. Be mindful of CalOptima's status as a public agency.

B. The Chief Executive Officer (CEO), in conjunction with the Executive Director of Human Resources, is directed to administer the compensation program consistent with the attached Compensation Administration Guidelines, which defines the principles upon which CalOptima's compensation practices will be managed, procedural aspects of how the compensation procedures will be administered, and how the overall compensation administration function will respond to changing market conditions and business demands. Some of these guidelines include, but are not limited to:

1. Establishing pay rates based on the market 50th percentile.
2. Determining appropriate pay rates within the pay range for a position by assessing an employee's or applicant's knowledge, skills, experience, and the pay rates currently being paid to similarly situated incumbents. Employees may be paid anywhere within the pay range based on proficiency levels. The following criteria shall be considered:

Minimum (Min)	The rate paid to an individual possessing the minimum job qualifications & meeting minimum job performance expectations

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Midpoint (Mid) aka: 50th percentile	The rate paid to individuals that are fully proficient in all aspects of the job's requirements & performance expectations
Maximum (Max)	The maximum rate paid to individuals who possess qualifications significantly above market norms & consistently deliver superior performance

3. All new hires and employees should have a pay rate equal to or greater than the pay range minimum, unless the minimum job requirements are not met, then a training rate equal to ten percent (10%) below the salary grade minimum may be used for six (6) months.

4. Base pay for all employees shall be capped at the pay range maximum, and once an employee reaches the base pay maximum, the employee will not be eligible for future base pay increases. However, in lieu of future base pay increases, these employees may be eligible for merit pay delivered as a lump sum bonus provided that the employee's performance warrants this additional compensation.

C. The CEO is authorized and directed to take all steps necessary and proper to implement the CalOptima compensation program and the Compensation Administration Guidelines not inconsistent therewith.

III. PROCEDURE

Not Applicable

IV. ATTACHMENT(S)

A. Compensation Administration Guidelines

V. REFERENCE(S)

Not Applicable

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

Date	Meeting
05/01/2014	Regular Meeting of the CalOptima Board of Directors
08/07/2014	Regular Meeting of the CalOptima Board of Directors
11/06/2014	Regular Meeting of the CalOptima Board of Directors
12/04/2014	Regular Meeting of the CalOptima Board of Directors
03/05/2015	Regular Meeting of the CalOptima Board of Directors
06/04/2015	Regular Meeting of the CalOptima Board of Directors
06/07/2018	Regular Meeting of the CalOptima Board of Directors
06/04/2020	Regular Meeting of the CalOptima Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	05/01/2014	GA.8057	Compensation Program and Salary Schedule	Administrative
Revised	08/07/2014	GA.8057	Compensation Program and Salary Schedule	Administrative
Revised	11/06/2014	GA.8057	Compensation Program and Salary Schedule	Administrative
Revised	12/04/2014	GA.8057	Compensation Program and Salary Schedule	Administrative
Revised	06/04/2015	GA.8057	Compensation Program	Administrative
Revised	06/07/2018	GA.8057	Compensation Program	Administrative
Revised	06/04/2020	GA.8057	Compensation Program	Administrative

IX. GLOSSARY

Not Applicable

Compensation Administration Guidelines

Revised June 04, 2020

Implemented March 29, 2020

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Contents

Pay Administration Guidelines

Common pay administration guidelines for CalOptima are detailed in this section. These Guidelines help maintain the integrity of the base pay program by introducing a common set of standards and assist managers in ongoing compensation program administration.

In addition, note the following administration of the Guidelines:

- Chief Executive Officer (CEO) compensation will be established by the Board of Directors.
- Chief and Executive Director compensation will be established by the CEO within the Guidelines.
- The Board will be informed of all Chief and Executive Director hires and compensation changes.

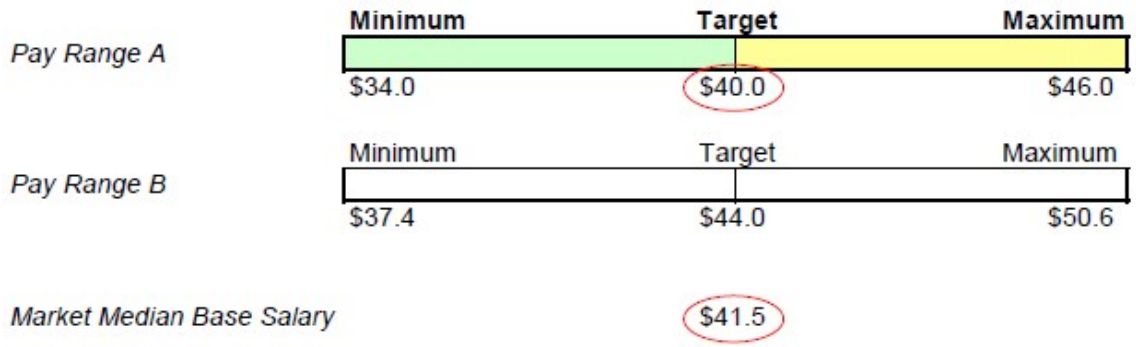
Proposed Pay Administration Guidelines

Pay ranges and pay levels	Pay range target Range minimums and maximums Pay above range maximums Pay range thirds Pay range halves Compa-ratio
Periodic pay adjustments/increases	New hire/Rehire Promotion Lateral Transfer Demotion Temporary Assignment Secondary job Job Re-evaluation Appeal Process Register/Certified Status Base pay program maintenance Salary structure adjustment Annual competitive assessment Market sensitive jobs
Annual pay adjustments/increases	Market Adjustment Merit pay Step increase
Special one-time pay considerations	Recruitment incentive

Pay Ranges and Pay Levels

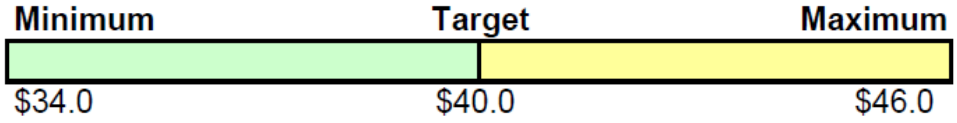
Range Target: internal "going market rate" for the job (50th percentile); represents the rate paid to individuals that are fully proficient in all aspects of the job's requirements and performance expectations.

- For benchmark jobs, the pay range (i.e. pay grade) is determined based on the comparability of values between market median base pay rates and the pay range targets.



Range Target $40.0 is Closest to Market Median of $41.5; job is assigned to Pay Range A

- For non-benchmark jobs, the pay range is determined based on comparability of the job to benchmark jobs within the same job family or other internal positions in terms of knowledge, skills, complexity and organizational impact.



Range Minimum: represents the rate paid to individuals possessing the minimum job qualifications and meeting minimum job performance expectations.

- All employees should have a pay rate equal to or greater than the pay range minimum.
- If the minimum job requirements are not met, a training rate equal to ten percent (10%) below the salary grade minimum may be used for six (6) months while a new incumbent is learning the skills to become proficient in the new role.

Range Maximum: represents the maximum rate paid to individuals who possess qualifications significantly above market norms and consistently deliver superior performance.

- Base pay growth is capped at the pay range maximum.

Pay Above Range Maximum: Employees are not paid above the range maximum.

- Employees whose current pay becomes above the pay range maximum will have their base pay frozen and will not be eligible for future base pay increases until such time as their base pay falls below the pay range maximum.

- In lieu of future base pay increases, these employees may be eligible for merit pay delivered as a lump sum bonus providing their performance warrants this additional compensation.

- As the pay structures and pay ranges move every twelve (12) – thirty-six (36) months or as necessary, the employees paid above the pay range maximum will eventually be paid below the pay range maximum and will then be eligible to receive base pay increases, as appropriate.

Pay Range: Employees may be paid anywhere within the open pay range; the pay range is divided into equal quartiles to assist in achieving competitive, equitable, and appropriate pay levels

- Developing Area – Below market pay; this area is used for employees possessing minimum job requirements and/or for those having significant learning curves to become fully proficient in the job's duties, responsibilities and performance expectations.

- Proficient/Fully Proficient Area – Market competitive pay; this area is used for employees possessing preferred job requirements and consistently demonstrate one hundred percent (100%) proficiency in all aspects of the job's duties, responsibilities and performance expectations.

- Expert Area – Above market pay; this area is used for employees possessing unique knowledge, skills, or abilities that far surpass the market's typical requirements and consistently demonstrate superior performance in all aspects of the job's duties, responsibilities, and performance expectations.

Compa-Ratio: In addition to pay range quartiles, this is a metric also used to communicate pay competitiveness.

- Compa-Ratio: A compa-ratio is calculated by taking the employee's base pay divided by his/her pay range target.

- Compa-Ratio of 100%: This ratio indicates the employee's base pay equals the pay range target, or the market rate.

  - Compa-Ratio <100%: This ratio indicates the employee's base pay is less than the pay range target.

  - Compa-Ratio >100%: This ratio indicates the employee's base pay is greater than the pay range target.

Illustrative Range Shown Below:

	Minimum	Target	Maximum
Compa-Ratio RNs	87.5%	100.0%	117.0%
Compa-Ratio Non-Exempt	88.0%	100.0%	117.0%
Compa-Ratio Exempt	83.0%	100.0%	118.0%

Note: *Range minimums and maximums will be based on the developed salary range spreads.*

Annual Pay Adjustments/Increases

Market Adjustment: A market adjustment is an increase or decrease to pay range grades based on market pay practices.

- A market adjustment may result in base pay increases for full-time, part-time, and some as-needed and limited term staff paid at or below the pay range target (there is no base pay increase between target and maximum for non-market sensitive jobs unless compression exists at the target).
    - For some market-sensitive jobs, a market adjustment may also be granted to full-time, part-time, and some as-needed and limited term staff paid above the pay range target but below the pay range maximum to maintain competitiveness and minimize pay compression.
- A market adjustment may result in a base pay increase to some staff to ensure employees are paid a base pay rate at least equal to the new pay range minimum.
    - If a market adjustment is made, employees paid below the new range minimum receive an increase to their base pay to ensure it is at least equal to the pay range minimum before any merit pay is awarded (cap at 10%).
- The appropriateness of a market adjustment is determined based on:
    1. A competitive assessment of the pay range target versus market base pay practices;
    2. Market trends and practices relative to average base pay and pay range increases; and
    3. Current recruiting and retention issues.
- Market adjustments are made prior to determining merit pay.
- Newly hired employees will be eligible for any market adjustments granted at the annual pay increase date if the employee is paid at or below the pay range target.

Base Pay Adjustment: All employees who achieve a satisfactory level of performance will be eligible for a merit pay adjustment.

- Merit Pay: Merit pay is variable pay that typically affects employees' base pay; it recognizes employees' job proficiency and performance of job duties.
    - Merit pay is applicable to full-time and part-time employees paid below, at, or above the pay range target; Per diem employees are not eligible for merit pay.
    - To be eligible for merit pay, the employee must have started work on or before March 31 to be eligible for a merit increase in July of the same year and have successfully completed the introductory period [three (3) months for transfers and new hires] prior to the annual pay adjustment date.
    - Merit pay will typically be an increase to base pay; however, it may also be delivered

as a one-time lump sum bonus for individuals paid above the pay range maximum.

- The budgeted amount for merit pay, if any, is based on 1) the organization's financial status; 2) market trends relative to average base pay increases; 3) competitiveness of current base pay practices; and, 4) recruiting and retention issues.

Merit Pay – Staff Paid At and Above Pay Range Target

- The combination of an individual's performance rating, the position of his/her pay within the pay range, the number of months he/she has been working, and the salary earned during those months determines the individual's merit pay opportunity.
  - Merit pay is typically calculated as a percent of base pay in effect on March 31, prorated to reflect the number of months an employee worked during the twelve (12)-month period starting from the first pay period in the fiscal year and ending with the last pay period of that same fiscal year.
  - Managers have the discretion to determine the actual increase amount within the published Guidelines; the appropriate merit pay amount will reflect the manager's internal equity, pay competitiveness, and performance recognition objectives.
  - Adjustments to employees' base pay are capped at the pay range maximums; therefore, some employees may receive a portion of their merit pay as a base pay increase up to the pay range maximum and also receive a lump sum amount for the remaining portion of the merit pay. Employees paid over the pay range maximum may be eligible to receive merit pay as a lump sum payment paid out in two (2) incremental amounts- the first half when merit pay is normally distributed; and the second half six (6) months later.
  - Merit pay may be held altogether or delayed for ninety (90) days if employees do not achieve a satisfactory level of performance or if a written warning or suspension/final written warning is active in their record.
  - Merit pay is typically awarded once a year at a specific time.
  - Full-time and part-time employees may receive both a market adjustment and a merit pay adjustment at the same time.
  - Executive Directors and Chief's must approve merit pay increases for all areas for which they are responsible before submitting to HR.
  - HR has final approval of all merit increases.

A Merit Pay Grid similar to the one shown below [assumes a three percent (3%) merit increase budget] is often used to provide managers with a guideline as to what merit pay increase may be appropriate based upon performance and to reflect:**

1. The organization's financial status;
2. Market trends relative to average base pay increases;
3. Competitiveness of current base practices; and

4. Recruiting and retention issues.

	Pay Range Position				
Performance Rating	1st Quartile	2nd Quartile	3rd Quartile	4th Quartile	Above Max
Highly Effective	6% - 5%	5% - 4%	4% - 3%	3% - 2%	3% - 2%
Effective	5% - 4%	4% - 3%	3% - 2%	3% - 2%	0%
Needs Improvement	0%	0%	0%	0%	0%

Above Max = Lump Sum Bonus

***The Merit Pay Grid is a sample only. Actual merit increase percentages will depend upon the salary distribution across the salary structure.*

- Employees who do not achieve a satisfactory level of performance at the time of their annual pay increase will not receive any type of pay increase – market adjustment, or merit pay.

- The increase may be withheld altogether or delayed ninety (90) days until the written performance improvement plan is complete and performance is judged to be acceptable by the manager; the pay increase will be effective at the time performance is judged to be acceptable (beginning of applicable pay period) and will not be retroactive; the manager is responsible for informing the employee in this situation and is responsible for notifying HR to initiate the increase.

- Employees on any type of leave of absence who are eligible for a market adjustment, and/or merit pay, may receive these adjustments upon their return to active status with a completed performance appraisal that is competent or above.

Special One-time Pay Considerations

Recruitment Incentive

- Recruitment incentives up to fifteen percent (15%) of an employee's base pay may be provided on an exception basis to entice an employee to join CalOptima.
    - Recruitment incentives require the approval of the CEO.
    - Board approval is required for recruitment incentives offered to Executive Director and above positions.

Incentives are provided with a "pay-back" provision if the employee terminates within twenty four (24) months of hire.

New Hires/Rehires

- A new hire's pay level corresponds to the appropriate pay range quartile and typically should not exceed the pay range target. Offers above the pay range target require the approval of the Executive Director of Human Resources and the CEO, when necessary.

- Factors to be considered in determining an appropriate pay level for a new hire include:

    - Job-related experience: What is the estimated learning curve given the individual's prior work experience? How many years of experience does the individual have in the same or equivalent classification?

    - Market conditions: What is the going rate of pay in the external market for the individual's skills and knowledge?

    - Internal equity: Is the proposed pay level lower, higher or in line with the pay levels of current employees having comparable skill and experience levels?

- At hire, external service is typically valued comparable to internal service.

    - For example, an RN having three (3) years of prior job experience is viewed comparably to an RN having three (3) years of job experience at CalOptima.

- Internal equity (how this position and compensation compares relative to existing employees) must be considered when making hiring decisions.

Process for Determining a New Hire Starting Pay Rate

HR determines applicable pay rate:

- Starting pay rate is at or near the minimum of the pay range for a candidate who only meets the job's minimum qualifications.

- Starting pay rate cannot be below the minimum of the pay range (unless it is viewed as a training rate).

- Determine appropriate pay rate by assessing candidate's knowledge, skills, and experience, as well as pay rates currently being paid to similarly situated incumbents.

- Candidates with superior knowledge, skills, and experience can be paid above the pay range midpoint. Starting pay rates above the pay range midpoint must have approval of the Executive Director of Human Resources and CEO, when necessary.

- There are certain positions that will usually be placed near the salary grade minimum (all entry level service and clerical).

- Pay rates for all positions are reviewed with the Compensation Unit before an offer is made. The Compensation Unit will review internal equity across the system to ensure that the appropriate offer is made.

- Rehires to the same classification should be paid at least the same amount they earned prior to termination, with adjustments and/or credit for recent additional career experience or education earned while away from CalOptima.

- The above policy applies to the current organization structure.
- Additional positions at the level of Chief or Executive Director require Board approval.

Promotion

An employee receives a promotion when the employee applies for and is selected for a job with a higher pay range target.

- An employee will receive a promotional increase to at least the pay range minimum of the new pay range.
- The amount of a promotional increase will be determined based on the incumbent's qualifications, performance, and internal pay practices. The typical promotional increase for a promotion without external competition is up to five percent (5%) of the employee's base pay per one (1) pay grade increase.
- Typically, the promotional increase should not exceed the pay range target.
- When an employee moves from non-exempt to exempt, the loss of overtime pay will be considered. However, the realization that overtime is not guaranteed must also be considered.
- The pay rate adjustment will be effective on the first day of the pay period in which the job change takes effect.
- Employees who are promoted after March 31, but prior to receiving their merit increase, will have their merit increase, if any, included in the base pay used to calculate their promotional pay. If the employee's performance evaluation rating and therefore merit increase amount is not known at the time the promotional pay is being calculated, a merit increase equivalent to "Fully Meets Expectations" will be included in the base pay used to calculate their promotional pay.
- The next merit pay adjustment after a promotion may be pro-rated based on the amount of time the employee has spent in the job.

Lateral Transfer

It is considered a lateral transfer if an employee moves to a job having the same pay range target.

- Lateral job changes will not typically result in a base pay increase or adjustment unless otherwise approved by the Executive Director of Human Resources.
- Employees who are laterally transferred after March 31, but prior to receiving their merit increase, will typically have their merit pay calculated as a percent of their base pay in effect on March 31.

Demotion

An employee is classified as having been demoted if the employee moves to a job with a lower pay range target.

- The pay of an employee demoted due to an organizational restructure, will not be decreased unless the employee is above the maximum on the new pay range; if so, the employee will be reduced to the maximum of the new pay range.

- For an involuntary demotion, due to performance, or for a voluntary demotion, the pay grade of the demoted employee will be assigned to the pay grade of the employee's new classification. The employee's base pay will typically be reduced up to five percent (5%) for each pay grade demoted.

- The pay rate adjustment will be effective on the first day of the pay period in which the job change takes effect.

- Future merit increases and market adjustments will not be affected by a demotion unless competent performance is not achieved.

- Employees who are demoted after March 31, but prior to receiving their merit increase, will typically have their merit pay calculated as a percent of their base pay in effect on March 31.

Temporary Assignment

An employee who is asked to assume a full-time temporary assignment in a job having a higher pay range target is eligible for a temporary base pay increase. The employee must assume some or all of the responsibilities of the new job to qualify for a temporary assignment increase.

- The employee's base pay rate prior to the assignment will be maintained and the higher temporary assignment rate will be added as a secondary job title and pay rate.

- This increased secondary pay rate is eliminated when the temporary assignment ends.

- The amount of the temporary assignment increase should be consistent with the promotion policy.

Training/Transition Overlap

In order to provide for a transition and/or training period, CalOptima may fill a regular position with a replacement in advance of the separation of a terminating employee. For the transition and/or training period, two employees may fill the same budgeted position for up to thirty (30) calendar days during the period of overlap. The immediate supervisor will determine which employee will be designated for decision-making and regulatory reporting purposes, if applicable.

Job Re-Evaluations

Job re-evaluations will be reviewed in the following priority order:

1. New Positions.

2. Change of thirty-five percent (35%) or more of duties [any change in responsibilities less than thirty-five percent (35%) will not be considered].

    - Enhancements must require a higher level of skills, abilities, scope of authority, autonomy, and/or education to qualify for a re-classification.

    - Additional duties that do not require the above will not be considered for reclassification.

    - All requests for job re-classification must be documented, signed by the department manager and submitted to the Compensation Unit.

    - In the case of management positions being re-classified, the appropriate Chief must sign the documentation.

    - The request must include the incumbent's current job description and revised job description with enhancements highlighted.

    - The request must also include justification that the re-classification supports a business need.

If the job is determined to be a priority, the Compensation Unit will analyze the job according to:

1. The job's scope against other jobs in the same discipline.

2. Available market data.

3. Appropriate title identification. The Compensation Unit will determine if the title fits within the hierarchy; if not, a benchmark title will be recommended.

4. Job family.

5. Fair Labor Standards Act (FLSA) status.

6. Appropriate pay grade – the job will be fit into one (1) of the pay grades that currently exists. No new pay grades created.

7. A pay rate will be determined.

8. A recommendation will be made to the Executive Director of Human Resources for approval, and the decision will be communicated to the appropriate manager.

If a job is reassigned to a higher grade, the change will be effective on the first day of the pay period following the evaluation. The pay increase is not retroactive to any earlier date. The manager will be informed of the decision to move the job to a higher pay grade by the Compensation Unit. The amount of the pay increase should follow the guidelines in the Promotion section. If the upgrade and a pay change occur less than six (6) months before the annual pay increase date, the employee's next merit pay adjustment may be pro-rated.

If the job is not reassigned to a higher pay grade, the manager will be notified. If dissatisfied with the decision, the manager may file an appeal with the Executive Director of Human Resources.

If a job is reassigned to a lower pay grade as a result of a job re-evaluation due to available market data, without a change in job responsibilities, the involuntary demotion due to organizational restructuring protocol will be followed.

If a job is reassigned to a lower pay grade due to a job evaluation and change in job responsibilities, the voluntary demotion protocol will be followed.

Job evaluations and re-evaluations will occur throughout the year; all priority jobs will be evaluated within one (1) month of the request.

If a job is not a priority or does not meet the guidelines, the manager will be notified.

Base Pay Program Maintenance

Salary Structure Adjustment

- The salary structure should be reviewed on a regular basis either annually or every other year to continue to reflect market competitiveness.
- The salary structure updates are designed to relieve any upward pressure on range minimums, midpoints and maximums that may impede the ability to attract, motivate, and retain the workforce.
- The salary structure is dynamic; it needs to be revised at regular intervals based upon market conditions to maintain market competitiveness. The goal is to keep the structure's market rates on track with market data.
- Market adjustments will be applied to the salary schedule as needed at least every two (2) years, using surveyed salary structure adjustment percentages.
- The salary structure adjustment approval process includes:
    - The Executive Director of Human Resources makes a recommendation to the CEO for approval.
    - CEO takes the recommendation to the Board for final approval.

Annual Competitive Assessment

- On a regular basis either annually or every other year, HR will identify the current competitiveness of CalOptima's pay practices by comparing: 1) current pay levels to market practices; 2) current pay levels to pay range targets; and, 3) current pay range targets to market practices.
    - CalOptima will on a regular basis either annually or every other year spot check benchmark jobs to determine market fluctuations in benchmark jobs' pay rates.
    - Based on market findings, the pay grade and ranges will be updated.
    - Any jobs in which reasonable benchmark data is not available can be slotted into the salary structure based on internal equity considerations.
- The results of these analyses, along with CalOptima's current financial performance and economic situation, will determine the appropriate market adjustments (i.e., pay range adjustments) and merit pay budgets.
- The following criteria is typically used to determine which jobs to market price each year:
    - Review job-level turnover statistics for jobs with above-average separation rates to identify jobs with potential retention issues.
    - Review the time-to-fill metrics for jobs requiring above-average recruiting efforts and

expenses to identify jobs with potential recruiting issues.

- Review the applicant tracking reports (if available) for jobs with a high level of initial/ subsequent offer rejections to identify additional potential recruiting issues.
- Review jobs with pay-to-pay range target compa-ratios in excess of 110% or below 90%.
- Review jobs with market-to-pay range target compa-ratios in excess of 110% or below 90%.
- Review all market-sensitive jobs and those on the "watch list."
- Review top ten (10) highest populated jobs on an annual basis.
- Jobs are ranked by degree of severity for each of the preceding criteria; the jobs that are most frequently identified across all criteria are typically market priced.
- It is recommended that at least two (2) jobs be selected from every pay range.

Market Adjustments (Structure and Pay Range Adjustments): Market adjustments to specific pay ranges or the entire pay structure may be made on an annual or as needed basis to reflect current competitiveness or market trends.

- On a regular basis either annually or every other year, the pay range targets are compared to the external market base pay practices and necessary adjustments are made to ensure alignment including job grade changes and range rate adjustments.
- Employees falling below the range minimum of the adjusted structures are typically brought to the pay range minimum, assuming the employee has a satisfactory level of performance; any pay compression resulting from structure adjustments should be addressed as part of the annual pay increase process.
    - Adjustments to pay range minimums occur prior to merit pay calculations.

Process for Making Market Adjustments

- HR performs, on a regular basis either annually or every other year, a review of compensation surveys to calculate the average market adjustment to pay structures; HR also analyzes the competitiveness of the current pay range targets to market practices for benchmarked jobs.
- HR reviews CalOptima's financial operating conditions and quantifies any recruiting/ retention issues.
- HR determines if an adjustment is appropriate (minor variations in the market may be recognized in the following year) and recommends the amount.
- HR multiplies the current pay range target of each grade by the necessary adjustment percentage; then HR recalculates the pay range minimum and maximum based on the existing structure design (i.e., pay range minimums = 80% of the new pay range target; pay range maximums = 120% of the new pay range target, etc.).

- HR identifies the cost implications for the market adjustment by identifying the difference between 1) current pay rates and new pay range minimums, and, 2) current pay rates.

- The market adjustment approval process will work as follows:

    - The Executive Director of Human Resources recommends an adjustment to the CEO for approval.

    - If the CEO agrees, the CEO will seek Board approval, unless the market adjustment is within the approved pay range for the classification as designated in the Board-approved salary schedule. In such case(s), the CEO may approve the market adjustment and inform the Board of such change(s).

Market-Sensitive Jobs: Market sensitive jobs are those for which market conditions make recruiting and retention challenging.

- Premium pay is built into the pay range targets for these jobs.

    - Prospectively, the pay range and grade selected for these jobs will reflect the desired market target rate (i.e., 60th or 75th percentile of base pay practices) based on business need.

    - The desired market target rate is established on a job-by-job basis to reflect specific market conditions.

- Criteria used to determine if a job is classified as market-sensitive typically includes two (2) or more of the following:

    - Time to fill the position – statistics will suggest the average amount of time required to fill a requisition for a market-sensitive position will be significantly higher than the historical norm for this position or similar positions.

    - Job offer rejections – statistics will illustrate an increase in the number of employment offers rejected due to low starting rates.

    - Turnover – statistics will suggest a higher than typical amount of turnover for the position within the last three (3) to six (6) months; turnover for the job will be compared to historical results for the same job and to other similarly-situated jobs.

    - Market Changes – market-sensitive jobs may experience an excessively large increase in competitive pay rates over the previous year's results; specifically, jobs considered to be market-sensitive may have:

        - a year-to-year increase significantly greater than the average year-to-year increase for other jobs analyzed,

        - a competitive market rate significantly higher [approximately ten percent (10%)] than its current pay range target, or

        - a competitive market rate with significantly higher pay practices [approximately ten percent (10%)] in the labor market than the average of current internal pay practices.

- When a job is classified as market-sensitive, typically some form of adjustment is made to employees' base pay rates and is typically referred to as a market adjustment and the pay increase policies noted under the market adjustment section apply.

- Jobs classified as market-sensitive are reviewed annually to determine if this status still applies.

    - Once a job is classified as market-sensitive, it typically remains as such until the recruiting and retention challenges subside and/or the market pay rates adjust themselves – typically not less than one (1) year.

    - When a job is no longer considered market-sensitive, the job's pay range and grade is reassigned to reflect a market median base pay rate target; no changes are typically made to the employees' base pay rates at this time.

- Throughout the year, jobs that are not yet considered market sensitive, but are showing signs of becoming so are placed on a "watch list" and monitored.

If necessary, these jobs will be moved to the market-sensitive category and handled accordingly.

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CalOptima

Compensation and Benefits Benchmarking and Analysis

July 9, 2019

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Competitive Analysis
Total Cash Compensation – Executives

		Market Data					
		Total Cash - National Data			Total Cash % of Market		
Title	Total Cash	P25	P50	P75	P25	P50	P75
Chief Executive Officer	$431,600	$797,000	$1,124,000	$1,714,000	54%	38%	25%
Chief Financial Officer	$320,216	$370,000	$520,000	$744,000	87%	62%	43%
Chief Operating Officer	$320,216	$324,000	$444,000	$624,000	99%	72%	51%
Chief Medical Officer	$320,216	$376,000	$453,000	$578,000	85%	71%	55%
Deputy Chief Medical Officer	$266,968	$246,000	$312,000	$371,000	109%	86%	72%
Chief Information Officer	$266,968	$265,000	$370,000	$600,000	101%	72%	44%
Chief Counsel	$266,968	$319,000	$494,000	$630,000	84%	54%	42%
Deputy Chief Counsel	$222,352	$281,000	$338,000	$450,000	79%	66%	49%
Executive Director Clinical Operations	$222,352	$202,000	$232,000	$268,000	110%	96%	83%
Executive Director Compliance	$222,352	$196,000	$248,000	$316,000	113%	90%	70%
Executive Director Human Resources	$222,352	$262,000	$352,000	$469,000	85%	63%	47%
Executive Director Operations	$222,352	$279,000	$328,000	$380,000	80%	68%	59%
Executive Director Network Operations	$222,352	$325,000	$427,000	$583,000	68%	52%	38%
Executive Director Program Implementation	$222,352	$289,000	$413,000	$475,000	77%	54%	47%
Executive Director Public Affairs	$222,352	$312,000	$344,000	$499,000	71%	65%	45%
Executive Director Quality Analytics	$222,352	$240,000	$285,000	$377,000	93%	78%	59%
Executive Director Behavioral Health Integration	$222,352	$235,000	$279,000	$309,000	95%	80%	72%
				Average	**88%**	**69%**	**53%**

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CalOptima

Compensation and Benefits Benchmarking and Analysis

May 21, 2020

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General Overview

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General Overview – About Grant Thornton

Grant Thornton LLP is the U.S. member firm of Grant Thornton International Ltd., one of the world's leading organizations of independent assurance, tax, and advisory firms. Proactive teams led by approachable partners in these firms use insights, experience and instinct to understand complex issues for not-for-profit, public sector, privately owned and publicly listed clients and help them to find solutions.

Our human capital services professionals are a senior team that possess the right mix of experience, technical skills, industry knowledge, and personal commitment to help you achieve your desired results. Not only do we know competitive benchmarking from the executive to staff level and short and long-term incentive design, but we also have the support and bench strength of national benefits and tax specialists to provide assessments on other compensation topics if needed.

We have extensive experience serving health plans similar to CalOptima. We conduct assessments of competitive compensation levels, deferred compensation and other benefits/perquisite programs using proven methodologies and relevant resources. Our ability to design and implement value-added strategies is grounded in our understanding of your business goals and value drives, as well as risk factors.

General Overview

A successful total compensation program is one that promotes the ability of an organization to recruit, retain and motivate qualified employees to help the organization achieve its mission and goals. The objective for this Compensation and Benefits Study is to assess the competitiveness of CalOptima's total compensation program, measured against similar organizations from which CalOptima competes for labor. Our review includes base salary and incentive compensation, where applicable. As well as, employee benefits that are an essential component of an employee's overall compensation such as retirement, health insurance, life insurance, pension, sick leave, vacation time, etc.

In an effort to have a program that is fair, equitable, and competitive, CalOptima has undertaken an internal review on the following key items:

- **Job descriptions.** Updated and accurate job descriptions that describe what employees are doing within their respective roles
- **Relevant markets**. Revised comparison markets by functional area and classification that more accurately captures the compensation paid at organizations from which CalOptima recruits employees
- **Market-based structure.** Salary structure that is based on a balance between defined, specific comparison markets and internal factors
- **Revised pay guidelines.** Key principles that help Human Resources administer compensation in a disciplined way to ensure that compensation of employees is managed fairly and consistently

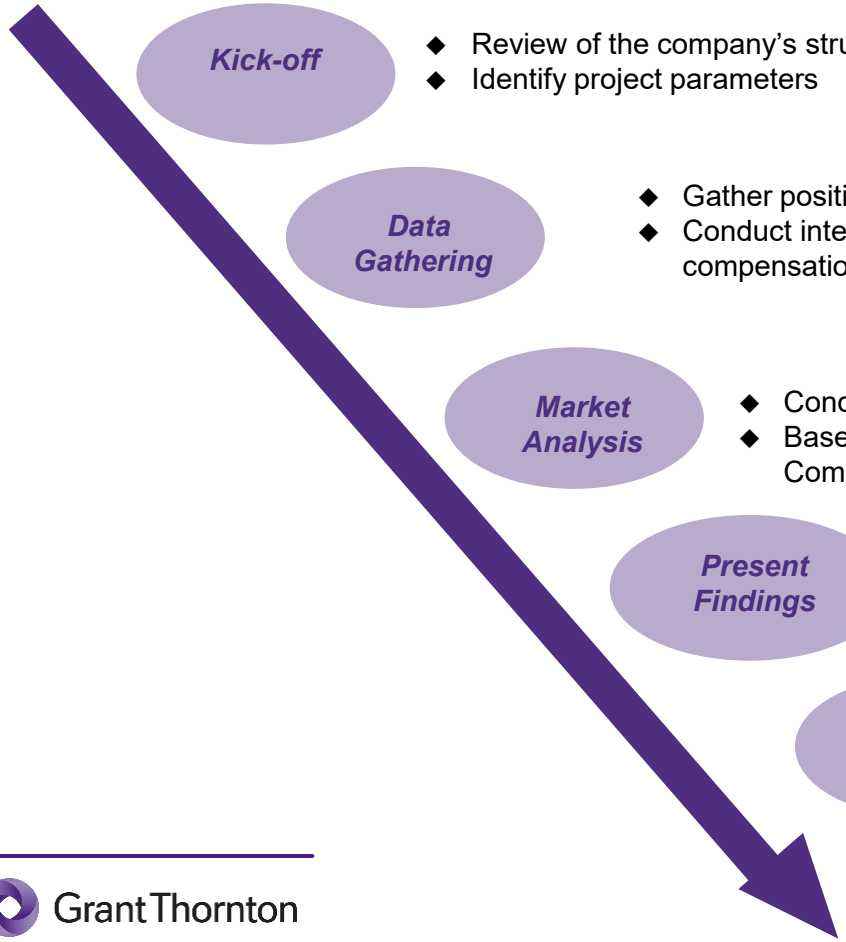
Scope of Work
Overview of Project

Grant Thornton was engaged to perform a Compensation Study (Salary and Benefits) to evaluate CalOptima's pay practices for human capital recruitment and retention as compared to other local, regional, and national organizations of similar size and operations i.e., hospitals (public agencies, non-profit and private), health plans (public agencies and private), health networks, and other employers (public agencies and private entities).

We reviewed and made recommendations on the appropriateness and competitiveness of CalOptima's current pay practices (Salary and Benefits) in order to remain competitive in the market, taking into account CalOptima's organization as a public agency and its obligation to remain fiscally prudent. We focused on skilled employees to fill and retain leadership roles and key positions essential to fulfilling the agency's strategic plan and operational goals.

The study included base pay, incentive pay, and other supplemental pay practices, along with all benefits offered to CalOptima employees (i.e. paid time off, employer share of health benefits, retirement benefits (CalPERS and PARS), life insurance, etc.) We benchmarked positions against internal CalOptima positions, where appropriate, to ensure fairness in its pay practices and to avoid pay compression. Some job titles with similar job functions and responsibilities were benchmarked against other CalOptima positions.

Scope of Work
Grant Thornton's Engagement Approach



Kick-off

- Review of the company's structure, goals, and objectives
- Identify project parameters

Data Gathering

- Gather position information, pay information, and benefit program summaries
- Conduct interviews with key stakeholders regarding issues relevant to compensation philosophy and executive pay

Market Analysis

- Conduct assessment and market comparisons:
- Base Salary, Total Cash Compensation, Total Direct Compensation, and Benefit Programs

Present Findings

- Prepare and present initial report
- Collaborate with compensation study workgroup

Next Steps

- Finalize report and any recommendations
- Implementation support as needed

Scope of Work
Peer Groups

CalOptima recruits and retains talent in the Southern California competitive job market for all positions, and broader regions - even national - for senior level management positions. Our peer groups have been customized to reflect the geographic pool for talent for these different positions.

Despite being a government agency, CalOptima competes with like health plan organizations, whether government, tax-exempt, or for-profit. Therefore, Grant Thornton (GT) conducted the competitive market analysis using a combined peer group of blended data from the following sectors of health plans on an equally blended basis:

- Government Peers
- Not-for-Profit Peers
- For-Profit Peers

Examples: An Accounts Payable Clerk was benchmarked using like positions, with equal weight on government, not-for-profit, and for-profit organizations regionally since this represents the labor pool. Alternatively, a senior executive position is benchmarked relative to the same peers, but looking at comparable organizations nationally.

Scope of Work
Peer Groups/Market Data Sources

- GT used the following peer groups and compensation surveys to assess competitive market levels:

Data Source	Description
Government Health Plan Peer Group	▪ Contains government health plan organizations of similar size and business focus to CalOptima, including LA Care and Inland Empire ▪ GT kept the same constituents of CalOptima's prior government health plan peer group (used in GT's 2017 CEO/CLO report) ▪ Used for comparison to CalOptima's executive team
Tax Exempt Health Plan Peer Group	▪ Contains tax exempt health plan organizations of similar size and business focus to CalOptima ▪ GT kept the same constituents of CalOptima's prior tax exempt health plan peer group (used in GT's 2017 CEO/CLO report) ▪ Used for comparison to CalOptima's executive team
For-Profit Health Plan Peer Group	▪ Contains for-profit health plan organizations of similar size and business focus to CalOptima ▪ GT kept the same constituents of CalOptima's prior public health plan peer group (used in GT's 2017 CEO/CLO report) ▪ Used for comparison to CalOptima's executive team

Scope of Work
Peer Groups/Market Data Sources

- GT used the following peer groups and compensation surveys to assess competitive market levels:

Data Source	Description
ERI	▪ Economic Research Institute ("ERI") is a nationally recognized for profit regression based survey ▪ We have pulled compensation data for the "Medical, Dental, & Disability Plans" sector for organizations with $700M in assets ▪ Used for comparison to CalOptima's executive team, directors, managers, and staff level positions
Health Plan Survey	▪ Lastly, we have used a confidential health plan survey that has compensation information for executives, directors, managers, and staff in tax exempt and public health plans. ▪ Used for comparison to CalOptima's executive team, directors, managers, and staff level positions

Executive Summary

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Executive Summary
Current Total Rewards Environment

CalOptima reviewed their total rewards program in 2013. To provide context on the current market, we highlighted the following total rewards trends for the last five years:

- Salaries
  - 3% to 4% annual salary increase in market, totaling an average market movement of 15% to 20% over the last five years
- Annual Incentives
  - Almost universal use of incentives in the health plan market, across all ownership types, with payouts often averaging above target or expected levels
- Long-Term Incentives
  - Universal use with for-profit health plans, and majority practice for large health plans
- Total Compensation (Inclusive of Benefits)
  - Increases at a rate consistent with salaries, since benefits and incentive values are typically expressed/provided as a percent of salary
  - Generally, benefit cost increases are shared partially employees/participants
- The market's total compensation increases are above the standard levels described above for growing job levels, considering that market total compensation increases by 5% to 20% for every doubling in organizational size (e.g., $3B health plan pay levels would tend to be 5% to 20% higher then $1.5B health plan)
  - Leadership position pay values are more sensitive to organizational size than staff levels
- The current labor market is an employees market due to the historically low unemployment rate

Executive Summary
Compensation Program

- Base Salary
  - On average:
    - Executives are positioned 13% below market median
    - Directors are positioned 13% below market median
    - Managers are positioned 6% below market median
    - Staff are positioned 4% below market median
- Total Cash Compensation (Base Salary + Annual Incentives)
  - On average:
    - Executives are positioned 30% below market median
    - Directors are positioned 24% below market median
    - Managers are positioned 13% below market median
    - Staff are positioned 7% below market median
    - Disparities are due to the limited incentive compensation offered
- Total Direct Compensation (Base Salary + Annual Incentives + Long-Term Incentives)
  - On average, executives are positioned 43% below market median
  - Disparity is due to the lack of a long-term incentive plan at CalOptima

Executive Summary
Compensation Program

- While we used a blend of data from government, tax exempt, and for-profit health plans in our study, we wanted to show how CalOptima pay compares against only government health plan pay data.
- We looked at the median market base salaries of 5 executives, 5 managers, and 5 staff positions to see how the government data compared against the blended data and CalOptima's midpoints. The charts below and on the next slide outline our findings:

Base Salary				
Title	CalOptima Base Salary Midpoint	Blended Peer Group P50	Government Peer Group P50	% Difference
Chief Financial Officer	$320,216	$397,000	$351,640	-11%
Chief Operating Officer	$320,216	$335,000	$284,380	-15%
Chief Medical Officer	$320,216	$380,000	$374,060	-2%
Chief Information Officer	$266,968	$299,000	$260,000	-13%
Chief Counsel	$266,968	$343,000	$293,800	-14%
			Average	**-11%**

Total Cash				
Title	CalOptima Total Cash Midpoint	Blended Peer Group P50	Government Peer Group P50	% Difference
Chief Financial Officer	$352,238	$520,000	$393,900	-24%
Chief Operating Officer	$352,238	$444,000	$318,500	-28%
Chief Medical Officer	$352,238	$453,000	$421,260	-7%
Chief Information Officer	$293,665	$370,000	$262,600	-29%
Chief Counsel	$293,665	$494,000	$382,200	-23%
			Average	**-22%**

Total Direct				
Title	CalOptima Total Direct Midpoint	Blended Peer Group P50	Government Peer Group P50	% Difference
Chief Financial Officer	$352,238	$663,000	$439,400	-34%
Chief Operating Officer	$352,238	$480,000	$352,300	-27%
Chief Medical Officer	$352,238	$619,000	$456,660	-26%
Chief Information Officer	$293,665	$392,000	$330,200	-16%
Chief Counsel	$293,665	$500,000	$442,500	-12%
			Average	**-23%**

- On average, the government peer group data is 11% lower than the blended peer group data for executive base salaries.
- On average, the government peer group data is 22% lower than the blended peer group data for executive total cash compensation.
- On average, the government peer group data is 23% lower than the blended peer group data for executive total direct compensation.

Executive Summary
Compensation Program

Title	CalOptima Base Salary Midpoint	Blended Peer Group P50	Government Peer Group P50	% Difference
Manager Accounting	$93,184	$120,000	$119,800	0%
Manager Communications	$93,184	$100,000	$95,000	-5%
Manager Customer Service	$93,184	$85,000	$83,500	-2%
Manager Facilities	$93,184	$89,000	$82,200	-8%
Manager Finance	$93,184	$117,000	$114,000	-3%
			Average	**-3%**

Title	CalOptima Base Salary Midpoint	Blended Peer Group P50	Government Peer Group P50	% Difference
Actuary	$107,328	$126,000	$110,000	-13%
Accountant Intermediate	$70,512	$73,000	$70,000	-4%
Accounting Clerk	$46,384	$42,000	$45,000	7%
Payroll Specialist	$53,352	$53,000	$52,000	-2%
Buyer Intermediate	$61,360	$69,000	$65,000	-6%
			Average	**-3%**

- On average, the government peer group data is 3% lower than the blended peer group data for manager and staff base salaries.
- While government health plans tend to have lower pay levels, it is important to consider organizational size and complexity when analyzing pay levels. Due to CalOptima's expansion of programs and members, which has resulted in increased complexity and more than doubling in size since 2014, we looked at data for labor markets for bigger organizations, including a blend of government, tax exempt, and for-profit health plans, comparable in size and revenue, in our analysis.
- With the increased complexity and size, CalOptima should expect to see a significant impact in salary for employees in management positions and above to account for growth and greater responsibilities.

Executive Summary
Benefits Program

- Health and Welfare Programs
  - Offering four medical plans allow employees more choice and flexibility
  - The health plans offered by CalOptima offer a high level of benefits
  - HMO plans have much lower employee contributions and slightly better cost-sharing than market
  - HDHP and PPO plans have average employee contributions and cost-sharing compared to market
  - Prescription drug, dental, vision, life, LTD, and STD benefits are competitive or above market
- Retirement Programs
  - Participants receive employer contributions in both the defined contribution (PARS) and a defined benefit plan (CalPERS)
- Vacation/Paid Time-Off Programs
  - Offers more time-off than the composite benchmark, but less than other public agencies

This analysis was based on composite benchmarks of organizations of similar size, geography, and industry

Executive Summary
Benefits Program

- CalOptima is above market from a total benefits program perspective
- Time-off programs are above market but less than other public agencies
- The strongest benefit is the CalPERS defined benefit plan, though CalOptima adopted one of the lowest benefit formulas as compared to other public agency peers

Market Competitiveness*	
Retirement Benefits	Above Market
Medical Benefits	Above Market
Dental Benefits	Above Market
Vision Benefits	At Market
Disability Benefits	At Market
Life Insurance Benefits	At Market
Time-Off Programs	Above Market
Total Benefits Program	**Above Market**

* This analysis was based on composite benchmarks of organizations of similar size, geography, and industry.

Executive Summary
Total Compensation

- By group, with compensation generally being below median and benefits being above median, average total compensation is as follows:
  - Executives and Directors are well below median
    - Driven primarily by aggressive incentive practices in peers
    - Compensation gap is not closed by above market benefits
  - Managers are moderately below median
    - Compensation gap is moderated based on above market benefits
  - Staff are positioned close to median
    - Compensation gap is made up due to highly competitive benefits

Recommendations

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Compensation Recommendations
Total Compensation Philosophy

The following are principles that can be used as the foundation of CalOptima's total compensation program:

- To reinforce the mission of the organization
- To achieve balance between the needs and concerns of CalOptima employees, and the communities it serves
- To attract and retain outstanding employees
- To motivate and reward outstanding performance
- To link compensation to consistent merit principles, including both individual and organizational performance
- To base decisions on appropriate comparability data provided by independent sources
- To ensure that compensation and benefits programs comply with all pertinent laws and regulations
- To maintain consistency and fairness, to the extent possible, without violating other principles
- To provide benefits in a manner that allows employees to participate in determining how best to meet their needs and those of their families

Compensation Recommendations
Total Rewards Competitive Positioning

- CalOptima wishes to recruit, retain, and motivate staff in order to accomplish organizational mission, vison, and strategic objectives. With this goal in mind, CalOptima intends to provide a total compensation program that is competitive with organizations that represent the competitive labor market for CalOptima's various staff positions.
- To achieve competitiveness, total compensation will be positioned at the:
  - 50th percentile for executives
  - 50th percentile for directors and managers
  - 50th percentile for most staff positions
  - Approximately the 62.5 percentile (between the 50th and 75th) for hard to fill staff positions, i.e. nursing, legal, and accounting staff.
- Base salaries, limited incentives and recognition and rewards, targeted at market median.
- Benefits targeted above market median.
- Pay for performance provides flexibility to position pay 10% to 20% above market for sustained outstanding performance.

Compensation Recommendations

Overall, CalOptima compensation is positioned below market, with the executives and directors most significantly lagging the market due to a combination of low salaries and low or no incentives. Our conceptual considerations are as follows:

- Base Salary
  - Implement CalOptima's compensation philosophy with market-based salary ranges, with market adjustments for those that are below market positioning and that have performed at a "meets expectations" level for a period of years.
  - With benefits above market, target base salary as follows:
    - 10% below 50th percentile total cash executives
    - 50th percentile total cash for directors and managers
    - 50th percentile total cash for most staff
    - For hard to recruit positions, we recommend positioning between the 50th and 75th percentile (62.5 percentile)

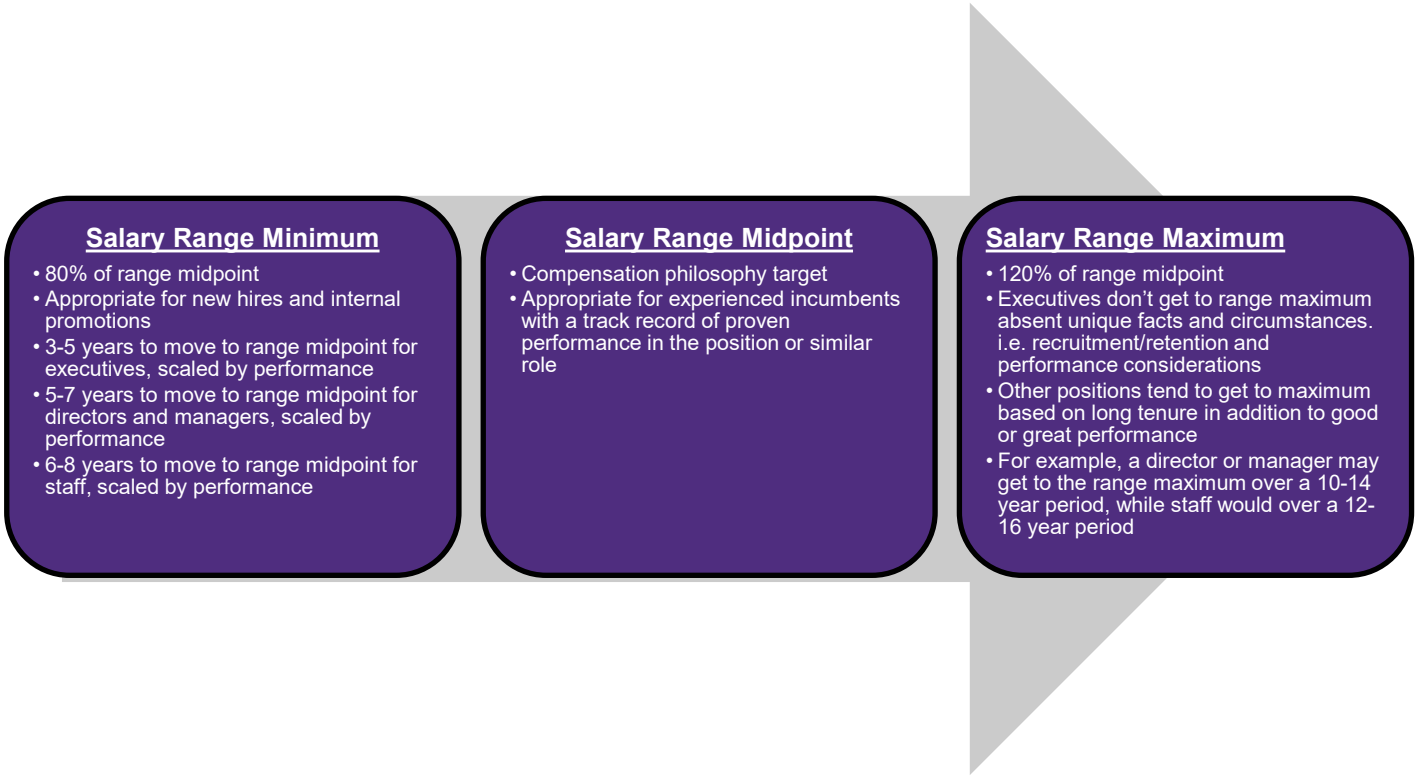
Compensation Recommendations

- Annual Incentive Compensation
  - Maintain existing annual incentive plan structure, with 10% target incentives, which would position target pay at the 50th percentile total cash
  - However, potentially add Directors and Managers to the annual incentive plan over the next two years

- Other Incentives
  - No additional incentives, for the time being, given the administrative difficulty on introducing higher incentives, either on an annual or long-term incentive basis

Compensation Recommendations
Base Salary Administration Guidelines

- The following is an example of competitive salary administration guidelines to help manage salaries around market-based compensation philosophy



Compensation Recommendations

- Adjustments for FY 2019-20:
  - Move employees who are below proposed salary range minimum to the minimum (as required by CalPERS reporting)
  - Move employees with a track record of proven performance in the same level or position at CalOptima to midpoint based on methodology identified on the previous slide

- Ongoing for FY 2020-21:
  - Increase the aggregate merit pool from 3% to 5%
  - Apply market adjustments per current policy if necessary

- ***Methodology will deal with internal equity and compression issues inherently within each job, and amongst like jobs***

Other Compensation Recommendations

- Upon implementation of 50th percentile total cash salary ranges, total compensation will still lag market for the executives and some directors
- We would suggest addressing a portion of this gap by implementing a non-qualified deferred compensation plan for executives and other select leadership positions, structured either as
  - A mid-term retention plan, whereby anywhere from 5% to 20% of salary is set aside per year, subject to a three to five year cliff vest (i.e., the dollars set aside are only earned and paid out to the extent the leader is employed by the organization at the end of the vesting period, or
  - Supplemental executive retirement plan, whereby a certain amount is set aside at the same value as the qualified retirement plan for those earnings above and beyond the qualified plan limits (i.e., restoration plan)
- The above strategy would still result in leadership pay being below market – but would assist in having incentives to retain key talent

Recommended Salary Structure

Grade Level	Minimum	Midpoint	Maximum
X	$ 347,000	$ 434,000	$ 521,000
W	$ 295,000	$ 369,000	$ 443,000
V	$ 251,000	$ 314,000	$ 377,000
U	$ 214,000	$ 267,000	$ 320,000
T	$ 182,000	$ 227,000	$ 272,000
S	$ 154,000	$ 193,000	$ 232,000
R	$ 144,000	$ 174,000	$ 204,000
Q	$ 130,000	$ 157,000	$ 184,000
P	$ 117,000	$ 141,000	$ 165,000
O	$ 105,000	$ 127,000	$ 149,000
N	$ 95,000	$ 114,000	$ 133,000
M	$ 85,000	$ 103,000	$ 121,000

Grade Level	Minimum	Midpoint	Maximum
L	$ 77,000	$ 93,000	$ 109,000
K	$ 70,000	$ 84,000	$ 98,000
J	$ 65,000	$ 78,000	$ 91,000
I	$ 61,000	$ 73,000	$ 85,000
H	$ 59,000	$ 68,000	$ 77,000
G	$ 55,000	$ 63,000	$ 71,000
F	$ 51,000	$ 59,000	$ 67,000
E	$ 48,000	$ 55,000	$ 62,000
D	$ 44,000	$ 51,000	$ 58,000
C	$ 41,000	$ 47,000	$ 53,000
B	$ 38,000	$ 44,000	$ 50,000
A	$ 36,000	$ 41,000	$ 46,000

*Please note that recommendation for CEO pay range is not included as part of this study

Benefits Recommendations
General Overview

- Annual Strategic Analysis
  - Develop a formalized annual review process to review the goals and strategies of CalOptima's benefits program
    - Develop broad strategies and goals for CalOptima's compensation and benefits programs
    - Develop the general framework of the programs and how they will support the needs of employees and the financial constraints
    - Determine the employee's value of the benefit offerings versus the cost and, if appropriate, shift resources to items that employees value
  - Prepare a written benefit program philosophy that can create guiding principles to make benefit program decisions such as plan design changes. (For example, employees should pay low medical premiums, but have higher cost sharing.)
- Financial Modeling and Projections
  - Analyze the relative costing information for each alternative to understand financial implications of the benefit program decisions
  - Analyze advantages and disadvantages of each alternative, including the financial implications, and document them
  - Prepare a cost/benefit analysis to assess the benefits as well as the employer and employee costs. (For example, reinstituting the employer HSA contributions can increase participant enrollment and save both the employee and employer money.)

Benefits Recommendations
Program Issues

Overall, CalOptima benefits are positioned above market. The benefits recommendations below would not significantly change CalOptima's position in the market.

- Medical/Health Insurance
  - CalOptima offers medical plans with above market benefit levels and high employer cost share. CalOptima should consider reviewing its benefit strategy in order to reduce total plan costs, such as
    - Plan designs changes to encourage in-network utilization
    - Promote participant consumerism and cost-effective decisions
- Prescription Drug Programs
  - Consider pharmacy cost-saving measures, such as:
    - Excluding certain drugs with lower cost alternatives
    - Encouraging participation in the mail-order program
    - Implementing step-therapy for certain high-cost drugs
- Life and Disability Insurance Programs
  - Consider increasing the basic life insurance maximum to $500,000 to give an increased benefit to highly paid employees
  - Consider a cost/benefit analysis to join the California Short-Term Disability Insurance
- Retirement Programs
  - Consider consolidating the 457(b) Plan and 401(a) PARS Plan to a single vendor in order to reduce administrative and investment fees that will benefit participants by increasing their investment returns

Appendix
Custom Peer Groups – Government Peer Group (like CalOptima)

Government Peer Organization	Industry	Total Revenues Most Recent Year (000,000)	Most Recent Year Total Assets (000,000)
Affinity Health Plan	Health-General & Financing	$1,418,105,612	$376,092,562
Boston Medical Center Health Plan	Health-General & Financing	$1,640,398,973	$429,520,379
CareOregon	Health-General & Financing	$971,484,613	$425,539,455
CareSource	Health-General & Financing	$6,531,587,542	$1,831,803,361
Commonwealth Care Alliance	Health-General & Financing	$809,417,329	$175,417,209
Community Health Choice	Health-General & Financing	$851,462,290	$239,892,454
Driscoll Childrens Health Plan	Health-General & Financing	$438,714,445	$83,473,281
ElderPlan Inc	Health-General & Financing	$904,056,324	$199,305,781
Inland Empire Health Plan*	Health-General & Financing	$4,302,922,597	$1,782,242,790
LA Care Health Plan	Health-General & Financing	$8,304,109,805	$459,986,900
Neighborhood Health Plan Inc	Health-General & Financing	$2,536,658,776	$456,299,895
Virginia Premier Health Plan	Health-General & Financing	$1,063,725,747	$386,298,189

CalOptima	$3,800,000,000	$1,800,000,000
Minimum	$438,714,445	$83,473,281
25th Percentile	$890,907,816	$229,745,786
Average	$2,481,053,671	$570,489,355
Median	$1,240,915,680	$405,918,822
75th Percentile	$2,978,224,731	$457,221,646
90th Percentile	$6,308,721,048	$1,650,017,201
Maximum	$8,304,109,805	$1,831,803,361

Appendix
Custom Peer Groups – NFP Peer Group

NFP Peer Organization	Industry	Total Revenues Most Recent Year (000,000)	Most Recent Year Total Assets (000,000)
Blue Cross Blue Shield	Health-General & Financing	$512,533,419	$650,271,510
Capital Health Plan Inc	Health-General & Financing	$939,178,501	$480,125,384
Care Wisconsin Health Plan	Health-General & Financing	$123,315,773	$34,840,468
Geisinger Health Plan	Health-General & Financing	$2,109,272,521	$535,769,375
Group Health Cooperative	Health-General & Financing	$416,836,322	$119,242,329
Harvard Pilgrim Health Care	Health-General & Financing	$1,979,581,176	$958,882,498
HealthFirst Health Plan	Health-General & Financing	$2,028,384,559	$652,104,450
Medica Health Plans	Health-General & Financing	$2,108,568,644	$896,765,075
Tufts Associated HMO	Health-General & Financing	$2,995,230	$1,126,552,016

.

CalOptima	$3,800,000,000	$1,800,000,000
Minimum	$2,995,230	$34,840,468
25th Percentile	$416,836,322	$480,125,384
Average	$1,135,629,572	$606,061,456
Median	$939,178,501	$650,271,510
75th Percentile	$2,028,384,559	$896,765,075
90th Percentile	$2,108,709,419	$992,416,402
Maximum	$2,109,272,521	$1,126,552,016

Appendix
Custom Peer Groups – For-Profit Peer Group

For-Profit Peer Organization	Industry	Total Revenues Most Recent Year (000,000)	Most Recent Year Total Assets (000,000)
CNO Financial Group Inc	Life & Health Insurance	$3,992,400,000	$31,975,200,000
Envision Healthcare Corp	Health Care Services	$3,696,000,000	$16,708,900,000
Health Net Inc	Managed Health Care	$16,243,587,000	$6,397,646,000
Healthequity Inc	Managed Health Care	$178,370,000	$279,136,000
Magellan Health Inc	Managed Health Care	$4,836,884,000	$2,443,687,000
Mednax Inc	Health Care Services	$3,183,159,000	$5,339,400,000
Stancorp Financial Group Inc	Life & Health Insurance	$2,902,400,000	$23,174,400,000
Team Health Holdings Inc	Health Care Services	$3,597,247,000	$4,060,842,000
Triple-S Management Corp	Managed Health Care	$2,984,806,000	$2,218,999,000
Universal American Corp	Managed Health Care	$1,379,646,000	$785,583,000
Wellcare Health Plans Inc	Managed Health Care	$14,237,100,000	$6,152,800,000

.

CalOptima	$3,800,000,000	$1,800,000,000
Minimum	$178,370,000	$279,136,000
25th Percentile	$2,943,603,000	$2,331,343,000
Average	$5,202,872,636	$9,048,781,182
Median	$3,597,247,000	$5,339,400,000
75th Percentile	$4,414,642,000	$11,553,273,000
90th Percentile	$14,237,100,000	$23,174,400,000
Maximum	$16,243,587,000	$31,975,200,000

Disclosure

Our review was limited to the documents provided by CalOptima and did not include the underlying plan documents and summary plan descriptions. Our findings were based on the documents provided including employment agreements, policies, and summaries.

Our conclusions relate only to our understanding of the facts provided by CalOptima which are stated in this analysis. We have not independently verified these facts, and if any of these facts prove to be in error, the conclusions reached in this memorandum do not apply. Our conclusions are based on the Department of Labor, Internal Revenue Code, regulations and interpretations thereunder in their form as of the date of this analysis. We are under no obligation to update our conclusions for future changes in these authorities. Our conclusions are based on our interpretation of the tax law. Another party, such as the Internal Revenue Service or a court, hearing the same facts may reach different conclusions.

In accordance with applicable professional regulations, please understand that, unless expressly stated otherwise, any written advice contained in, forwarded with, or attached to this document is not intended or written by Grant Thornton LLP to be used, and cannot be used, by any person for the purpose of avoiding any penalties that may be imposed under the Internal Revenue Code.

Policy:	GA.8057
Title:	**Compensation Program**
Department:	CalOptima Administrative
Section:	Human Resources
Interim CEO Approval:	*/s/ Richard Sanchez 06/10/2020*
Effective Date:	05/01/2014
Revised Date:	06/04/2020
Applicable to:	☐ Medi-Cal ☐ OneCare ☐ OneCare Connect ☐ PACE ☒ Administrative

I. PURPOSE

This policy establishes a compensation program for CalOptima job classifications within clearly defined guidelines that promote consistent, competitive and equitable pay practices.

II. POLICY

A. CalOptima's compensation program is intended to:

1. Provide fair compensation based on organization and individual performance;
2. Attract, retain, and motivate employees;
3. Balance internal equity and market competitiveness to recruit and retain qualified employees; and
4. Be mindful of CalOptima's status as a public agency.

B. The Chief Executive Officer (CEO), in conjunction with the Executive Director of Human Resources, is directed to administer the compensation program consistent with the attached Compensation Administration Guidelines, which defines the principles upon which CalOptima's compensation practices will be managed, procedural aspects of how the compensation procedures will be administered, and how the overall compensation administration function will respond to changing market conditions and business demands. Some of these guidelines include, but are not limited to:

1. Establishing pay rates based on the market 50th percentile.
2. Determining appropriate pay rates within the pay range for a position by assessing an employee's or applicant's knowledge, skills, experience, and the pay rates currently being paid to similarly situated incumbents. Employees may be paid anywhere within the pay range based on proficiency levels. The following criteria shall be considered:

Minimum (Min)	The rate paid to an individual possessing the minimum job qualifications & meeting minimum job performance expectations

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Midpoint (Mid) aka: 50th percentile	The rate paid to individuals that are fully proficient in all aspects of the job's requirements & performance expectations
Maximum (Max)	The maximum rate paid to individuals who possess qualifications significantly above market norms & consistently deliver superior performance

3. All new hires and employees should have a pay rate equal to or greater than the pay range minimum, unless the minimum job requirements are not met, then a training rate equal to ten percent (10%) below the salary grade minimum may be used for six (6) months.

4. Base pay for all employees shall be capped at the pay range maximum, and once an employee reaches the base pay maximum, the employee will not be eligible for future base pay increases. However, in lieu of future base pay increases, these employees may be eligible for merit pay delivered as a lump sum bonus provided that the employee's performance warrants this additional compensation.

C. The CEO is authorized and directed to take all steps necessary and proper to implement the CalOptima compensation program and the Compensation Administration Guidelines not inconsistent therewith.

III. PROCEDURE

Not Applicable

IV. ATTACHMENT(S)

A. Compensation Administration Guidelines

V. REFERENCE(S)

Not Applicable

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

Date	Meeting
05/01/2014	Regular Meeting of the CalOptima Board of Directors
08/07/2014	Regular Meeting of the CalOptima Board of Directors
11/06/2014	Regular Meeting of the CalOptima Board of Directors
12/04/2014	Regular Meeting of the CalOptima Board of Directors
03/05/2015	Regular Meeting of the CalOptima Board of Directors
06/04/2015	Regular Meeting of the CalOptima Board of Directors
06/07/2018	Regular Meeting of the CalOptima Board of Directors
06/04/2020	Regular Meeting of the CalOptima Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	05/01/2014	GA.8057	Compensation Program and Salary Schedule	Administrative
Revised	08/07/2014	GA.8057	Compensation Program and Salary Schedule	Administrative
Revised	11/06/2014	GA.8057	Compensation Program and Salary Schedule	Administrative
Revised	12/04/2014	GA.8057	Compensation Program and Salary Schedule	Administrative
Revised	06/04/2015	GA.8057	Compensation Program	Administrative
Revised	06/07/2018	GA.8057	Compensation Program	Administrative
Revised	06/04/2020	GA.8057	Compensation Program	Administrative

IX. GLOSSARY

Not Applicable

Compensation Administration Guidelines

Revised June 04, 2020

Implemented March 29, 2020

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Contents

Pay Administration Guidelines

Common pay administration guidelines for CalOptima are detailed in this section. These Guidelines help maintain the integrity of the base pay program by introducing a common set of standards and assist managers in ongoing compensation program administration.

In addition, note the following administration of the Guidelines:

- Chief Executive Officer (CEO) compensation will be established by the Board of Directors.
- Chief and Executive Director compensation will be established by the CEO within the Guidelines.
- The Board will be informed of all Chief and Executive Director hires and compensation changes.

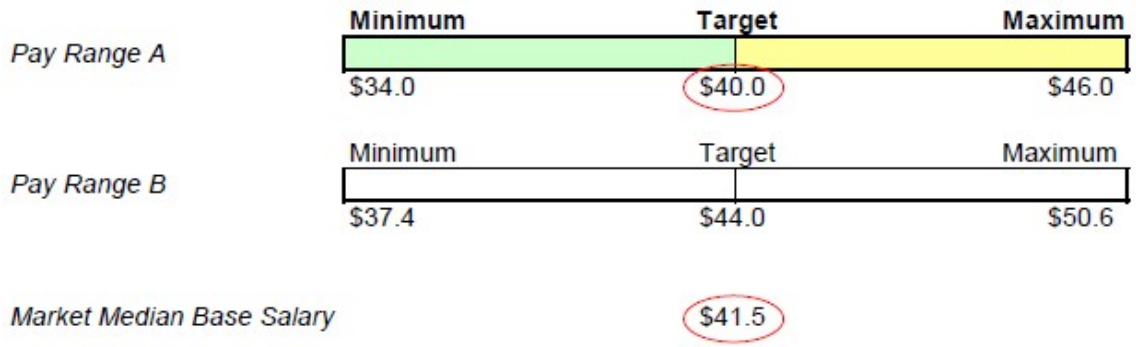
Proposed Pay Administration Guidelines

Pay ranges and pay levels	Pay range target Range minimums and maximums Pay above range maximums Pay range thirds Pay range halves Compa-ratio
Periodic pay adjustments/increases	New hire/Rehire Promotion Lateral Transfer Demotion Temporary Assignment Secondary job Job Re-evaluation Appeal Process Register/Certified Status Base pay program maintenance Salary structure adjustment Annual competitive assessment Market sensitive jobs
Annual pay adjustments/increases	Market Adjustment Merit pay Step increase
Special one-time pay considerations	Recruitment incentive

Pay Ranges and Pay Levels

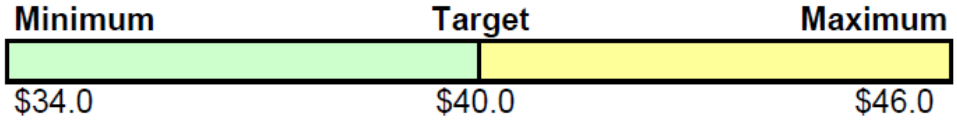
Range Target: internal "going market rate" for the job (50th percentile); represents the rate paid to individuals that are fully proficient in all aspects of the job's requirements and performance expectations.

- For benchmark jobs, the pay range (i.e. pay grade) is determined based on the comparability of values between market median base pay rates and the pay range targets.



Range Target $40.0 is Closest to Market Median of $41.5; job is assigned to Pay Range A

- For non-benchmark jobs, the pay range is determined based on comparability of the job to benchmark jobs within the same job family or other internal positions in terms of knowledge, skills, complexity and organizational impact.



Range Minimum: represents the rate paid to individuals possessing the minimum job qualifications and meeting minimum job performance expectations.

- All employees should have a pay rate equal to or greater than the pay range minimum.
- If the minimum job requirements are not met, a training rate equal to ten percent (10%) below the salary grade minimum may be used for six (6) months while a new incumbent is learning the skills to become proficient in the new role.

Range Maximum: represents the maximum rate paid to individuals who possess qualifications significantly above market norms and consistently deliver superior performance.

- Base pay growth is capped at the pay range maximum.

Pay Above Range Maximum: Employees are not paid above the range maximum.

- Employees whose current pay becomes above the pay range maximum will have their base pay frozen and will not be eligible for future base pay increases until such time as their base pay falls below the pay range maximum.

- In lieu of future base pay increases, these employees may be eligible for merit pay delivered as a lump sum bonus providing their performance warrants this additional compensation.

- As the pay structures and pay ranges move every twelve (12) – thirty-six (36) months or as necessary, the employees paid above the pay range maximum will eventually be paid below the pay range maximum and will then be eligible to receive base pay increases, as appropriate.

Pay Range: Employees may be paid anywhere within the open pay range; the pay range is divided into equal quartiles to assist in achieving competitive, equitable, and appropriate pay levels

- Developing Area – Below market pay; this area is used for employees possessing minimum job requirements and/or for those having significant learning curves to become fully proficient in the job's duties, responsibilities and performance expectations.

- Proficient/Fully Proficient Area – Market competitive pay; this area is used for employees possessing preferred job requirements and consistently demonstrate one hundred percent (100%) proficiency in all aspects of the job's duties, responsibilities and performance expectations.

- Expert Area – Above market pay; this area is used for employees possessing unique knowledge, skills, or abilities that far surpass the market's typical requirements and consistently demonstrate superior performance in all aspects of the job's duties, responsibilities, and performance expectations.

Compa-Ratio: In addition to pay range quartiles, this is a metric also used to communicate pay competitiveness.

- Compa-Ratio: A compa-ratio is calculated by taking the employee's base pay divided by his/her pay range target.

- Compa-Ratio of 100%: This ratio indicates the employee's base pay equals the pay range target, or the market rate.

  - Compa-Ratio <100%: This ratio indicates the employee's base pay is less than the pay range target.

  - Compa-Ratio >100%: This ratio indicates the employee's base pay is greater than the pay range target.

Illustrative Range Shown Below:

	Minimum	Target	Maximum
Compa-Ratio RNs	87.5%	100.0%	117.0%
Compa-Ratio Non-Exempt	88.0%	100.0%	117.0%
Compa-Ratio Exempt	83.0%	100.0%	118.0%

Note: *Range minimums and maximums will be based on the developed salary range spreads.*

Annual Pay Adjustments/Increases

Market Adjustment: A market adjustment is an increase or decrease to pay range grades based on market pay practices.

- A market adjustment may result in base pay increases for full-time, part-time, and some as-needed and limited term staff paid at or below the pay range target (there is no base pay increase between target and maximum for non-market sensitive jobs unless compression exists at the target).
    - For some market-sensitive jobs, a market adjustment may also be granted to full-time, part-time, and some as-needed and limited term staff paid above the pay range target but below the pay range maximum to maintain competitiveness and minimize pay compression.
- A market adjustment may result in a base pay increase to some staff to ensure employees are paid a base pay rate at least equal to the new pay range minimum.
    - If a market adjustment is made, employees paid below the new range minimum receive an increase to their base pay to ensure it is at least equal to the pay range minimum before any merit pay is awarded (cap at 10%).
- The appropriateness of a market adjustment is determined based on:
    1. A competitive assessment of the pay range target versus market base pay practices;
    2. Market trends and practices relative to average base pay and pay range increases; and
    3. Current recruiting and retention issues.
- Market adjustments are made prior to determining merit pay.
- Newly hired employees will be eligible for any market adjustments granted at the annual pay increase date if the employee is paid at or below the pay range target.

Base Pay Adjustment: All employees who achieve a satisfactory level of performance will be eligible for a merit pay adjustment.

- Merit Pay: Merit pay is variable pay that typically affects employees' base pay; it recognizes employees' job proficiency and performance of job duties.
    - Merit pay is applicable to full-time and part-time employees paid below, at, or above the pay range target; Per diem employees are not eligible for merit pay.
    - To be eligible for merit pay, the employee must have started work on or before March 31 to be eligible for a merit increase in July of the same year and have successfully completed the introductory period [three (3) months for transfers and new hires] prior to the annual pay adjustment date.
    - Merit pay will typically be an increase to base pay; however, it may also be delivered

as a one-time lump sum bonus for individuals paid above the pay range maximum.

- The budgeted amount for merit pay, if any, is based on 1) the organization's financial status; 2) market trends relative to average base pay increases; 3) competitiveness of current base pay practices; and, 4) recruiting and retention issues.

Merit Pay – Staff Paid At and Above Pay Range Target

- The combination of an individual's performance rating, the position of his/her pay within the pay range, the number of months he/she has been working, and the salary earned during those months determines the individual's merit pay opportunity.
  - Merit pay is typically calculated as a percent of base pay in effect on March 31, prorated to reflect the number of months an employee worked during the twelve (12)-month period starting from the first pay period in the fiscal year and ending with the last pay period of that same fiscal year.
  - Managers have the discretion to determine the actual increase amount within the published Guidelines; the appropriate merit pay amount will reflect the manager's internal equity, pay competitiveness, and performance recognition objectives.
  - Adjustments to employees' base pay are capped at the pay range maximums; therefore, some employees may receive a portion of their merit pay as a base pay increase up to the pay range maximum and also receive a lump sum amount for the remaining portion of the merit pay. Employees paid over the pay range maximum may be eligible to receive merit pay as a lump sum payment paid out in two (2) incremental amounts- the first half when merit pay is normally distributed; and the second half six (6) months later.
  - Merit pay may be held altogether or delayed for ninety (90) days if employees do not achieve a satisfactory level of performance or if a written warning or suspension/final written warning is active in their record.
  - Merit pay is typically awarded once a year at a specific time.
  - Full-time and part-time employees may receive both a market adjustment and a merit pay adjustment at the same time.
  - Executive Directors and Chief's must approve merit pay increases for all areas for which they are responsible before submitting to HR.
  - HR has final approval of all merit increases.

A Merit Pay Grid similar to the one shown below [assumes a three percent (3%) merit increase budget] is often used to provide managers with a guideline as to what merit pay increase may be appropriate based upon performance and to reflect:**

1. The organization's financial status;
2. Market trends relative to average base pay increases;
3. Competitiveness of current base practices; and

4. Recruiting and retention issues.

	Pay Range Position				
Performance Rating	1st Quartile	2nd Quartile	3rd Quartile	4th Quartile	Above Max
Highly Effective	6% - 5%	5% - 4%	4% - 3%	3% - 2%	3% - 2%
Effective	5% - 4%	4% - 3%	3% - 2%	3% - 2%	0%
Needs Improvement	0%	0%	0%	0%	0%

Above Max = Lump Sum Bonus

***The Merit Pay Grid is a sample only. Actual merit increase percentages will depend upon the salary distribution across the salary structure.*

- Employees who do not achieve a satisfactory level of performance at the time of their annual pay increase will not receive any type of pay increase – market adjustment, or merit pay.

- The increase may be withheld altogether or delayed ninety (90) days until the written performance improvement plan is complete and performance is judged to be acceptable by the manager; the pay increase will be effective at the time performance is judged to be acceptable (beginning of applicable pay period) and will not be retroactive; the manager is responsible for informing the employee in this situation and is responsible for notifying HR to initiate the increase.

- Employees on any type of leave of absence who are eligible for a market adjustment, and/or merit pay, may receive these adjustments upon their return to active status with a completed performance appraisal that is competent or above.

Special One-time Pay Considerations

Recruitment Incentive

- Recruitment incentives up to fifteen percent (15%) of an employee's base pay may be provided on an exception basis to entice an employee to join CalOptima.
    - Recruitment incentives require the approval of the CEO.
    - Board approval is required for recruitment incentives offered to Executive Director and above positions.

Incentives are provided with a "pay-back" provision if the employee terminates within twenty four (24) months of hire.

New Hires/Rehires

- A new hire's pay level corresponds to the appropriate pay range quartile and typically should not exceed the pay range target. Offers above the pay range target require the approval of the Executive Director of Human Resources and the CEO, when necessary.

- Factors to be considered in determining an appropriate pay level for a new hire include:

    - Job-related experience: What is the estimated learning curve given the individual's prior work experience? How many years of experience does the individual have in the same or equivalent classification?

    - Market conditions: What is the going rate of pay in the external market for the individual's skills and knowledge?

    - Internal equity: Is the proposed pay level lower, higher or in line with the pay levels of current employees having comparable skill and experience levels?

- At hire, external service is typically valued comparable to internal service.

    - For example, an RN having three (3) years of prior job experience is viewed comparably to an RN having three (3) years of job experience at CalOptima.

- Internal equity (how this position and compensation compares relative to existing employees) must be considered when making hiring decisions.

Process for Determining a New Hire Starting Pay Rate

HR determines applicable pay rate:

- Starting pay rate is at or near the minimum of the pay range for a candidate who only meets the job's minimum qualifications.

- Starting pay rate cannot be below the minimum of the pay range (unless it is viewed as a training rate).

- Determine appropriate pay rate by assessing candidate's knowledge, skills, and experience, as well as pay rates currently being paid to similarly situated incumbents.

- Candidates with superior knowledge, skills, and experience can be paid above the pay range midpoint. Starting pay rates above the pay range midpoint must have approval of the Executive Director of Human Resources and CEO, when necessary.

- There are certain positions that will usually be placed near the salary grade minimum (all entry level service and clerical).

- Pay rates for all positions are reviewed with the Compensation Unit before an offer is made. The Compensation Unit will review internal equity across the system to ensure that the appropriate offer is made.

- Rehires to the same classification should be paid at least the same amount they earned prior to termination, with adjustments and/or credit for recent additional career experience or education earned while away from CalOptima.

- The above policy applies to the current organization structure.
- Additional positions at the level of Chief or Executive Director require Board approval.

Promotion

An employee receives a promotion when the employee applies for and is selected for a job with a higher pay range target.

- An employee will receive a promotional increase to at least the pay range minimum of the new pay range.
- The amount of a promotional increase will be determined based on the incumbent's qualifications, performance, and internal pay practices. The typical promotional increase for a promotion without external competition is up to five percent (5%) of the employee's base pay per one (1) pay grade increase.
- Typically, the promotional increase should not exceed the pay range target.
- When an employee moves from non-exempt to exempt, the loss of overtime pay will be considered. However, the realization that overtime is not guaranteed must also be considered.
- The pay rate adjustment will be effective on the first day of the pay period in which the job change takes effect.
- Employees who are promoted after March 31, but prior to receiving their merit increase, will have their merit increase, if any, included in the base pay used to calculate their promotional pay. If the employee's performance evaluation rating and therefore merit increase amount is not known at the time the promotional pay is being calculated, a merit increase equivalent to "Fully Meets Expectations" will be included in the base pay used to calculate their promotional pay.
- The next merit pay adjustment after a promotion may be pro-rated based on the amount of time the employee has spent in the job.

Lateral Transfer

It is considered a lateral transfer if an employee moves to a job having the same pay range target.

- Lateral job changes will not typically result in a base pay increase or adjustment unless otherwise approved by the Executive Director of Human Resources.
- Employees who are laterally transferred after March 31, but prior to receiving their merit increase, will typically have their merit pay calculated as a percent of their base pay in effect on March 31.

Demotion

An employee is classified as having been demoted if the employee moves to a job with a lower pay range target.

- The pay of an employee demoted due to an organizational restructure, will not be decreased unless the employee is above the maximum on the new pay range; if so, the employee will be reduced to the maximum of the new pay range.

- For an involuntary demotion, due to performance, or for a voluntary demotion, the pay grade of the demoted employee will be assigned to the pay grade of the employee's new classification. The employee's base pay will typically be reduced up to five percent (5%) for each pay grade demoted.

- The pay rate adjustment will be effective on the first day of the pay period in which the job change takes effect.

- Future merit increases and market adjustments will not be affected by a demotion unless competent performance is not achieved.

- Employees who are demoted after March 31, but prior to receiving their merit increase, will typically have their merit pay calculated as a percent of their base pay in effect on March 31.

Temporary Assignment

An employee who is asked to assume a full-time temporary assignment in a job having a higher pay range target is eligible for a temporary base pay increase. The employee must assume some or all of the responsibilities of the new job to qualify for a temporary assignment increase.

- The employee's base pay rate prior to the assignment will be maintained and the higher temporary assignment rate will be added as a secondary job title and pay rate.

- This increased secondary pay rate is eliminated when the temporary assignment ends.

- The amount of the temporary assignment increase should be consistent with the promotion policy.

Training/Transition Overlap

In order to provide for a transition and/or training period, CalOptima may fill a regular position with a replacement in advance of the separation of a terminating employee. For the transition and/or training period, two employees may fill the same budgeted position for up to thirty (30) calendar days during the period of overlap. The immediate supervisor will determine which employee will be designated for decision-making and regulatory reporting purposes, if applicable.

Job Re-Evaluations

Job re-evaluations will be reviewed in the following priority order:

1. New Positions.

2. Change of thirty-five percent (35%) or more of duties [any change in responsibilities less than thirty-five percent (35%) will not be considered].

    - Enhancements must require a higher level of skills, abilities, scope of authority, autonomy, and/or education to qualify for a re-classification.

    - Additional duties that do not require the above will not be considered for reclassification.

    - All requests for job re-classification must be documented, signed by the department manager and submitted to the Compensation Unit.

    - In the case of management positions being re-classified, the appropriate Chief must sign the documentation.

    - The request must include the incumbent's current job description and revised job description with enhancements highlighted.

    - The request must also include justification that the re-classification supports a business need.

If the job is determined to be a priority, the Compensation Unit will analyze the job according to:

1. The job's scope against other jobs in the same discipline.

2. Available market data.

3. Appropriate title identification. The Compensation Unit will determine if the title fits within the hierarchy; if not, a benchmark title will be recommended.

4. Job family.

5. Fair Labor Standards Act (FLSA) status.

6. Appropriate pay grade – the job will be fit into one (1) of the pay grades that currently exists. No new pay grades created.

7. A pay rate will be determined.

8. A recommendation will be made to the Executive Director of Human Resources for approval, and the decision will be communicated to the appropriate manager.

If a job is reassigned to a higher grade, the change will be effective on the first day of the pay period following the evaluation. The pay increase is not retroactive to any earlier date. The manager will be informed of the decision to move the job to a higher pay grade by the Compensation Unit. The amount of the pay increase should follow the guidelines in the Promotion section. If the upgrade and a pay change occur less than six (6) months before the annual pay increase date, the employee's next merit pay adjustment may be pro-rated.

If the job is not reassigned to a higher pay grade, the manager will be notified. If dissatisfied with the decision, the manager may file an appeal with the Executive Director of Human Resources.

If a job is reassigned to a lower pay grade as a result of a job re-evaluation due to available market data, without a change in job responsibilities, the involuntary demotion due to organizational restructuring protocol will be followed.

If a job is reassigned to a lower pay grade due to a job evaluation and change in job responsibilities, the voluntary demotion protocol will be followed.

Job evaluations and re-evaluations will occur throughout the year; all priority jobs will be evaluated within one (1) month of the request.

If a job is not a priority or does not meet the guidelines, the manager will be notified.

Base Pay Program Maintenance

Salary Structure Adjustment

- The salary structure should be reviewed on a regular basis either annually or every other year to continue to reflect market competitiveness.
- The salary structure updates are designed to relieve any upward pressure on range minimums, midpoints and maximums that may impede the ability to attract, motivate, and retain the workforce.
- The salary structure is dynamic; it needs to be revised at regular intervals based upon market conditions to maintain market competitiveness. The goal is to keep the structure's market rates on track with market data.
- Market adjustments will be applied to the salary schedule as needed at least every two (2) years, using surveyed salary structure adjustment percentages.
- The salary structure adjustment approval process includes:
    - The Executive Director of Human Resources makes a recommendation to the CEO for approval.
    - CEO takes the recommendation to the Board for final approval.

Annual Competitive Assessment

- On a regular basis either annually or every other year, HR will identify the current competitiveness of CalOptima's pay practices by comparing: 1) current pay levels to market practices; 2) current pay levels to pay range targets; and, 3) current pay range targets to market practices.
    - CalOptima will on a regular basis either annually or every other year spot check benchmark jobs to determine market fluctuations in benchmark jobs' pay rates.
    - Based on market findings, the pay grade and ranges will be updated.
    - Any jobs in which reasonable benchmark data is not available can be slotted into the salary structure based on internal equity considerations.
- The results of these analyses, along with CalOptima's current financial performance and economic situation, will determine the appropriate market adjustments (i.e., pay range adjustments) and merit pay budgets.
- The following criteria is typically used to determine which jobs to market price each year:
    - Review job-level turnover statistics for jobs with above-average separation rates to identify jobs with potential retention issues.
    - Review the time-to-fill metrics for jobs requiring above-average recruiting efforts and

expenses to identify jobs with potential recruiting issues.

- Review the applicant tracking reports (if available) for jobs with a high level of initial/ subsequent offer rejections to identify additional potential recruiting issues.
- Review jobs with pay-to-pay range target compa-ratios in excess of 110% or below 90%.
- Review jobs with market-to-pay range target compa-ratios in excess of 110% or below 90%.
- Review all market-sensitive jobs and those on the "watch list."
- Review top ten (10) highest populated jobs on an annual basis.
- Jobs are ranked by degree of severity for each of the preceding criteria; the jobs that are most frequently identified across all criteria are typically market priced.
- It is recommended that at least two (2) jobs be selected from every pay range.

Market Adjustments (Structure and Pay Range Adjustments): Market adjustments to specific pay ranges or the entire pay structure may be made on an annual or as needed basis to reflect current competitiveness or market trends.

- On a regular basis either annually or every other year, the pay range targets are compared to the external market base pay practices and necessary adjustments are made to ensure alignment including job grade changes and range rate adjustments.
- Employees falling below the range minimum of the adjusted structures are typically brought to the pay range minimum, assuming the employee has a satisfactory level of performance; any pay compression resulting from structure adjustments should be addressed as part of the annual pay increase process.
    - Adjustments to pay range minimums occur prior to merit pay calculations.

Process for Making Market Adjustments

- HR performs, on a regular basis either annually or every other year, a review of compensation surveys to calculate the average market adjustment to pay structures; HR also analyzes the competitiveness of the current pay range targets to market practices for benchmarked jobs.
- HR reviews CalOptima's financial operating conditions and quantifies any recruiting/ retention issues.
- HR determines if an adjustment is appropriate (minor variations in the market may be recognized in the following year) and recommends the amount.
- HR multiplies the current pay range target of each grade by the necessary adjustment percentage; then HR recalculates the pay range minimum and maximum based on the existing structure design (i.e., pay range minimums = 80% of the new pay range target; pay range maximums = 120% of the new pay range target, etc.).

- HR identifies the cost implications for the market adjustment by identifying the difference between 1) current pay rates and new pay range minimums, and, 2) current pay rates.

- The market adjustment approval process will work as follows:

    - The Executive Director of Human Resources recommends an adjustment to the CEO for approval.

    - If the CEO agrees, the CEO will seek Board approval, unless the market adjustment is within the approved pay range for the classification as designated in the Board-approved salary schedule. In such case(s), the CEO may approve the market adjustment and inform the Board of such change(s).

Market-Sensitive Jobs: Market sensitive jobs are those for which market conditions make recruiting and retention challenging.

- Premium pay is built into the pay range targets for these jobs.

    - Prospectively, the pay range and grade selected for these jobs will reflect the desired market target rate (i.e., 60th or 75th percentile of base pay practices) based on business need.

    - The desired market target rate is established on a job-by-job basis to reflect specific market conditions.

- Criteria used to determine if a job is classified as market-sensitive typically includes two (2) or more of the following:

    - Time to fill the position – statistics will suggest the average amount of time required to fill a requisition for a market-sensitive position will be significantly higher than the historical norm for this position or similar positions.

    - Job offer rejections – statistics will illustrate an increase in the number of employment offers rejected due to low starting rates.

    - Turnover – statistics will suggest a higher than typical amount of turnover for the position within the last three (3) to six (6) months; turnover for the job will be compared to historical results for the same job and to other similarly-situated jobs.

    - Market Changes – market-sensitive jobs may experience an excessively large increase in competitive pay rates over the previous year's results; specifically, jobs considered to be market-sensitive may have:

        - a year-to-year increase significantly greater than the average year-to-year increase for other jobs analyzed,

        - a competitive market rate significantly higher [approximately ten percent (10%)] than its current pay range target, or

        - a competitive market rate with significantly higher pay practices [approximately ten percent (10%)] in the labor market than the average of current internal pay practices.

- When a job is classified as market-sensitive, typically some form of adjustment is made to employees' base pay rates and is typically referred to as a market adjustment and the pay increase policies noted under the market adjustment section apply.

- Jobs classified as market-sensitive are reviewed annually to determine if this status still applies.

    - Once a job is classified as market-sensitive, it typically remains as such until the recruiting and retention challenges subside and/or the market pay rates adjust themselves – typically not less than one (1) year.

    - When a job is no longer considered market-sensitive, the job's pay range and grade is reassigned to reflect a market median base pay rate target; no changes are typically made to the employees' base pay rates at this time.

- Throughout the year, jobs that are not yet considered market sensitive, but are showing signs of becoming so are placed on a "watch list" and monitored.

If necessary, these jobs will be moved to the market-sensitive category and handled accordingly.

GOVERNMENT CODE - GOV

TITLE 5. LOCAL AGENCIES [50001 - 57607] *(Title 5 added by Stats. 1949, Ch. 81.)*
DIVISION 2. CITIES, COUNTIES, AND OTHER AGENCIES [53000 - 55821] *(Division 2 added by Stats. 1949, Ch. 81.)*
PART 1. POWERS AND DUTIES COMMON TO CITIES, COUNTIES, AND OTHER AGENCIES [53000 - 54999.7] *(Part 1 added by Stats. 1949, Ch. 81.)*

CHAPTER 9. Meetings [54950 - 54963] *(Chapter 9 added by Stats. 1953, Ch. 1588.)*

54953. (a) All meetings of the legislative body of a local agency shall be open and public, and all persons shall be permitted to attend any meeting of the legislative body of a local agency, except as otherwise provided in this chapter.

(b) (1) Notwithstanding any other provision of law, the legislative body of a local agency may use teleconferencing for the benefit of the public and the legislative body of a local agency in connection with any meeting or proceeding authorized by law. The teleconferenced meeting or proceeding shall comply with all otherwise applicable requirements of this chapter and all otherwise applicable provisions of law relating to a specific type of meeting or proceeding.

(2) Teleconferencing, as authorized by this section, may be used for all purposes in connection with any meeting within the subject matter jurisdiction of the legislative body. All votes taken during a teleconferenced meeting shall be by rollcall.

(3) If the legislative body of a local agency elects to use teleconferencing, it shall post agendas at all teleconference locations and conduct teleconference meetings in a manner that protects the statutory and constitutional rights of the parties or the public appearing before the legislative body of a local agency. Each teleconference location shall be identified in the notice and agenda of the meeting or proceeding, and each teleconference location shall be accessible to the public. During the teleconference, at least a quorum of the members of the legislative body shall participate from locations within the boundaries of the territory over which the local agency exercises jurisdiction, except as provided in subdivisions (d) and (e). The agenda shall provide an opportunity for members of the public to address the legislative body directly pursuant to Section 54954.3 at each teleconference location.

(4) For the purposes of this section, “teleconference” means a meeting of a legislative body, the members of which are in different locations, connected by electronic means, through either audio or video, or both. Nothing in this section shall prohibit a local agency from providing the public with additional teleconference locations.

(c) (1) No legislative body shall take action by secret ballot, whether preliminary or final.

(2) The legislative body of a local agency shall publicly report any action taken and the vote or abstention on that action of each member present for the action.

(3) Prior to taking final action, the legislative body shall orally report a summary of a recommendation for a final action on the salaries, salary schedules, or compensation paid in the form of fringe benefits of a local agency executive, as defined in subdivision (d) of Section 3511.1, during the open meeting in which the final action is to be taken. This paragraph shall not affect the public’s right under the California Public Records Act (Chapter 3.5 (commencing with Section 6250) of Division 7 of Title 1) to inspect or copy records created or received in the process of developing the recommendation.

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(d) (1) Notwithstanding the provisions relating to a quorum in paragraph (3) of subdivision (b), if a health authority conducts a teleconference meeting, members who are outside the jurisdiction of the authority may be counted toward the establishment of a quorum when participating in the teleconference if at least 50 percent of the number of members that would establish a quorum are present within the boundaries of the territory over which the authority exercises jurisdiction, and the health authority provides a teleconference number, and associated access codes, if any, that allows any person to call in to participate in the meeting and the number and access codes are identified in the notice and agenda of the meeting.

(2) Nothing in this subdivision shall be construed as discouraging health authority members from regularly meeting at a common physical site within the jurisdiction of the authority or from using teleconference locations within or near the jurisdiction of the authority. A teleconference meeting for which a quorum is established pursuant to this subdivision shall be subject to all other requirements of this section.

(3) For purposes of this subdivision, a health authority means any entity created pursuant to Sections 14018.7, 14087.31, 14087.35, 14087.36, 14087.38, and 14087.9605 of the Welfare and Institutions Code, any joint powers authority created pursuant to Article 1 (commencing with Section 6500) of Chapter 5 of Division 7 for the purpose of contracting pursuant to Section 14087.3 of the Welfare and Institutions Code, and any advisory committee to a county-sponsored health plan licensed pursuant to Chapter 2.2 (commencing with Section 1340) of Division 2 of the Health and Safety Code if the advisory committee has 12 or more members.

(e) (1) A local agency may use teleconferencing without complying with the requirements of paragraph (3) of subdivision (b) if the legislative body complies with the requirements of paragraph (2) of this subdivision in any of the following circumstances:

(A) The legislative body holds a meeting during a proclaimed state of emergency, and state or local officials have imposed or recommended measures to promote social distancing.

(B) The legislative body holds a meeting during a proclaimed state of emergency for the purpose of determining, by majority vote, whether as a result of the emergency, meeting in person would present imminent risks to the health or safety of attendees.

(C) The legislative body holds a meeting during a proclaimed state of emergency and has determined, by majority vote, pursuant to subparagraph (B), that, as a result of the emergency, meeting in person would present imminent risks to the health or safety of attendees.

(2) A legislative body that holds a meeting pursuant to this subdivision shall do all of the following:

(A) The legislative body shall give notice of the meeting and post agendas as otherwise required by this chapter.

(B) The legislative body shall allow members of the public to access the meeting and the agenda shall provide an opportunity for members of the public to address the legislative body directly pursuant to Section 54954.3. In each instance in which notice of the time of the teleconferenced meeting is otherwise given or the agenda for the meeting is otherwise posted, the legislative body shall also give notice of the means by which members of the public may access the meeting and offer public comment. The agenda shall identify and include an opportunity for all persons to attend via a call-in option or an internet-based service option. This subparagraph shall not be construed to require the legislative body to provide a physical location from which the public may attend or comment.

(C) The legislative body shall conduct teleconference meetings in a manner that protects the statutory and constitutional rights of the parties and the public appearing before the legislative body of a local agency.

(D) In the event of a disruption which prevents the public agency from broadcasting the meeting to members of the public using the call-in option or internet-based service option, or in the event of a disruption within the local agency's control which prevents members of the public from offering public comments using the call-in option or internet-based

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service option is restored. Actions taken on agenda items during a disruption which prevents the public agency from broadcasting the meeting may be challenged pursuant to Section 54960.1.

(E) The legislative body shall not require public comments to be submitted in advance of the meeting and must provide an opportunity for the public to address the legislative body and offer comment in real time. This subparagraph shall not be construed to require the legislative body to provide a physical location from which the public may attend or comment.

(F) Notwithstanding Section 54953.3, an individual desiring to provide public comment through the use of an internet website, or other online platform, not under the control of the local legislative body, that requires registration to log in to a teleconference may be required to register as required by the third-party internet website or online platform to participate.

(G) (i) A legislative body that provides a timed public comment period for each agenda item shall not close the public comment period for the agenda item, or the opportunity to register, pursuant to subparagraph (F), to provide public comment until that timed public comment period has elapsed.

(ii) A legislative body that does not provide a timed public comment period, but takes public comment separately on each agenda item, shall allow a reasonable amount of time per agenda item to allow public members the opportunity to provide public comment, including time for members of the public to register pursuant to subparagraph (F), or otherwise be recognized for the purpose of providing public comment.

(iii) A legislative body that provides a timed general public comment period that does not correspond to a specific agenda item shall not close the public comment period or the opportunity to register, pursuant to subparagraph (F), until the timed general public comment period has elapsed.

(3) If a state of emergency remains active, or state or local officials have imposed or recommended measures to promote social distancing, in order to continue to teleconference without compliance with paragraph (3) of subdivision (b), the legislative body shall, not later than 30 days after teleconferencing for the first time pursuant to subparagraph (A), (B), or (C) of paragraph (1), and every 30 days thereafter, make the following findings by majority vote:

(A) The legislative body has reconsidered the circumstances of the state of emergency.

(B) Any of the following circumstances exist:

(i) The state of emergency continues to directly impact the ability of the members to meet safely in person.

(ii) State or local officials continue to impose or recommend measures to promote social distancing.

(4) For the purposes of this subdivision, “state of emergency” means a state of emergency proclaimed pursuant to Section 8625 of the California Emergency Services Act (Article 1 (commencing with Section 8550) of Chapter 7 of Division 1 of Title 2).

(f) This section shall remain in effect only until January 1, 2024, and as of that date is repealed.

(Amended by Stats. 2021, Ch. 165, Sec. 3. (AB 361) Effective September 16, 2021. Repealed as of January 1, 2024, by its own provisions. See later operative version added by Sec. 4 of Stats. 2021, Ch. 165.)

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AMENDMENT I

TO EXECUTIVE EMPLOYMENT AGREEMENT

THE EXECUTIVE EMPLOYMENT AGREEMENT ("Agreement") between the Orange County Health Authority, dba Orange Prevention and Treatment Integrated Medical Assistance, dba CalOptima ("Employer" or "CalOptima") and Richard Sanchez ("Employee") is modified by this first amendment ("Amendment I"), effective September 12, 2021, with respect to the following facts.

RECITALS

WHEREAS, between April 6, 2020 to November 5, 2020, Employee served as the Interim Chief Executive Officer of CalOptima by way of an Executive Employment Agreement with an Effective Date of April 6, 2020; and

WHEREAS, CalOptima entered into a subsequent Executive Employment Agreement with Employee to serve as Chief Executive Officer of CalOptima with an Effective Date of November 5, 2020 (hereinafter, the "Agreement"); and

WHEREAS, consistent with the Board of Directors' (Board) action to revise CalOptima's Salary Schedule on September 2, 2021, and with CalOptima Policy GA. 8057: Compensation Program, CalOptima and Employee now wish to further modify the Agreement.

NOW, THEREFORE, the Parties agree to the following modifications to the Agreement.

AGREEMENT

Effective September 12, 2021, the Agreement shall be modified as follows:

1. Section 3.a. of the Agreement shall be deleted in its entirety and replaced with the following language:

   a. Salary: Employee will receive a Base Annual Salary of $560,000 payable in equal installments according to the Employer's regular payroll schedule, less any applicable taxes and withholding. Base compensation is subject to annual review by the Board. Merit increases, if any, will be determined by the Board at a future date(s).

2. This Amendment I is by this reference made part of said Agreement. Except as otherwise provided in this Amendment I, all of the terms, conditions, and provisions of the Agreement, shall continue in full force in effect.

Employer:

ORANGE COUNTY HEALTH AUTHORITY

Andrew Do, Chairman
Board of Directors

Date: 9/2/21

Employee:

Richard Sanchez

Date: 9-2-21

Continued to a future meeting

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken October 7, 2021
Regular Meeting of the CalOptima Board of Directors

Report Item
14. Consider Approval of Program Year 1 CalAIM Performance Incentive Payment Methodology

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

Recommended Actions
1. Approve Program Year (PY) 1 CalAIM Performance Incentive Payment Methodology for the Medi-Cal line of business that defines measures and allocations effective January 1, 2022, through December 31, 2022;
2. Authorize the allocation of CalAIM Program Incentive Dollars for PY 1 in an amount up to $45.0 million to fund CalOptima and delegated health network incentive payments; and
3. Authorize funding for and the distribution of incentive payments prior to CalOptima's receipt of CalAIM Program Incentive Dollars from the State of California.

Background
In preparation for the start of CalAIM's Enhanced Care Management (ECM) and In Lieu of Services (ILOS) programs on January 1, 2022, the California Department of Health Care Services (DHCS) will provide managed care plans with performance incentives to promote provider participation and capacity building. The state budget includes funding for incentive payments beginning on January 1, 2022 and ending in Fiscal Year (FY) 2024-25. Specifically, the state budget includes an allocation of $300 million for plan incentives from January 1, 2022 through June 30, 2022; $600 million for FY 2022-23; and $600 million for FY 2023-24. The incentive funding will phase out in FY 2024-25.

The initial PY 1 funding priority areas include:
- Delivery System Infrastructure;
- ECM Provider Capacity Building;
- ILOS Provider Capacity Building and managed care plan take-up; and
- Quality "Pay for Reporting" measures (which will be incorporated in the ECM provider capacity and ILOS provider capacity building priorities.

For PY 1, the state budget includes a $600 million allocation. DHCS plans to set a cap on the potential incentive dollars managed care plans may earn each program year and will provide a breakdown of the dollars across each priority area. These amounts will be based on total managed care enrollment and revenue. The actual payments earned by a plan in PY 1 will be based on the achievement of DHCS-specified "Gate" and "Ladder" milestones.

Discussion
In order to properly assess the delivery system infrastructure and ECM and ILOS provider capacity in Orange County, CalOptima is required to submit a "Gap Assessment and Gap Filling Plan" in Fall 2021. This plan will report to DHCS on baseline data and outlines CalOptima's implementation plan to address the identified gaps and needs. Attachment 2 provides information on DHCS' proposed milestones and measures.

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DHCS Funding

On September 28, 2021, DHCS informed CalOptima that the amount of potential incentive dollars for PY 1 is approximately $45.0 million. This funding level accounts for the already existing Whole Person Care (WPC) and Health Homes Program (HHP) infrastructure in Orange County. DHCS plans to divide the timing of the PY 1 payments and the requirements for earning such payments into two (2); the first in January 2022 and the second in December 2022.

Payment 1: Anticipated January 2022

CalOptima management anticipates receiving half of the potential incentive amount or approximately $22.5 million in January 2022. DHCS intends managed care plans to use prepaid dollars to implement the activities outlined in the Gap Filling Plan. As such, CalOptima will need to complete the specified "Gate" requirements and report back to DHCS in Fall 2021. If CalOptima fails to make a minimum level of effort to implement their Gate-Filling Plan, DHCS reserves the right to recoup a portion of the prepaid funding.

Payment 2: December 2022

CalOptima management anticipates receiving the second half of the potential incentive amount or $22.5 million in December 2022. The state will measure CalOptima's performance against targets linked to the achievement of measures in the Gap Filling Plan (i.e., "Ladder" measures). CalOptima will need to report these measures to DHCS in Fall 2022 based on activities completed from January through June 2022.

CalOptima, in its capacity as a managed care plan, shall retain a portion of the incentive funding for retained ILOS risk. Staff estimates PY 1 funding of up to $14.5 million for this purpose. Up to $30.5 million in incentive funding will be distributed to health networks.

Health Networks

CalOptima Direct Networks (CCN/COD)

CCN/COD will be subject to the same allocation criteria as those described below.

Delegated Health Networks (HMO, PHC, SRG)

To ensure adequate revenue to support provider participation and capacity building, CalOptima will distribute incentive dollars consistent with DHCS guidance, based on the assumed delegated risk under CalAIM and contingent on the maximum potential incentive dollars as communicated by DHCS. CalOptima will employ the following to make incentive payments to delegated health networks.

Payment 1: A health network must be in good standing with CalOptima at the time of disbursement. Eligible health networks shall receive as prefunding, an allocation of the amount of incentive dollars available. This allocation will take into account the anticipated delivery system infrastructure and ECM and ILOS provider capacity, as well as the level of delegated responsibility.

- CalOptima will distribute each health network's allocation upon completion of a final calculation. The allocation will include a fixed component of $250,000 per health network and

variable components based on the health network's projected proportion by "populations of focus," as defined by DHCS; and
- CalOptima, at its sole discretion, may make annual or more frequent payments to health networks.

A health network shall submit a completed attestation form, signed by its Chief Executive Officer or Chief Financial Officer. CalOptima will provide a form that each health network can use to attest to the level of spending by PY 1 funding priority area. The health network's minimum allocation of incentive dollars is as follows:

- 30% to Delivery System Infrastructure;
- 30% to ECM Provider Capacity Building;
- 15% to ILOS Provider Capacity Building; and
- 25% to health network discretion to one or more of the above priority areas.

Each health network shall participate in data collection, reporting activities and data submission to CalOptima, including measures for the Gap Assessment and Gap-Filling Plan and other subsequent data reporting requested by CalOptima. As of this writing, DHCS continues to develop and finalize guidance for the implementation of ECM and ILOS, including policy guidance for incentive payments and data sharing. Staff will return to the Board with additional information on measures and health network data sharing requirements pursuant to DHCS final guidance.

Payment 2: To qualify for funding, a health network must be in good standing with CalOptima at the time of disbursement.

- CalOptima will distribute each health network's allocation upon completion of a final calculation. The allocation will be based on demonstrated performance against measure targets and the projected health network proportion by "populations of focus," as defined by DHCS; and
- CalOptima, at its sole discretion, may make annual or more frequent payments to health networks.

Each health network shall participate in data collection, reporting activities and data submission to CalOptima, including measures for the "Ladder" measures and other subsequent data reporting requested by CalOptima.

In the event DHCS recoups any portion of the incentive funding due to a lack of effort to implement or to demonstrate performance against measure targets, CalOptima reserves the right to make subsequent recoupments from health networks. A health network shall participate in taking corrective actions and submitting updates to CalOptima on process measures identified by DHCS through a corrective action plan to CalOptima.

Fiscal Impact

The fiscal impact of the PY 1 CalAIM performance incentive for the Medi-Cal line of business for January 1, 2022 through December 31, 2022 is projected to be budget neutral to CalOptima. The

amount payable to CalOptima and delegated health networks is not anticipated to exceed $45.0 million for PY 1. Staff anticipates any cash expended for the provider incentive payments will be replenished when CalAIM performance incentive dollars are received from DHCS.

Rationale for Recommendation

The recommended actions will enable CalOptima to support provider participation and capacity building in preparation of CalAIM ECM and ILOS programs.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. Contracted Entities Covered by this Recommended Board Action
2. DHCS Proposed Milestones and Measures for CalAIM Incentive Payments (Draft for stakeholder feedback dated August 30, 2021)
3. CalAIM Performance Incentives (Draft for stakeholder feedback dated June 30, 2021)

/s/ Richard Sanchez — *09/29/2021*

Authorized Signature — **Date**

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ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

CalOptima Medi-Cal Health Networks				
Name	**Address**	**City**	**State**	**Zip Code**
AltaMed Health Services Corporation	2040 Camfield Ave.	Los Angeles	CA	90040
AMVI Care Health Network	600 City Parkway West Ste. 800	Orange	CA	92868
ARTA Western California, Inc.	2175 Park Place	El Segundo	CA	90245
CHOC Physicians Network and Children's Hospital of Orange County	1120 West La Veta Avenue Ste. 450	Orange	CA	92868
Family Choice Medical Group, Inc.	7631 Wyoming St. Ste. 202	Westminster	CA	92683
Fountain Valley Regional Hospital and Medical Center	17100 Euclid St.	Fountain Valley	CA	92708
Heritage Provider Network, Inc.	8510 Balboa Blvd. Ste. 285	Northridge	CA	91325
Kaiser Foundation Health Plan, Inc.	393 Walnut St.	Pasadena	CA	91188
Monarch Health Plan, Inc.	11 Technology Dr.	Irvine	CA	92618
Orange County Physicians IPA Medical Group, Inc dba Noble Community Medical Associates, Inc.	5785 Corporate Ave.	Cypress	CA	90630
Prospect Health Plan, Inc.	600 City Parkway West Ste. 800	Orange	CA	92868
Talbert Medical Group, P.C.	2175 Park Place	El Segundo	CA	90245
United Care Medical Group, Inc.	600 City Parkway West	Orange	CA	92868

Continued to a future meeting

DHCS

Proposed Milestones and Measures for CalAIM Incentive Payments
DRAFT - August 30, 2021

Priority	Percentage of Dollars (i.e., Max Cap) Allocated to Priority Area	Points Needed to Earn Max Payment 1	Points Needed to Earn Max Payment 2
1. Delivery System Infrastructure	Minimum 20%	200	200
2. ECM Provider Capacity Building	Minimum of 20%	200	200
3. ILOS Provider Capacity Building and ILOS Take-Up	Minimum of 30%	300	300
4. Quality	Optional measures with values allocated to either ECM or ILOS	N/A	To be allocated to ECM or ILOS based on measure
Total Points		700	700
MCP Discretion to Allocate to One or More Priority Areas	Up to 30% of Max Cap to be added to one or more of the above priority areas based on discretion of the plan, as reported in the Gap-Filling Plan template		

MCPs are required to submit information pertaining to the measures noted as mandatory, and can select among additional optional measures, to earn up to their full cap. DHCS will evaluate the MCP submissions and award payments proportional to the number of points earned per measure (as specified in the Reporting Template).MCPs are permitted and encouraged to work closely with providers and other stakeholders on these measures.

High Performance Pool: MCPs will receive payments from the high performance pool based on their performance against their individualized targets for each of their quantitative requirements reported as part of the submission for Payment 2. MCPs must meet minimum requirements to be eligible to earn high performance pool dollars, including:
-- Report on all mandatory requirements for the Gap/Need Assessment and Gap Filling Plan;
-- Offer at least three ILOS, and;
-- Demonstrate a minimum level of effort to implement their Gap-Filling Plan (i.e., are not placed on a corrective action plan).

Priority	Payment 1 Measures	Target for Payment 1 Measures	Optional / Mandatory for Payment 1	Weighting for Payment 1 Measures (Points Out of 700 Across Domains)	Payment 2 Measures	Target for Payment 2 Measure	Optional / Mandatory for Payment 2 Measures	Weighting for Payment 2 Measures (Points Out of 700 Across Domains)	Measure to Determine if Payment 1 is Fully Earned (i.e., Not Subject to Recoupment)?
1. Delivery System Infrastructure	Number and percent of contracted ECM Providers capable of electronically exchanging care plan information and clinical documents with other care team members	N/A - Pay for Reporting	**Mandatory** for Payment 1 Tied to Delivery System Infrastructure	20	Number and percentage point increase in contracted ECM Providers capable of electronically exchanging care plan information and clinical documents with other care team members	Individualized Target to be Developed Based on MCP's Baseline Data Submission	**Mandatory** for Payment 2 Tied to Delivery System Infrastructure	20	No
1. Delivery System Infrastructure	Number and percent of contracted ECM Providers with access to certified EHR technology or a care management documentation system able to generate and manage a patient care plan	N/A - Pay for Reporting	**Mandatory** for Payment 1 Tied to Delivery System Infrastructure	20	Number and percentage point increase in contracted ECM Providers with access to certified EHR technology or a care management documentation systems able to generate and manage a patient care plan	Individualized Target to be Developed Based on MCP's Baseline Data Submission	**Mandatory** for Payment 2 Tied to Delivery System Infrastructure	20	No
1. Delivery System Infrastructure	Number and percent of contracted ECM and ILOS Providers who are capable of submitting a claim or invoice to an MCP, or have access to a system or service that can process and send a claim or invoice to an MCP with information necessary for the MCP to submit a compliant encounter to DHCS	N/A - Pay for Reporting	**Mandatory** for Payment 1 Tied to Delivery System Infrastructure	20	Number and percentage point increase in contracted ECM and ILOS providers capable of submitting a claim or invoice to a MCP, or have access to a system or service that can process and send a claim or invoice to a MCP with information necessary for the MCP to submit a compliant encounter to DHCS	Individualized Target to be Developed Based on MCP's Baseline Data Submission	**Mandatory** for Payment 2 Tied to Delivery System Infrastructure	20	No
1. Delivery System Infrastructure	Number and percent of contracted ILOS Providers for those ILOS offered by the MCP starting January 1, 2022 or July 1, 2022 who have access to closed-loop referral systems	N/A - Pay for Reporting	**Mandatory** for Payment 1 Tied to Delivery System Infrastructure	20	Number and percentage point increase in contracted ILOS Providers for those ILOS offered by the MCP starting January 1, 2022 or July 1, 2022 with access to closed-loop referral systems	Individualized Target to be Developed Based on MCP's Baseline Data Submission	**Mandatory** for Payment 2 Tied to Delivery System Infrastructure	20	No
1. Delivery System Infrastructure	Number and percent of contracted behavioral health providers able to electronically exchange care plan information and clinical documents with other care team members	N/A - Pay for Reporting	**Mandatory** for Payment 1 Tied to Delivery System Infrastructure	20	Number and percentage point increase in contracted behavioral health providers able to electronically exchange care plan information and clinical documents with other care team members	Individualized Target to be Developed Based on MCP's Baseline Data Submission	**Mandatory** for Payment 2 Tied to Delivery System Infrastructure	20	No
1. Delivery System Infrastructure	Submission of a narrative or joint MOU describing how the MCP will collaborate with other MCPs in the county to enhance and develop needed ECM/ILOS infrastructure, including certified EHR technology, care management document systems, closed-loop referral, billing systems/services, and onboarding/enhancements to health information exchange capabilities and submission of documentation demonstrating good faith efforts to begin this collaboration in the form of letters with MCPs in county, emails demonstrating progress, meeting meetings, or other documentation. If only one MCP is operating in the county, the MCP must submit a narrative describing how they will leverage and expand existing WPC capacity and support ongoing ECM and ILOS capacity building approaches	See reporting template for evaluation criteria for MOU	**Mandatory** for Payment 1 Tied to Delivery System Infrastructure	20	Narrative describing how the MCP successfully collaborated with other MCPs in the county to enhance and develop needed ECM/ILOS infrastructure, including certified EHR technology, care management document systems, closed-loop referral, billing systems/services, and onboarding/enhancements to health information exchange capabilities	Individualized Target to be Developed Based on MCP's Baseline Data Submission	**Mandatory** for Payment 2 Tied to Delivery System Infrastructure	20	No
1. Delivery System Infrastructure	Submission of a narrative Gap-Filling plan describing how MCPs will identify underserved populations and the ECM providers they are assigned to, and enhance those ECM Providers' capabilities to: (1) Electronically exchange care plan information and clinical documents with other care team members (2) Have access to certified EHR technology or a care management documentation system able to generate and manage a patient care plan. (3) Submit a claim or invoice to an MCP, or have access to a system or service that can process and send a claim or invoice to an MCP with information necessary for the MCP to submit a compliant encounter to DHCS MCPs should also describe any plans to build physical plant infrastructure (e.g., sobering centers) to support the launch of ECM and ILOS. Gap-Filling Plan narrative should include approaches for collaborating with, Social Services, County Behavioral Health, and County/Local Public Health Agencies within the county to achieve the above activities, and should describe how health plans will leverage existing WPC infrastructure, including how they will track the ongoing viability of WPC infrastructure and improve data integration across behavioral health and physical health providers	See reporting template for evaluation criteria for Gap-Filling Plan	**Mandatory** for Payment 1 Tied to Delivery System Infrastructure	80	Submission of a narrative demonstrating progress against Gap-Filling Plan, including identification of underserved populations and the ECM providers they are assigned to, and enhancements that have been made to those ECM Providers' capabilities to: (1) Electronically exchange care plan information and clinical documents with other care team members (2) Have access to certified EHR technology or a care management documentation system able to generate and manage a patient care plan. (3) Submit a claim or invoice to an MCP, or have access to a system or service that can process and send a claim or invoice to an MCP with information necessary for the MCP to submit a compliant encounter to DHCS MCPs should also describe any progress to build physical plant infrastructure (e.g., sobering centers) to support the launch of ECM and ILOS. Narrative should outline progress on collaborations with Social Services, County Behavioral Health, and Counties/Local Public Health Agencies within the county to achieve the above activities, and should describe how health plans have leveraged existing WPC infrastructure and improved data integration across behavioral health and physical health providers.	See reporting template for evaluation criteria for Gap-Filling Plan	**Mandatory** for Payment 2 Tied to Delivery System Infrastructure	80	**Yes**
2. ECM Provider Capacity Building	Number of contracted ECM Providers	N/A - Pay for Reporting	**Mandatory** for Payment 1 Tied to ECM Provider Capacity	20	Number of contracted ECM Providers	N/A - Pay for Reporting	**Mandatory** for Payment 2 Tied to EMC Provider Capacity	20	No
2. ECM Provider Capacity Building	Number of members identified as eligible to transition from HHP/WPC to ECM	N/A - Pay for Reporting	**Optional,** Report on One Optional Payment 1 Measure in ECM Provider Capacity Building Priority Area to Earn 20 points	Report on One Optional Payment 1 Measure in ECM Provider Capacity Building Priority Area to Earn 20 Points	Number of Members receiving ECM	N/A - Pay for Reporting	**Mandatory** for Payment 2 Tied to EMC Provider Capacity	10	No
2. ECM Provider Capacity Building	Number of Members across Program Year 1 Populations of Focus expected to require ECM. Break out of Members across Program Year 1 Populations of Focus expected to require ECM by race, ethnicity, and primary language.	N/A - Pay for Reporting	**Mandatory** for Payment 1 Tied to ECM Provider Capacity	10	Number of Members across Program Year 1 Populations of Focus receiving ECM. Break out of Members across Program Year 1 Populations of Focus receiving ECM by race, ethnicity, and primary language.	Individualized Target to be Developed Based on MCP's Baseline Data Submission	**Mandatory** for Payment 2 Tied to EMC Provider Capacity	10	No
2. ECM Provider Capacity Building	Submission of a narrative or joint MOU describing how the MCP will collaborate with other MCPs in the county to support expansion of ECM Provider capacity, including leveraging and expanding existing WPC capacity and building/expanding ECM Provider networks and compliance and oversight capabilities. MCP should also submit documentation demonstrating good faith efforts to begin this collaboration in the form of letters with MCPs in county, emails demonstrating progress, meeting meetings, or other documentation. If only one MCP is operating in the county, the MCP must submit a narrative describing how they will leverage and expand existing WPC capacity and support ongoing ECM capacity building approaches	See reporting template for evaluation criteria for MOU	**Mandatory** for Payment 1 Tied to ECM Provider Capacity	10	Narrative describing how the MCP successfully collaborated with other MCPs in the county to support ECM Provider capacity expansion, and leverage existing WPC capacity. If only one MCP is operating in the county, the narrative must describe how they successfully leveraged and expanded existing WPC capacity to support ECM capacity building	See reporting template for evaluation criteria for narrative summary	**Mandatory** for Payment 2 Tied to EMC Provider Capacity	20	No
2. ECM Provider Capacity Building	Narrative summary that outlines landscape of Providers, faith-based groups, and community based organizations in the county and submission of a narrative plan to develop an MOU or other agreements with a subset of Providers, faith-based groups, county agencies and community based organizations in the county to develop strategies for closing health disparities experienced by Populations of Focus, including agreement to meet at least quarterly to advance strategy	See reporting template for evaluation criteria for narrative summary	**Optional,** Report on One Optional Payment 1 Measure in ECM Provider Capacity Building Priority Area to Earn 20 points	Report on One Optional Payment 1 Measure in ECM Provider Capacity Building Priority Area to Earn 20 Points	Submission of MOU or other collaborative agreement, associated agenda and meeting notes and narrative description of progress against narrative plan submitted as part of Payment 1 measure for the strategic partnership with the MCP, Providers, faith-based groups, county agencies and community based organizations to a develop strategy for closing health disparities experienced by Populations of Focus	See reporting template for evaluation criteria for MOU	**Optional,** Report on Five Optional Payment 2 Measures in ECM Provider Capacity Building Priority Area to Earn 30 points	Report on Five Optional Payment 2 Measures in ECM Provider Capacity Building Priority Area to Earn 30 Points	No
2. ECM Provider Capacity Building	Narrative summary that outlines landscape of Tribes and Tribal providers used by members in the county and submission of a narrative plan to develop an MOU to establish a strategic partnership with Tribes and Tribal providers used by members in county to develop Provider capacity and provision of ECM services for members of Tribes	See reporting template for evaluation criteria for narrative summary	**Mandatory** for Payment 1 Tied to ECM Provider Capacity, except for Plans in Counties without recognized Tribes	30	Submission of MOU or other collaborative agreement, associated agenda and meeting notes and narrative description of progress against narrative plan submitted as part of Payment 1 measure, to demonstrate progress made to work with Tribes and Tribal providers used by members in county on Provider capacity and provision of ECM services for members of Tribes in county	See reporting template for evaluation criteria for MOU	**Mandatory** for Payment 2 Tied to EMC Provider Capacity	20	No

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Priority	Payment 1 Measures	Target for Payment 1 Measures	Optional / Mandatory for Payment 1	Weighting for Payment 1 Measures (Points Out of 700 Across Domains)	Payment 2 Measures	Target for Payment 2 Measure	Optional / Mandatory for Payment 2 Measures	Weighting for Payment 2 Measures (Points Out of 700 Across Domains)	Measure to Determine if Payment 1 is Fully Earned (i.e., Not Subject to Recoupment)?
2. ECM Provider Capacity Building	Submission of narrative plan describing how the managed care plan will improve outreach to and engagement with the following Population of Focus: "*people experiencing homelessness or chronic homelessness, or who are at risk of becoming homeless with complex health and/or behavioral health conditions,* " with a focus on Black/African American and other racial and ethnic groups who are disproportionately experiencing homelessness	See reporting template for evaluation criteria for narrative summary	**Mandatory** for Payment 1 Tied to ECM Provider Capacity	30	Baseline data for individuals who are Black/African American and from other racial and ethnic groups who are disproportionately experiencing homelessness and who meet the Population of Focus definition: "*people experiencing homelessness or chronic homelessness, or who are at risk of becoming homeless with complex health and/or behavioral health conditions* " **and narrative summary** of progress the MCP made to improve outreach to and engagement with individuals who are Black/African American and other racial and ethnic groups who are disproportionately experiencing homelessness	N/A - Pay for Reporting	**Mandatory** for Payment 2 Tied to EMC Provider Capacity	20	No
2. ECM Provider Capacity Building	Submission of narrative plan describing how the managed care plan will improve outreach to and engagement with the following Population of Focus: "individuals transitioning from incarceration who have significant complex physical or behavioral health needs requiring immediate transition of sevices to the community," with a focus on Black/African American and other racial and ethnic groups who are disproportionately experiencing transitions from incarceration settings in the county	See reporting template for evaluation criteria for narrative summary	**Optional,** Report on One Optional Payment 1 Measure in ECM Provider Capacity Building Priority Area to Earn 20 points	Report on One Optional Payment 1 Measure in ECM Provider Capacity Building Priority Area to Earn 20 Points	Baseline data for individuals who are Black/African American and from other racial and ethnic groups who disproportionately meet the Population of Focus definition: "*individuals transitioning from incarceration who have significant complex physical or behavioral health needs requiring immediate transition of services to the community* " who have been successfully outreached to and engaged by an ECM Provider and **narrative summary** of progress the MCP made to improve outreach to and engagement with Black/African American and other racial and ethnic groups who are disproportionately experiencing transitions from incarceration settings	N/A - Pay for Reporting	**Optional,** Report on Five Optional Payment 2 Measures in ECM Provider Capacity Building Priority Area to Earn 30 points	Report on Five Optional Payment 2 Measures in ECM Provider Capacity Building Priority Area to Earn 30 Points	No
2. ECM Provider Capacity Building	Reporting on racial and ethnic demographics of ECM Providers for each Program Year 1 Populations of Focus relative to the racial and ethnic demographics of the Members in each Program Year 1 Populations of Focus	N/A - Pay for Reporting	**Optional,** Report on One Optional Payment 1 Measure in ECM Provider Capacity Building Priority Area to Earn 20 points	Report on One Optional Payment 1 Measure in ECM Provider Capacity Building Priority Area to Earn 20 Points	Reporting on racial and ethnic demographics of ECM Providers for each Program Year 1 Populations of Focus relative to the racial and ethnic demographics of the beneficiaries in the Program Year 1 Populations of Focus	N/A - Pay for Reporting	**Optional,** Report on Five Optional Payment 2 Measures in ECM Provider Capacity Building Priority Area to Earn 30 points	Report on Five Optional Payment 2 Measures in ECM Provider Capacity Building Priority Area to Earn 30 Points	No
2. ECM Provider Capacity Building					Hired full time Health Equity Officer by July 1, 2022 who has the necessary qualifications or training at the time of hire or within 1 year of hire to meet the requirements of the position, as outlined in the MCP Procurement	N/A - Pay for Reporting	**Optional,** Report on Five Optional Payment 2 Measures in ECM Provider Capacity Building Priority Area to Earn 30 points	Report on Five Optional Payment 2 Measures in ECM Provider Capacity Building Priority Area to Earn 30 Points	No
2. ECM Provider Capacity Building					Rates of sharing ECM assessment and care plan information across physical and behavioral health care teams	N/A - Pay for Reporting	**Mandatory** for Payment 2 Tied to EMC Provider Capacity	10	No
2. ECM Provider Capacity Building	Submission of a narrative Gap-Filling plan describing: (1) How the MCP will address identified gaps in ECM Provider capacity for Program Year 1 Populations of Focus (2) Identified ECM workforce, training, TA needs in county, including specific cultural competency needs by county (3)Plan for ECM Provider workforce recruiting and hiring of necessary staff to build capacity (4) Approach for MCP to develop and administer an MCP training and TA program for ECM Providers (5) Strategy to ensure ECM Providers are successfully engaging with hard to reach Populations of Focus, including homeless and justice involved populations, among others Gap-Filling Plan narrative should include approach for collaborating with Social Service, County Behavioral Health, County/Local Public Health Agencies, Tribes and Tribal providers (except for Plans in Counties without recognized Tribes), community based organizations and ECM Providers to achieve the above activities, improve outreach to and engagement with hard to reach individuals within each Populations of Focus and reduce underlying health disparities	See reporting template for evaluation criteria for Gap-Filling Plan	**Mandatory** for Payment 1 Tied to ECM Provider Capacity	70	Submission of a narrative describing progress against Gap-Filling plan, including: (1) Progress in increasing ECM Provider capacity and MCP oversight capacity (1) Progress in addressing ECM workforce, training, TA needs in county, including specific cultural competency needs by county (2) Progress in supporting ECM Provider workforce recruiting and hiring of necessary staff to build capacity (3) Progress in developing and administering a MCP training and TA program for ECM Providers (4) Progress in successfully engaging with hard to reach Populations of Focus, including homeless and justice involved populations, among others Narrative should outline progress and results from collaborations with County Social Service, Behavioral Health, County/Local Public Health Agencies, Tribes and Tribal providers (except for Plans in Counties without recognized Tribes), community based organizations and ECM Providers to achieve the above activities, improve outreach to and engagement with hard to reach individuals within each Populations of Focus and reduce underlying health disparities.	See reporting template for evaluation criteria for Gap-Filling Plan	**Mandatory** for Payment 2 Tied to EMC Provider Capacity	60	**Yes**
2. ECM Provider Capacity Building *Quality Measure*					**Submission of baseline data for Plan All-Cause Readmissions (PCR)** For beneficiaries ages 18 to 64 who are in the ECM populations of focus, the number of acute inpatient and observation stays during the measurement year that were followed by an unplanned acute readmission for any diagnosis within 30 days and the predicted probability of an acute readmission. Data are reported in the following categories: • Count of Index Hospital Stays (IHS) • Count of Observed 30-Day Readmissions • Count of Expected 30-Day Readmissions	N/A - Pay for Reporting in CY 2022	**Optional,** Report on Five Optional Payment 2 Measures in ECM Provider Capacity Building Priority Area to Earn 30 points	Report on Five Optional Payment 2 Measures in ECM Provider Capacity Building Priority Area to Earn 30 Points	No
2. ECM Provider Capacity Building *Quality Measure*					**Submission of baseline data for Ambulatory Care—Emergency Department Visits (AMB-ED)** Rate of emergency department (ED) visits per 1,000 beneficiary months for beneficiaries who are in the ECM populations of focus	N/A - Pay for Reporting in CY 2022	**Optional,** Report on Five Optional Payment 2 Measures in ECM Provider Capacity Building Priority Area to Earn 30 points	Report on Five Optional Payment 2 Measures in ECM Provider Capacity Building Priority Area to Earn 30 Points	No
2. ECM Provider Capacity Building *Quality Measure*					**Depression Screening and Follow-Up for Adolescents and Adults (DSF)** The percentage of beneficiaries 12 years of age and older who are in the ECM populations of focus and who were screened for clinical depression using a standardized tool and, if screened positive, who received follow-up care.	N/A - Pay for Reporting in CY 2022	**Optional,** Report on Five Optional Payment 2 Measures in ECM Provider Capacity Building Priority Area to Earn 30 points	Report on Five Optional Payment 2 Measures in ECM Provider Capacity Building Priority Area to Earn 30 Points	No
2. ECM Provider Capacity Building *Quality Measure*					**Utilization of the PHQ-9 to Monitor Depression Symptoms for Adolescents and Adults (DMS)** The percentage of members 12 years of age and older with a diagnosis of depression, who had an outpatient encounter with a PHQ-9 score present in their record in the same assessment period as the encounter	N/A - Pay for Reporting in CY 2022	**Optional,** Report on Five Optional Payment 2 Measures in ECM Provider Capacity Building Priority Area to Earn 30 points	Report on Five Optional Payment 2 Measures in ECM Provider Capacity Building Priority Area to Earn 30 Points	No
2. ECM Provider Capacity Building *Quality Measure*					**Submission of baseline data for Follow-Up After Emergency Department Visit for Mental Illness (FUM)** Percentage of emergency department (ED) visits for beneficiaries age 18 and older who are in the ECM populations of focus and who have a principal diagnosis of mental illness or intentional self-harm and who had a follow-up visit for mental illness. Two rates are reported: • Percentage of ED visits for mental illness for which the beneficiary received follow-up within 30 days of the ED visit (31 total days) • Percentage of ED visits for mental illness for which the beneficiary received follow-up within 7 days of the ED visit (8 total days)	N/A - Pay for Reporting in CY 2022	**Optional,** Report on Five Optional Payment 2 Measures in ECM Provider Capacity Building Priority Area to Earn 30 points	Report on Five Optional Payment 2 Measures in ECM Provider Capacity Building Priority Area to Earn 30 Points	No
2. ECM Provider Capacity Building *Quality Measure*					**Submission of baseline data for Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA)** Percentage of emergency department (ED) visits for beneficiaries age 18 and older who are in the ECM populations of focus and have a principal diagnosis of alcohol or other drug (AOD) abuse or dependence who had a follow-up visit for AOD abuse or dependence. Two rates are reported: • Percentage of ED visits for which the beneficiary received follow-up within 30 days of the ED visit (31 total days) • Percentage of ED visits for which the beneficiary received follow-up within 7 days of the ED visit (8 total days)	N/A - Pay for Reporting in CY 2022	**Optional,** Report on Five Optional Payment 2 Measures in ECM Provider Capacity Building Priority Area to Earn 30 points	Report on Five Optional Payment 2 Measures in ECM Provider Capacity Building Priority Area to Earn 30 Points	No
2. ECM Provider Capacity Building *Quality Measure*					**Submission of baseline data for Controlling High Blood Pressure (CBP)** Percentage of beneficiaries ages 18 to 85 who are in the ECM populations of focus and who had a diagnosis of hypertension and whose blood pressure (BP) was adequately controlled (< 140/90 mm Hg) during the measurement year	N/A - Pay for Reporting in CY 2022	**Optional,** Report on Five Optional Payment 2 Measures in ECM Provider Capacity Building Priority Area to Earn 30 points	Report on Five Optional Payment 2 Measures in ECM Provider Capacity Building Priority Area to Earn 30 Points	No
2. ECM Provider Capacity Building *Quality Measure*					**Submission of baseline data for Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM)** Percentage of children ages 1 to 17 who are in the ECM populations of focus and who had two or more antipsychotic prescriptions and had metabolic testing. Three rates are reported: • Percentage of children and adolescents on antipsychotics who received blood glucose testing • Percentage of children and adolescents on antipsychotics who received cholesterol testing • Percentage of children and adolescents on antipsychotics who received blood glucose and cholesterol testing	N/A - Pay for Reporting in CY 2022	**Optional,** Report on Five Optional Payment 2 Measures in ECM Provider Capacity Building Priority Area to Earn 30 points	Report on Five Optional Payment 2 Measures in ECM Provider Capacity Building Priority Area to Earn 30 Points	No
3. ILOS Provider Capacity Building and ILOS Take-Up	Number of contracted ILOS Providers	N/A - Pay for Reporting	**Mandatory** for Payment 1 Tied to ILOS Provider Capacity and Take-Up	20	Number of contracted ILOS Providers	N/A - Pay for Reporting	**Mandatory** for Payment 2 Tied to ILOS Provider Capacity and Take-Up	20	No

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Priority	Payment 1 Measures	Target for Payment 1 Measures	Optional / Mandatory for Payment 1	Weighting for Payment 1 Measures (Points Out of 700 Across Domains)	Payment 2 Measures	Target for Payment 2 Measure	Optional / Mandatory for Payment 2 Measures	Weighting for Payment 2 Measures (Points Out of 700 Across Domains)	Measure to Determine if Payment 1 is Fully Earned (i.e., Not Subject to Recoupment)?
3. ILOS Provider Capacity Building and ILOS Take-Up	Number of members identified as eligible to transition from HHP/WPC to ILOS	N/A - Pay for Reporting	**Optional,** Report on One Optional Payment 1 Measure in ILOS Provider Capacity Building & Take-up Priority Area to Earn 50 points	Report on One Optional Payment 1 Measure in ILOS Provider Capacity Building & Take-up Priority Area to Earn 50 Points	Number of Members receiving ILOS	N/A - Pay for Reporting	**Mandatory** for Payment 2 Tied to ILOS Provider Capacity and Take-Up	20	No
3. ILOS Provider Capacity Building and ILOS Take-Up	Offer ILOS housing suite: housing transition navigation, housing deposits, housing tenancy and sustaining services, short-term post-hospitalization housing, day habilitation programs, and medical respite starting in January 2022 or July 2022	N/A - MCPs must offer the full ILOS housing suite to earn incentive dollars tied to this measure	**Optional,** Report on One Optional Payment 1 Measure in ILOS Provider Capacity Building & Take-up Priority Area to Earn 50 points	Report on One Optional Payment 1 Measure in ILOS Provider Capacity Building & Take-up Priority Area to Earn 50 Points					
3. ILOS Provider Capacity Building and ILOS Take-Up	Number of ILOS offered county-wide by the MCP starting January 2022 or July 2022 *If the ILOS Provider network/capacity will not reasonably allow for county-wide provision of ILOS to all eligible Members in the county at the time of implementation, please provide additional information in the Gap-Filling Plan. DHCS will review the information provided to determine if the county-wide provision of a given ILOS is not a reasonable expectation and work with the MCP to assess if a given ILOS not offered county-wide will count toward this measure.*	Evaluated based on number of ILOS offered county-wide: 1-4 = 60 points 5-7 = 70 point 8+ = 80 points	**Mandatory** for Payment 1 Tied to ILOS Provider Capacity and Take-Up	Points awarded based on number of ILOS offered: 1-4 = 60 points 5-7 = 70 point 8+ = 80 points					
3. ILOS Provider Capacity Building and ILOS Take-Up	Narrative summary that outlines landscape of Tribes and Tribal providers used by members in the county and submission of a narrative plan to develop an MOU to establish a strategic partnership with Tribes and Tribal providers used by members in county to develop Provider capacity and provision of provision of ILOS for members of Tribes in county	See reporting template for evaluation criteria for narrative summary	**Mandatory** for Payment 1 Tied to ILOS Provider Capacity and Take-Up, except for Plans in Counties without recognized Tribes	20	Submission of MOU or other collaborative agreement, associated agenda and meeting notes and narrative description of progress against narrative plan submitted as part of Payment 1 measure, to demonstrate progress made to work with Tribes and Tribal providers used by members in county on Provider capacity and provision of ILOS for members of Tribes and Tribal providers used by members in county	See reporting template for evaluation criteria for MOU	**Mandatory** for Payment 2 Tied to ILOS Provider Capacity and Take-Up	20	No
3. ILOS Provider Capacity Building and ILOS Take-Up					Percent of enrollees receiving ILOS by race, ethnicity, and primary language, relative to the demographics in the underlying enrollee population	N/A - Pay for Reporting	**Mandatory** for Payment 2 Tied to ILOS Provider Capacity and Take-Up	50	No
3. ILOS Provider Capacity Building and ILOS Take-Up	Submission of a narrative or joint MOU describing how the MCP will collaborate with other MCPs in the county to leverage and expand existing WPC capacity and support ongoing ILOS capacity building approaches. MCP should also submit documentation demonstrating good faith efforts to begin this collaboration in the form of letters with MCPs in county, emails demonstrating progress, meeting meetings, or other documentation. If only one MCP is operating in the county, the MCP must submit a narrative describing how they will leverage and expand existing WPC capacity and support ongoing ILOS capacity building approaches	See reporting template for evaluation criteria for narrative summary	**Mandatory** for Payment 1 Tied to ILOS Provider Capacity and Take-Up	50	Narrative describing how the MCP successfully collaborated with other MCPs in the county to leverage and expand existing WPC capacity and support ongoing ILOS capacity building approaches. If only one MCP is operating in the county, the MCP must submit a narrative describing how they successfully leveraged and expanded existing WPC capacity to support ongoing ILOS capacity building approaches.	See reporting template for evaluation criteria for narrative summary	**Mandatory** for Payment 2 Tied to ILOS Provider Capacity and Take-Up	50	No
3. ILOS Provider Capacity Building and ILOS Take-Up	Submission of a narrative Gap-Filling plan describing: (1) Identified gaps or limitations in ILOS coverage within county (2) Plan to increase number and/or reach of ILOS offered in January 2022 or July 2022 (3) Identified ILOS Provider capacity and MCP oversight capability gaps and plan to address gaps (4) Identified ILOS workforce, training, TA needs in region / county, including specific cultural competency needs by region/county (5) Plan to develop and administer a training and TA program for ILOS Providers (6) Plan to establish programs to support ILOS workforce recruiting and hiring, including incentives for ILOS Providers to hire necessary staff Gap-Filling Plan narrative should include approach for collaborating with Social Service, County Behavioral Health, County/Local Public Health Agencies, and ILOS Providers to achieve the above activities, improve outreach to and engagement with hard to reach individuals and reduce underlying health disparities.	See reporting template for evaluation criteria for Gap-Filling Plan	**Mandatory** for Payment 1 Tied to ILOS Provider Capacity and Take-Up	80	Submission of a narrative demonstrating progress against Gap-Filling plan, including: (1) Reduced gaps or limitations in ILOS coverage across county (2) Increased number and/or reach of ILOS offered in January 2022 or July 2022 (3) Reduction in ILOS Provider capacity and MCP oversight capability gaps (4) Resolution of ILOS workforce, training, TA needs in region / county, including specific cultural competency needs by region/county (5) Successfully administered training and TA program for ILOS Providers (6) Demonstrated support for ILOS workforce recruiting and hiring Narrative should outline progress and results from collaborations with County Social Service, Behavioral Health, County/Local Public Health Agencies, and ILOS Providers to achieve the above activities, improve outreach to and engagement with hard to reach individuals, and reduce underlying health disparities.	See reporting template for evaluation criteria for Gap-Filling Plan	**Mandatory** for Payment 2 Tied to ILOS Provider Capacity and Take-Up	120	Yes
3. ILOS Provider Capacity Building and ILOS Take-Up *Quality Measure*					**Submission of baseline data for Asthma Medication Ratio** The percentage of beneficiaries ages 5 to 64 who are receiving ILOS, who were identified as having persistent asthma and had a ratio of controller medications to total asthma medications of 0.50 or greater during the measurement year	N/A - Pay for Reporting in CY 2022	**Optional,** Report on One Optional Payment 2 Measure in ILOS Provider Capacity Building & Take-up Priority Area to Earn 20 points	Report on One Optional Payment 2 Measure in ILOS Provider Capacity Building & Take-up Priority Area to Earn 20 Points	No

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CalAIM Performance Incentives

DRAFT for Stakeholder Feedback

June 30, 2021

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- Overview of Incentive Payment Approach
- Allocation Methodology and Timing
- Payment Priorities and Measure Domains
- High Performance Pool
- Consequences for Failure to Meet Requirements of "Gate Payment Advance"
- Questions

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Overview

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CalAIM Performance Incentives Overview

CalAIM's Enhanced Care Management (ECM) and In Lieu Of Services (ILOS) programs will launch in January 2022, requiring significant new investments in care management capabilities, ILOS infrastructure, information technology (IT) and data exchange, and workforce capacity at both the managed care plan (MCP) and provider levels.

- Incentive payments will be a critical component of CalAIM to promote MCP and provider participation in, and capacity building for, ECM and ILOS.
- The Governor's budget allocated $300 million for plan incentives from January to June 2022, $600 million from July 2022 to June 2023, and $600 million from July 2023 to June 2024. Incentive funding will phase out in FY 2024-25.
- DHCS has designed the proposed incentive payment approach with input from stakeholders with the goal of issuing initial payments to MCPs beginning in January 2022 for the achievement of defined milestones.

Performance Incentive Goals

- **Build appropriate and sustainable ECM and ILOS capacity**
- **Drive MCP investment in necessary delivery system infrastructure**
- **Incentivize MCP take-up of ILOS**
- **Bridge current silos across physical and behavioral health delivery**
- **Reduce health disparities and promote health equity**
- **Achieve improvements in quality performance**

Infrastructure development, ECM and ILOS Provider capacity building, and ILOS take-up are priority areas for Program Year (PY)1 (i.e., Calendar Year (CY) 2022). DHCS will incorporate behavioral and physical health integration and health disparities reduction measures within those priority areas.

Quality "pay for reporting" measures will be incorporated into the ECM Provider Capacity and ILOS Provider Capacity priorities in PY 1 (i.e. CY 2022). Quality outcome measures will be incorporated in PY 2 (i.e., CY 2023) and beyond.

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Performance Incentive Design Principles

1. Develop a clear incentive payment allocation methodology where all plans have an opportunity to participate equitably
2. Set ambitious, yet achievable measure targets
3. Ensure efficient and effective use of all performance incentive dollars
4. Drive significant investments in core priority areas up front
5. Minimize administrative complexity
6. Address variation in existing infrastructure and capacity between Whole Person Care (WPC) / Health Home Program (HHP) counties and non-WPC/HHP counties
7. Ensure use of incentive dollars does not overlap with other DHCS incentive programs or with services funded through the rates
8. Measure and report on the impact of incentive funds

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Incentive Payment Allocation Methodology

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Allocating Incentive Dollars to MCPs in Program Year 1

DHCS plans to set a cap on the maximum potential incentive dollars that can be earned by an MCP in each program year. Actual payments earned by an MCP would be based on achievement of "Gate" and "Ladder" Milestones.

"Gate" Milestone Linked to 50% of Available Dollars in PY1

- Consists of submission of "Gap Assessment and Gap-Filling Plan" measures outlining implementation approach to address gaps and needs.
- Completion of "Gate" requirements triggers upfront, incentive payment "advance" / interim payment.
- Advance / interim payment intended to be used to implement activities outlined in the Gap-Filling Plan.
- DHCS will recoup a portion of the advance from MCPs who fail to make a minimum level of effort to implement their Gap-Filling Plan.

"Ladder" Milestones Linked to 50% of Available Dollars in PY1

- Demonstrated performance against measure targets linked to achievement of "Gap-Filling Plan" targets.
- Achievement of "Ladder" measure targets result in subsequent incentive payments.

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Timing of PY1 Payments

DHCS proposes a bi-annual payment cycle to issue $600M in payments to MCPs in PY1 (CY 2022).

January 2022 Payment

- DHCS issues 50% of available dollars ($300 M)
- Tied to completion of “Gate” requirements
- “Gate” requirements to be completed and reported by MCPs in fall 2021

December 2022 Payment

- DHCS issues 50% of available dollars ($300 M)
- Tied to completion of second set of “Ladder” measures, which will be based on PY 1 priority areas
- “Ladder” measures to be submitted by MCPs in fall 2022, based on activity from January – June 2022

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DHCS Will Set Cap on *Maximum Potential* Incentive Dollars Each MCP Can Earn

DHCS plans to establish a three-step process to set the cap on the *maximum potential* amount of incentive dollars each MCP can earn. Incentive payments *actually earned* by MCPs will be determined by performance on measures.

- **Step 1.** Set maximum **potential** incentive amount that can be earned **across MCPs within a given county** based on total managed care enrollment or revenue
  - ***Adjustment:*** Increase potential payments in counties without WPC/HHP
- **Step 2.** Set maximum **potential** amount that can be earned **by each MCP within a given county** based on their managed care enrollment or revenue
  - ***Adjustment*:** Increase potential payments based on proportion of enrollees who are members of the ECM populations of focus
- **Step 3.** Set **potential** amount available to be earned **across priority areas** for PY1 (CY 2022) (see Slide 11 for detail on allocation by priority)
  - ***Priority areas*:** 1) Infrastructure development; 2) ECM capacity; 3) ILOS uptake and capacity

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Allocation of Dollars by Priority Area

MCPs will have some flexibility to propose the percentage of their cap that can be earned in each priority area based on a submission to DHCS as part of their Gap-Filling Plans. Final determinations will be made by DHCS.

- MCPs will propose the percentage of their cap that can be earned in each priority area based on the following methodology:
  - **70% of the cap must be allocated as follows:**
    - *Minimum of 20% tied to Delivery System Infrastructure measures*
    - *Minimum of 20% tied to ECM Provider capacity building measures* [2]
    - *Minimum of 30% tied to ILOS Provider capacity building and take-up measures* [1,2]
  - **Remaining 30% is allocated at the plans discretion to one or more areas**
    - MCPs who want to request more than the 30% allocated for discretionary use will need to provide their rationale to DHCS as soon as possible; DHCS may consider granting exceptions in very limited cases where the MCP's rationale is compelling
- **DHCS must ultimately approve the approach via review of Gap-Filling Plan**

[1] In CY 2022 (PY 1), MCPs are eligible to earn a "Gate" payment for ILOS if offering ILOS in January 2022 ***or*** *July 2022*

[2] Quality "pay for reporting" measures will be incorporated into the ECM Provider Capacity and ILOS Provider Capacity priorities

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Incentive Payment Priorities and Measure Domains

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Program Year 1 Priorities

DHCS focused initial PY 1 (i.e., CY 2022) funding priority areas* on capacity building, infrastructure, and ILOS take-up.

Delivery System Infrastructure	ECM Provider Capacity Building	ILOS Provider Capacity Building & MCP Take-Up
Fund core MCP, ECM and ILOS Provider HIT and data exchange infrastructure required for ECM and ILOS	*Fund ECM workforce, training, TA, workflow development, operational requirements and oversight*	*Fund ILOS training, TA, workflow development, operational requirements, take-up and oversight*

Physical and behavioral health integration between and among Providers and MCPs, health equity advancement, and health disparities reduction have been integrated into all three goal areas wherever feasible.

** Quality "pay for reporting" measures will be incorporated into the ECM Provider Capacity and ILOS Provider Capacity priorities in PY 1 (i.e. CY 2022). Quality outcome measures will be incorporated in PY 2 (i.e., CY 2023) and beyond.*

Measure Domains by Priority Area

PY 1 Priorities	Measure Domains
1. Delivery System Infrastructure	**1A.** Purchase or upgrade of ECM and ILOS IT systems and Provider capabilities including certified EHR technology, care management document systems, closed-loop referral, billing systems/services, and onboarding/enhancements to health information exchange capabilities
2. ECM Provider Capacity Building	**2A.** Building/expanding ECM Provider networks and compliance and oversight capabilities to ensure populations of focus within a county can be effectively served
	2B. Hiring and training ECM care managers, care coordinators, community health workers, and supervisors to ensure core competencies to support ECM requirements
3. ILOS Provider Capacity Building and ILOS Take-Up	**3A.** Offering ILOS, expanding reach of ILOS offered
	3B. Building/expanding ILOS Provider networks and compliance and oversight capabilities of ILOS to ensure populations within a county can be effectively served
	3C. Hiring and training ILOS Provider support staff, workflow redesign, and training
4. Quality	**4A.** Reporting of baseline data ("Pay for Reporting" only in Program Year 1) to inform quality outcome measures to be collected in future program years.

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High Performance Pool

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Distribution of High Performance Pool

DHCS plans to create a high-performance pool for unearned "Gate" and "Ladder" dollars. MCPs who qualify for the high performance pool and meet additional targets can earn incentive dollars above and beyond those dollars tied to "Gate" and "Ladder" measures.

- If a plan does earn the "Gate" advance/interim payment or does not meet sufficient "Ladder" measures to earn up to their cap (i.e., does not earn their maximum potential for incentive dollars), DHCS will reallocate the unearned dollars to a high performance pool that can be earned by other MCPs.
- An MCP's unearned "Ladder" measure incentive dollars would be eligible to be earned by other MCPs statewide who meet minimum standards and high performance pool targets.

High Performance Pool Eligibility

MCPs must meet minimum requirements to be eligible to earn high performance pool dollars; actual allocation of high performance pool dollars to be determined based on performance on measures and available funds, as evaluated during PY1 reporting periods.

High Performance Pool Minimum Requirements

- Meet all requirements to earn "Gate" interim payment/advance, and;
- Offer at least one ILOS, and;
- Perform in the top Xth percentage of MCPs for ladder measures across domains; percentile to be set by DHCS based on dollars available for high performance pool

High Performance Pool Measures

- Meet "stretch goal" targets for the "Ladder" measures already required across priority areas

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Consequences for Failure to Meet Requirements of “Payment Advance”

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Consequences for Failure to Meet Requirements of "Payment Advance"

Completion of Gap/Need Assessment and Gap-Filling Plan triggers an upfront, "Gate" payment "advance"/interim payment. MCPs must *implement* activities outlined in the Gap-Filling Plan to fully meet the "Gate" measure. DHCS reserves the right to recoup a portion of the advance from MCPs who fail to make a minimum level of effort to implement their Gap-Filling Plan.

- In PY1, DHCS will evaluate MCPs based on their results and achievement of process measures outlined in the Gap-Filling Plan.
- MCPs that fail to demonstrate a minimum level of effort, as determined by DHCS, must work with DHCS on a corrective action plan aimed at improving results and performance on the process measures.
- MCPs that fail to follow the corrective action plan and meet the minimum level of effort must return a portion of the "Gate" payment advance, to be determined by DHCS.

Thank you

Please visit the DHCS ECM & ILOS Website for more information and access to this deck as well as the Incentive Payment measure list: https://www.dhcs.ca.gov/Pages/ECMandILOS.aspx

Please send questions to CalAIMECMILOS@dhcs.ca.gov

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken October 7, 2021
Regular Meeting of the CalOptima Board of Directors

Report Item
15. Consider Authorization of Unbudgeted Expenditures for Various Capital Improvements

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

Recommended Actions
Authorize unbudgeted expenditures and appropriate funds from existing reserves for capital improvements at the 505 City Parkway West building in amounts of up to:

1. $4,230 to "Upgrade Card Access System;" and
2. $275,000 for "New Roof Membrane."

Background/Discussion
505 Building, Upgrade Card Access System
The CalOptima Fiscal Year (FY) 2017-18 Capital Budget approved by the Board on June 1, 2017, included a project to upgrade the 505 Building card access system, which restricts entry into CalOptima facilities to authorized personnel. Staff included the best available information at the time of budgeting. Following the completion of a Request for Proposal (RFP), CalOptima contracted with Diversified Thermal Services (DTS) in November 2019. The installation of the system was completed in spring 2020. However, in August 2020, Staff became aware that the system required additional badging software and card readers. In June 2021, DTS submitted a final estimate to CalOptima to complete the project. Given the additional expense, Staff requests $4,230 from reserves to address this unbudgeted expense to complete the project.

505 Building, New Roof Membrane
The CalOptima FY 2019-20 Capital Budget approved by the Board on June 6, 2019, included a project for the new roof membrane for the 505 Building. Staff released an RFP in September 2020. Several issues arose that delayed the initiation of the project:

- December 2020: The building engineer conducted a job walk that raised concerns that the proposed roofing material would become damaged and unable to support the existing track rail system for the window washing equipment.
- January 2021: Conducted further investigation and consultations with additional roofing professionals
- April - May 2021: Tests on the roof membrane were completed. Results showed approximately 20% of the main roof surface would need repair work prior to installation of the new roofing material. Subsequently, Staff revised the scope of work to include this repair work.
- June 2021: CalOptima's roofing consultant advised Staff of the serious shortages in labor and materials, which are contributing to price increases and scheduling delays.

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- July 2021: Staff issued a revised RFP to address the additional work to remove and repair areas with moisture, remove and replace the walking pad, reinforce the roof under the track rail system and install a fluid-applied coating over the entire roof surface.

The CalOptima FY 2021-22 Capital Budget approved by the Board on June 3, 2021, included $100,000 for the continuation of the new roof membrane project for the 505 Building. The roofing consultant estimates that the capital project under the revised scope of work will cost approximately $375,000. Based on this discrepancy, Staff is now requesting an additional $275,000 from reserves to address the additional anticipated costs associated with this capital project.

Fiscal Impact
The recommended action is unbudgeted. As proposed, an appropriation of up to $279,230 from existing reserves will fund this action if authorized.

Rationale for Recommendation
Staff recommends approval of the recommended action to protect CalOptima's property and assets and to keep them fully functional and operational in accordance with State and Federal guidelines. Authorization of the expenditures will allow CalOptima to provide a secure and professional work environment for our employees and members.

Concurrence
Gary Crockett, Chief Counsel

Attachment
1. Entities Covered by this Recommended Board Action

/s/ Richard Sanchez *09/29/2021*
Authorized Signature **Date**

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ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
Diversified Thermal Services (DTS)	1220 N. Barsten Way	Anaheim	CA	92806

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken October 7, 2021
Regular Meeting of the CalOptima Board of Directors

Report Item
16. Consider Authorizing Extension of Contracts Related to CalOptima's Key Operational Systems

Contacts
Ladan Khamseh, Chief Operations Officer, (714) 246-8866
Nora Onishi, Director, Information Services, (714) 246-8630

Rev 10/7/21: All contracts below extended for 3 years, except c. and d. were extended for 3.5 years.

Rev. 10/7/21: Option for one-year extensions exercisable at the Board's discretion.

Recommended Actions
Authorize the Chief Executive Officer (CEO) to:

1. Extend the contracts with the following vendors through the dates indicated in the attached Tables 1, 2 and 3:
    a. Cognizant TriZetto Software Group, Inc.
    b. Catalyst Solutions, LLC
    c. Edifecs, Inc.
    d. Imagenet, LLC
    e. LexisNexis Risk Solutions FL Inc, and Enclarity, Inc.
    f. Symplr
    g. Change Healthcare Technologies, LLC
    h. Ceridian Corporation
    i. Silk Road Technology, Inc.
    j. Varis, LLC
    k. SmartComms, LLC
    l. InfoCrossing, A WIPRO Company
    m. Intuitive Technology Group, Inc.
    n. Lumen Technologies
2. Authorize payment of maintenance and support fees to these vendors through the dates and up to the amounts indicated in the attached Tables 1, 2 and 3.

Background
CalOptima contracts with several vendors that provide a variety of software solutions to support CalOptima's overall business model. There are two core systems, Facets and Guiding Care, that are central to CalOptima's infrastructure while many other supporting solutions surround them.

Within the managed care industry, it is standard practice to have multiple systems because no commercially available single solution can meet the demands of the industry for all necessary functions. The trend over the past ten years or more has been to utilize each core application for what that system handle best, and to use specialty solutions to supplement the core. CalOptima, along with virtually all other local health plans in the state, use this approach.

Primary and supporting systems include:

a. **Cognizant TriZetto Software Group, Inc. –** Facets is CalOptima's core business system that manages Membership/eligibility data, Customer Service, Claims and Provider Dispute

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Requests. In 2018, CalOptima initiated a Request for Information (RFI) to review available systems within the industry to determine whether it would make sense for CalOptima to replace the current system. There is no one system that handles everything well, and although we identified systems that can perform some functions better than CalOptima's current core system, there are trade-offs to consider. To replace a core system like this would require a minimum of two to three years to issue a Request for Proposal (RFP), enter into a contract and implement the transition. In addition, the cost would be at a minimum of $10–15 million (based on information from other county organized health systems (COHS) that have recently gone through this process). In further review and discussion with Gartner[1], the recommendation was to consider procuring supplemental systems to offset some of the functionality gaps within the core system. At the February 2020 meeting of the Finance and Audit Committee (FAC) of the Board, staff recommended staying with our current core system and to consider supplemental functions to fill any gaps. One such supplemental initiative include the Provider Data Management System RFP that is currently in progress. Staff recommends approval of extending the Facets contract for three additional years with the options to extend the agreement for two additional one-year terms (through June 2027) in order to provide staff with sufficient time to implement supplemental systems and re-evaluate whether the functional gaps have been fully addressed.

b. **Catalyst Solutions, LLC** is a vendor utilized for technical support for Facets. This vendor has supported many of our Facets upgrades over the years. The vendor is extremely familiar with our infrastructure and the Facets product. Catalyst Solutions' contract was extended by the Board on December 6, 2018, in line with the Facets Core System extension, due to the vendor's knowledge of CalOptima's infrastructure and the application. Staff recommends extending the contract for three additional years with the options to extend the agreement for two additional one-year terms (through June 2027) in alignment with the Facets contract.

c. **Edifecs, Inc.** is a software tool that supports quality for the CalOptima Facets Claims processes. XEngine through Edifecs is a tool that validates and ensures compliance with regulatory transaction standards and streamlines operational efficiency. This vendor has provided solutions that are tightly integrated with our core system. Staff recommends approval of extending the contract for three and a half additional years with the option to add two one-year extensions (through June 2027) to match the extension date of the Facets contract.

d. **Imagenet, LLC** is the vendor that provides imaging, scanning, data lift and document archive solutions. Multiple departments utilize their scanning and image data lift to provide data files for claims and enrollment selection processes. Along with that, Imagenet provides the electronic data imaging archives for provider documents and Medication Therapy Management (MTM) letter documentation, as well as historical Grievance and Appeals documentation. This vendor has provided solutions that are tightly integrated with our core system. Staff recommends approval of extending the contract for three and a half additional years with the option to add two one-year extensions (through June 2027) to match the extension date of the Facets contract.

e. **LexisNexis Risk Solutions FL Inc. and Enclarity, Inc.** provides a solution to validate Provider Data used at CalOptima, including demographic data and identification of providers that are on Federal exclusion lists. This software is tightly integrated to the core system. Staff

[1] Gartner is a leading technical research and advisory company that provides senior CalOptima leaders with the indispensable business insights and advice to achieve the mission-critical priorities.

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recommends approval of extending the contract for an additional two years and eight months with the option to add three one-year extensions (through June 2027) to match the extension date of the Facets contract.

Provider Credentialing and Contracting Systems:

The following two contracts are for provider credentialing (Symplr) and provider contracting (Change Healthcare Technologies). Staff is currently in the RFP process to select and implement an integrated solution for Provider Data Management, Contracting and Credentialing. This integrated solution will potentially replace the current Credentialing and Contracting systems if new vendor(s) are selected consistent with the Board-approved Purchasing policy. Due to the complexity of this effort, staff estimates that the integrated solution implementation will be completed by the end of 2024. Staff recommends approval of extending both contracts annually for up to two additional years (through December 2024) to allow sufficient time for completion of the RFP and implementation of the selected system.

a. **Symplr** provides provider credentialing software. As noted above, staff plans to complete the RFP process and implement a new solution by the end of 2024. Staff recommends approval of extending the contract for one additional year and sixteen days with an option for two additional one year extensions.(through December 2024).
b. **Change Healthcare Technologies, LLC** is a provider contract management software system. As noted above, staff plans to complete the RFP process and implement a new solution by the end of 2024. Staff recommends approval of extending the contract for an additional one year and one day with an option for two additional one year extensions (through December 2024).

Human Capital Management (HCM) Systems:

The following three systems support our Human Resources (HR) function. CalOptima's HR Department currently utilizes several disparate systems to assist in managing employee information and applicant tracking. The RFP planned for FY 2019–2020 to replace these three systems was deferred due to other priorities related to the COVID pandemic. Staff is currently preparing a Human Capital Management (HCM) solution RFP to be issued in Fall 2021 to review products in the marketplace. This RFP seeks an integrated solution to support several HR and Finance functions, including, but not limited to, core HR functions, benefits, workforce management, payroll, applicant tracking and recruitment, and performance management, which are currently provided by several different systems. By allowing a one-year extension to these three systems below, staff will have time to complete the RFP, contract with the successful vendor, and implement a new solution for HCM.

a. **Ceridian Corporation-** Dayforce is the primary HR and Finance system handling employee benefits and payroll. As noted above, by allowing a one-year extension to this contract, staff will have sufficient time to complete the HCM RFP and implement a new solution. Staff recommends approval of extending the contract for one additional year (through January 6th 2023).
b. **Silk Road Technology, Inc.-** OpenHire is the current HR applicant tracking and recruitment system. WingSpan is the current employee performance management system where all CalOptima staff performance evaluations are created and stored. As noted above, by allowing a one-year extension to this contract, staff will have sufficient time to complete the HCM RFP and implement a new solution. Staff recommends approval of extending the contract for one additional year (through December 2022).

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Other Systems

a. **Varis LLC** provides overpayment identification and post-payment recovery services of potential overpayment of services that utilized Diagnosis Related Group (DRG) for Inpatient Medicare and Medi-Cal and Outpatient or Ambulatory Payment Classification (APC) payment guidelines to determine the claims payment amount. To summarize the audit review process, Varis conducts the data and clinical analysis based on CalOptima's paid files and review of medical records, as needed, and identifies the dollar recovery amounts based on their audit findings. By allowing a one-year extension, staff will have time to complete the RFP process, and if the same vendor is not selected, it will allow sufficient time to contract and implement a new solution. Staff recommends approval of extending the contract for one additional year (through September 24th, 2023).

b. **SmartComms, LLC** provides system generated letters for claims requests as well as claims denials. This solution was originally selected to support the Care Management vendor solution. With the decision to process a RFP to select a Care Management solution, the letter generating solution may change with that direction. Staff recommends approval of extending the contract for one additional year (through December 30th, 2022) to allow time to complete the Care Management System RFP which will impact the letter communication system.

c. **InfoCrossing, A WIPRO Company** is a CMS third party vendor that supports our process to submit enrollment and disenrollment updates to CMS. The vendor provides CMS data files for membership reconciliation for OneCare, OneCare Connect, and PACE. WIPRO supports file transfers between CalOptima and CMS. This vendor has maintained our stability to process regulatory file requirements to CMS. With the Duals Demonstration coming to an end and the transition of member planning in progress, it would be best to stay with the existing vendor to assure stability in transition. Staff recommends approval of extending the contract for an additional three years, two months and three days, to cover the period of the transition and the first year thereafter (through December 31st, 2024). Post transition, staff will issue an RFP to review the available systems in the market.

d. **Intuitive Technology Group, Inc.** Tableau is an enterprise-wide reporting and analysis tool that provides staff with the capability to review and analyze clinical, financial, and other data to monitor and improve performance. In addition to costs associated with selecting and implementing a new tool, to replace a system like this, it would require the use of a new tool for staff to perform data analysis and to be re-trained to re-create the many reports and dashboards developed over the last four years. Staff's recommendation is to approve extending the contract for three additional years (through November 28th, 2024).

e. **Lumen Technologies** is CalOptima's carrier for telecommunications as well as Internet connectivity. This vendor supports this particular area of the County. Internet and telecommunication stability during the pandemic has been essential to keep our communications functioning. We have not experienced any major issues with the vendor during the pandemic. Staff's recommendation is to approve extending the contract for three additional years (through 12/31/2024).

Discussion

The vendors listed above and in the attached tables represent the solutions described and contracts expiring in 2021 and 2022. Replacing any of these solutions in the short term would require substantial additional investment, time commitment, as well as significant disruption to operations.

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Many of these solutions are tightly embedded and integrated into either Facets or Guiding Care (the core systems):

I. Table 1. Unless core systems are replaced, replacing these tightly integrated solutions is not feasible without substantial investment and significant disruption to the operations. Some of the vendors also represent the most viable solution considering CalOptima's operating environment.

II. Table 2. The vendors in this category have expiring contracts, but due to the complications related to the COVID-19 pandemic during the past 18 months, staff needs additional time to complete the RFP processes and selection of new vendors. Extending these contracts as proposed will allow sufficient time for selection and implementation of new systems and avoid potential gaps in services.

III. Table 3. This table lists the technical solutions that provide support to the infrastructure and stability for the above systems. Extending these vendor solution contracts will allow additional time to complete the other RFP processes and determine whether an RFP to change technical directions is needed.

Fiscal Impact

The CalOptima Fiscal Year 2021–22 Operating Budget, approved by the Board on June 3, 2021 includes the annual fees for the listed contracted vendors related to CalOptima's core and supporting systems through June 30, 2022. Management will include expenses for the recommended contract extension periods on or after July 1, 2022, in future CalOptima operating budgets.

Rationale for Recommendation

Extension of the contracts for these systems will ensure there is no disruption to the services provided by each of the solutions and allows continuity of operations throughout the organization that impact CalOptima's member and provider community.

Concurrence

Gary Crockett, Chief Counsel

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Rev. 10/7/21: Option for one-year extensions exercisable at the Board's discretion.

Attachments

1. Tables of Proposed Contract Extensions
2. Entities Covered by this Recommended Board Action
3. Appendix: Summary of Contract History
4. Board Action dated June 3, 2021: Consider Approval of the CalOptima Fiscal Year 2021–22 Operating Budget
5. Board Action dated March 5, 2020: Consider Authorization of Expenditures in the CalOptima Fiscal Year 2019–20 Operating Budget for Claims Editing Solution and Recovery Services
6. Board Action dated December 6, 2018: Consider Extension of Contract Related to CalOptima's Core System, Facets
7. Board Action dated December 6, 2018: Consider Extension of Contracts Related to CalOptima's Key Operational and Human Resource Systems
8. Board Action dated September 1, 2016: Consider Extension of Contracts Related to CalOptima's Core Systems

/s/ Richard Sanchez — **Authorized Signature**

09/29/2021 — **Date**

Rev 10/7/21: All contracts below extended for 3 years, except c. and d. were extended for 3.5 years.

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Tables — Proposed Contract Extensions

Table 1 — Solutions tightly integrated with the two core systems (Facets and/or Altruista)

Number from List, Vendor, Solution Name (if applicable)	Description of Service	Original Contract Start Date	Current Contract Expires	Recommend Contract Extension Through	Annual Cost Based on Fiscal Year 2021–22 Budget
a. Cognizant TriZetto Software Group, Inc.	Core business applications supporting membership, claims	2/22/2000	6/30/2022	6/30/2027	$1,915,000
b. Catalyst Solutions, LLC	Technical consultant support for Facets	4/21/2014	6/30/2022	6/30/2027	$28,000
c. Edifecs, Inc.	Electronic transaction standardization software	03/09/2011	12/31/2021	6/30/2027	$114,100
d. Imagenet, LLC	Archiving and document imaging services	11/21/2017	12/31/2021	6/30/2027	$350,000
e. Lexis Nexis Risk Solutions Fl Inc. and Enclarity, Inc.	Provider exclusion software	5/01/2015	10/31/2021	6/30//2027	$324,000

Table 2 — Solutions defined as essential systems with contracts that need extending to allow time for RFP selection and contract negotiation with implementation of the selected vendor to replace existing systems, and to assure there are no gaps in service.

Number from List, Vendor, Solution Name (if applicable)	Description of Service	Original Contract Start Date	Current Contract Expires	Recommend Contract Extension Through	Annual Cost Based on Fiscal Year 2021–22 Budget
f. Symplr	Credentialling system	11/29/2011	12/15/2021	12/31/2024	$119,000
g. Change Healthcare Technologies, LLC	Contract management software system	12/30/2016	12/30/2021	12/31/2024	$355,000
h. Ceridian Corporation	Employee payroll	6/29/2008	1/06/2022	1/06/2023	$384,000
i. Silk Road Technology, Inc.	HR recruitment tracking (Open Hire) and HR performance management (Wingspan)	06/19/2009	12/31/2021	12/31/2022	$81,000
j. Varis LLC	High dollar and forensic claims review	9/25/2017	9/24/2022	9/24/2023	$1,450,000
k. SmartComms, LLC	Letter generation software	12/31/2016	12/30/2021	12/30/2022	$145,000
l. InfoCrossing, A WIPRO Company	CMS enrollment/eligibility verification and CMS file reconciliation	05/01/2005	10/28/2021	12/31/2024	$24,000

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Table 3 — Technical solutions that maintain service level consistency.

Number from List, Vendor, Solution Name (if applicable)	Description of Service	Original Contract Start Date	Current Contract Expires	Recommend Contract Extension Through	Annual Cost Based on Fiscal Year 2021–22 Budget
m. Intuitive Technology Group, Inc.	Business intelligence software — Tableau	11/22/2017	11/28/2021	11/28/2024	$238,505
n. Lumen Technologies	Internet connectivity	02/15/2012	12/31/2021	12/31/2024	$984,000

ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
Cognizant Trizetto Software Group, Inc.	300 Frank W Burr Blvd.	Teaneck	NJ	07666
Catalyst Solutions, LLC	6400 S. Fiddlers Green Circle	Greenwood Village	CO	80111
Edifecs, Inc	1756 114th Ave. SE	Bellevue	WA	98004
Imagenet, LLC	5401 W. Kennedy Blvd.	Tampa	FL	33609
LexisNexis Risk Solutions FL Inc. and Enclarity, Inc.	1105 N Market St, Ste 501	Wilmington	DE	19801
Symplr	315 Capitol St., Suite 100	Houston	TX	77002
Change Healthcare Technologies, LLC	100 Airpark Center Dive East	Nashville	TN	37217
Ceridian Corporation	3311 E Old Shakopee Rd	Minneapolis	MN	55425
Silk Road Technology, Inc	100 S. Wacker Dr, Suite 425	Chicago	IL	60606
Varis, LLC	3915 Security Park Dr, Ste B	Rancho Cordova	CA	95742
SmartComms, LLC	250 Commercial Street	Manchester	NH	03101
InfoCrossing, A WIPRO Company	2 Tower Center	East Brunswick	NJ	08816
Intuitive Technology Group, Inc.	4530 W 77th Street, Suite 255	Edina	MN	55435
Lumen Technologies	100 CenturyLink Dr.	Monroe	LA	71203

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APPENDIX TO AGENDA ITEM 16

Summary of Contract History

Vendor	Contract Number(s)	History of Contract Changes (Summary)	Last Approval
a. Cognizant TriZetto Software Group, Inc.	00-849-2197	There have been 48 amendments to the contract. These amendments have included time extensions, functional enhancements to support changes to regulatory and business requirements over the years, and administrative changes. Staff conducted multiple RFIs to survey the market for claims processing and customer service systems. Most recently, at the February 2020 meeting of the Finance and Audit Committee (FAC) of the Board, staff recommended to stay with our current core systems and to consider supplemental functions to fill the gap.	Board Approval December 6, 2018
b. Catalyst Solutions, LLC	14005	There have been 9 amendments to the contract. The amendments included date extensions along with technical support for system configuration changes required to meet regulatory and business requirements.	Board Approval December 6, 2018
c. Edifecs, Inc.	MC 01759	This contract has been extended 10 times. The extensions have included date extensions along with licensing modifications and technical support to accommodate changes to regulatory and business requirements.	Board Approval December 6, 2018
d. Imagenet, LLC	18-10184	There have been 7 amendments to the contract. The amendments include service additions to accommodate changes to regulatory and business requirements and the exercise of options to extend the contract that was included in the original contract.	Budget Approval June 3, 2021
e. Lexis Nexis Risk Solutions FL Inc. and Enclarity, Inc.	15-0964/ 15-0973	There have been 6 amendments to the contract. The amendments include date extensions, administrative changes and pricing updates.	Budget Approval June 3, 2021

Rev 10/7/21: All contracts below extended for 3 years, except c. and d. were extended for 3.5 years.
Rev. 10/7/21: Option for one-year extensions exercisable at the Board's discretion.

Vendor	Contract Number(s)	History of Contract Changes (Summary)	Last Approval
f. Symplr	MC 01611	There have been 9 extensions to the contract. The extensions have included date extensions along with licensing modifications and technical support to accommodate changes to regulatory and business requirements.	Budget Approval June 3, 2021
g. Change Healthcare Technologies, LLC	17-10538	There have been 2 amendments to the contract. The amendments include technical support services related to the implementation and upgrade of the software.	Budget Approval June 3, 2021
h. Ceridian Corporation	MC 03232	There have been 12extensions to the contract. The extensions have included software license modifications and technical support services related to the implementation and upgrade required to meet regulatory and business requirements.	Board Approval December 6, 2018
i. Silk Road Technology, Inc.	MC 02042	There have been 10 extensions to the contract. The extensions have included technical support services related to the implementation and upgrade of the software.	Board Approval December 6, 2018
j. Varis, LLC	17-10537	There have been 2 amendments to the contract. The amendments were for date extensions.	Board Approval March 5, 2020
k. SmartComms, LLC	17-10511	There have been 2 amendments to the contract. The amendments include technical service additions to support implementation and the exercise of options to extend the contract that was included in the original contract.	Budget Approval June 3, 2021
l. InfoCrossing, A WIPRO Company	PO 06195	There have been 8 amendments to the contract. The amendments included date extensions along with service modifications required to meet CMS regulatory requirements.	Budget Approval June 3, 2021
m. Intuitive Technology Group, Inc.	18-10487	There have been 2 amendments to the contract. The amendments include additional licenses to support organizational growth and the exercise of options to extend the contract that was included in the original contract.	Budget Approval June 3, 2021

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken June 3, 2021
Regular Meeting of the CalOptima Board of Directors

Report Item
24. Consider Approval of the CalOptima Fiscal Year 2021-22 Capital Budget

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

Recommended Actions
1. Approve the CalOptima Fiscal Year (FY) 2021-22 Capital Budget; and
2. Authorize the expenditures and appropriate the funds for the items listed in Attachment A: Fiscal Year 2021-22 Capital Budget by Project, which shall be procured in accordance with CalOptima Board-approved policies.

Background
As of March 31, 2021, CalOptima recorded gross capital assets of $103.9 million in the 505 Building, building improvements, furniture, equipment, and information systems. To account for these fixed assets wearing out over time, Staff has charged against the cost of these assets an accumulated depreciation totaling $58.2 million. Staff will record capital assets acquired in FY 2021-22 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 $45.8 million, as of March 31, 2021. Prior Board-approved capital budgets were $16.2 million in FY 2020-21, and $11.0 million in FY 2019-20.

Pursuant to CalOptima Policies GA.3202: CalOptima Signature Authority, GA.5002: Purchasing Policy, and GA.5003: Budget and Operations Forecasting, the Board's approval of the budget authorizes the expenditure of the item and appropriates the funds requested without further Board action to the extent the Board has or is, as indicated in the budget attachments, delegating authority to Management.

Discussion
Management proposes a Capital Budget of $14.7 million for FY 2021-22 within three (3) asset categories summarized in the following table and detailed below:

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Category	Amount	% of Total
1. Information Systems		
Hardware	$3,708,000	25.2%
Software	$6,850,500	46.6%
Professional fees related to implementation	$2,298,500	15.6%
Subtotal	$12,857,000	87.4%
2. 505 Building Improvements	$1,428,000	9.7%
3. PACE	$422,000	2.9%
Total	**$14,707,000**	**100.0%**

1. Information Systems

Information Systems represent nearly $12.9 million or 87.4% of the proposed Capital Budget. This asset category primarily addresses CalOptima's information technology infrastructure needs.

Project Type	Amount	% of Total
Infrastructure	$4,702,000	36.6%
Applications Management	$3,380,000	26.3%
Applications Development	$4,775,000	37.1%
Total	**$12,857,000**	**100.0%**

The Capital Budget includes funding for hardware, software, and professional fees related to the implementation of multiple systems upgrades. More detailed information is provided in Attachment A: Fiscal Year 2021-22 Capital Budget by Project. These upgrades are necessary to support internal operations, and to ensure compliance with state and federal requirements.

2. 505 Building Improvements

505 Building Improvements represent $1.4 million or 9.7% of the proposed Capital Budget. The largest item of $625,000 or 43.8% of the 505 Building capital expenditures is to fund a New Member Services Entrance and Lobby Improvements for Enhanced Security.

Project Type	Amount	% of Total
New Member Services Entrance and Lobby Improvements for Enhanced Security	$625,000	43.8%
Office Suite Renovation and Improvements	$478,000	33.5%
New Roof Membrane Continuation	$100,000	7.0%
Capital Lease for Copiers	$75,000	5.3%
Enhanced HVAC Ionization Filter to Treat Airborne Viruses	$75,000	5.3%
Cooling Tower Continuation	$40,000	2.8%
IDF Room HVAC Unit Replacement	$25,000	1.8%
Recording Studio for Education, Training, Outreach, and Marketing	$10,000	0.7%
Total	**$1,428,000**	**100.0%***

* Total may not add due to rounding

3. Program for All-Inclusive Care for the Elderly (PACE)
The remaining portion of $422,000 or 2.9% of the proposed Capital Budget is for capital expenditures at the PACE Center.

Project Type	Amount	% of Total
Electronic Storage Expansion	$123,000	29.1%
Interior Light Repairs	$75,000	17.8%
Work Station Renovation	$57,000	13.5%
Conference Rooms 110 and 109 Furniture and Analog Audio Visual Systems Upgrade	$50,000	11.8%
Conference Room Table Upgrades	$44,000	10.4%
Upgrade Phone Systems to Add Redundancy	$35,000	8.3%
Upgrade Employee Outdoor Patio	$20,000	4.7%
Upgrade Lobby Furniture	$18,000	4.3%
Total	**$422,000**	**100.0%***

* Total may not add due to rounding

Fiscal Impact
Investment in the proposed Capital Budget will reduce CalOptima's investment principal by $14,707,000. Depreciation expenses for the Capital Budget projects are reflected in CalOptima's Operating Budget.

Rationale for Recommendation
The proposed FY 2021-22 Capital Budget will enable necessary system upgrades, enhance operational efficiencies, support strategic initiatives, comply with federal and state requirements, and improve and upgrade the 505 Building and the PACE Center.

Concurrence
Gary Crockett, Chief Counsel
Board of Directors' Finance and Audit Committee

Attachments
1. Attachment A: Fiscal Year 2021-22 Capital Budget by Project

/s/ Richard Sanchez *05/26/2021*
Authorized Signature **Date**

Attachment A

Fiscal Year 2021 - 2022 Capital Budget by Project

INFRASTRUCTURE	HARDWARE	SOFTWARE	PROFESSIONAL FEES	TOTAL CAPITAL
Upgrade the Portal Application Load Balancer Appliance	303,000	176,000	81,000	560,000
Office Wireless Network System Upgrade	164,000	84,000	153,000	401,000
Implement Data Operations and Virtualization	165,000	133,000	30,000	328,000
Implement a New Virtual Desktop For Employee Computers To Centralize Support	125,000	125,000	75,000	325,000
Upgrade the Database Disk Storage Equipment	300,000		3,500	303,500
Implement a Test Lab to Support Production Upgrades	300,000			300,000
Encrypt Sensitive Data Within Production Environments	60,000	200,000	40,000	300,000
Upgrade the Citrix Virtual Servers to Support Version	249,000	2,500	7,500	259,000
Upgrade and Expand the Server Monitoring Software	72,000	170,000		242,000
Implement a Solution to Prevent Data Loss Within Cloud Application		140,000	60,000	200,000
Implement the Customer Services Call Recording System		150,000	50,000	200,000
Upgrade the Online Fax System to a Cloud Solution		170,000	15,000	185,000
Increase Virus Protection Licenses for On-Premise Servers		85,000	100,000	185,000
Upgrade the Citrix Disk Storage Equipment	150,000		3,500	153,500
Upgrade and Expand the Network Monitoring Software	140,000			140,000
Implement New Software to Manage Employee Access Accounts			100,000	100,000
Upgrade the Core Systems Development and Test Environments	100,000			100,000
Upgrade the Database Security And Monitoring Software	60,000		25,000	85,000
Upgrade the Corporate Building Server Disk Storage	75,000		3,000	78,000
Upgrade the System Backup Application Disk Storage	75,000			75,000
Computer Network Load Balancer System Upgrade	46,000			46,000
Implement Secure Data Masking for HIPAA Transaction File Sets		36,000		36,000
Upgrade the Email Phishing Software		30,000		30,000
Upgrade the Internet Secure Email Gateway Software	24,000			24,000
Implement New Software to Monitor and Resolve Computer Network Traffic Issues		23,000		23,000
Upgrade and Expand the Computer Network Switches	15,000			15,000
Upgrade the Internet Monitoring Appliance		8,000		8,000
TOTAL INFRASTRUCTURE	**$ 2,423,000**	**$ 1,532,500**	**$ 746,500**	**$ 4,702,000**

APPLICATIONS MANAGEMENT	HARDWARE	SOFTWARE	PROFESSIONAL FEES	TOTAL CAPITAL
Implement a New Provider Data Management System Including Credentialing And Contract Management		2,250,000	225,000	2,475,000
Upgrade the Core Facets System to Latest Supported Version	329,000	5,000	41,000	375,000
Implement a Provider to Provider eConsult Application (Additional Funding)		200,000	150,000	350,000
Implement Claims Auditing Software		150,000	30,000	180,000
TOTAL APPLICATIONS MANAGEMENT	**$ 329,000**	**$ 2,605,000**	**$ 446,000**	**$ 3,380,000**

APPLICATIONS DEVELOPMENT	HARDWARE	SOFTWARE	PROFESSIONAL FEES	TOTAL CAPITAL
Implement a New Human Capital Management (HCM) System for HR Benefits, Payroll, Employee Performance and Relations, and Recruiting	75,000	500,000	150,000	725,000
Implement and Install Business Continuity Plan Software		400,000	250,000	650,000
Implement a New Service Desk Software to Support, Track, and Monitor Employee Operational Requests	10,000	425,000	85,000	520,000
Implement a New Board Material Software to Streamline Operations		365,000	150,000	515,000
Implement Data Governance Software to Inventory, Label, Categorize, and Define Data Through the Organization's Information Records		400,000	50,000	450,000
Upgrade the Portal Application Audit Log Storage	350,000	50,000		400,000
Upgrade the Caloptima.Org Web Content Management Infrastructure	300,000	15,000	40,000	355,000
Implement a Risk Management Software Application to Support and Manage Compliance and Security Activities		235,000	62,000	297,000
Implement Software to Support Compliance with Americans with Disabilities Act and Web Content Accessibility On Caloptima.Org Website		233,000	59,000	292,000
Upgrade the Accounting AR/AP Software			135,000	135,000
Upgrade the Web Portal Access Management Software	100,000		20,000	120,000
Increase the Portal File System to Support Provider Performance and Member Education Campaigns	100,000	5,000	10,000	115,000
Migrate the Budget Software to Cloud Solution		49,000	38,000	87,000
Implement Customer Service Member Online Chat Services		36,000	12,000	48,000
Implement a New Procurement and Requisition Software Application			35,000	35,000
Upgrade the Data Warehouse Infrastructure	17,000			17,000
Integrate Employees Online Chat Services With the HR Learning Management System for Educational Collaboration			10,000	10,000
Implement Test Automation Software for Web Application Development	4,000			4,000
TOTAL APPLICATIONS DEVELOPMENT	**$ 956,000**	**$ 2,713,000**	**$ 1,106,000**	**$ 4,775,000**

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Attachment A

Fiscal Year 2021 - 2022 Capital Budget by Project

505 BUILDING IMPROVEMENTS	BUILDING	EQUIPMENT	PROFESSIONAL FEES	TOTAL CAPITAL
New Member Services Entrance and Lobby Improvements for Enhanced Security	530,000		95,000	625,000
Office Suite Renovation and Improvements	443,000		35,000	478,000
New Roof Membrane Continuation	100,000			100,000
Capital Lease for Copiers	75,000			75,000
Enhanced HVAC Ionization Filter to Treat Airborne Viruses	75,000			75,000
Cooling Tower Continuation	40,000			40,000
IDF Room HVAC Unit Replacement	20,000		5,000	25,000
Recording Studio for Education, Training, Outreach, and Marketing	8,000		2,000	10,000
TOTAL 505 BUILDING IMPROVEMENTS	**$ 1,291,000**	**$ -**	**$ 137,000**	**$ 1,428,000**

PACE	EQUIPMENT		PROFESSIONAL FEES	TOTAL CAPITAL
Electronic Storage Expansion	120,000		3,000	$123,000
Interior Light Repairs	75,000			$75,000
Work Station Renovation	57,000			$57,000
Conference Rooms 110 and 109 Furniture and Analog Audio Visual Systems Upgrade	35,000	5,000	10,000	$50,000
Conference Room Table Upgrades	24,000	20,000		$44,000
Upgrade Phone Systems to Add Redundancy		24,000	11,000	$35,000
Upgrade Employee Outdoor Patio	20,000			$20,000
Upgrade Lobby Furniture	18,000			$18,000
TOTAL PACE	**$ 349,000**	**$ 49,000**	**$ 24,000**	**$ 422,000**

TOTAL FY22 NEW CAPITAL BUDGET	**$ 5,348,000**	**$ 6,899,500**	**$ 2,459,500**	**$ 14,707,000**

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FY 2021-22 Capital Budget

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Overview of Capital Budget

Category	FY 2021-22 Budget	% of Total
Information Systems		
Hardware	$3,708,000	25.2%
Software	$6,850,500	46.6%
Professional fees related to implementation	$2,298,500	15.6%
Subtotal	$12,857,000	87.4%
505 Building Improvements	$1,428,000	9.7%
PACE	$422,000	2.9%
Total	**$14,707,000**	**100.0%**

- Departments submit requests for capital projects based on strategic and operational needs
- Information Services Department reviews technology requests

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Information Systems Budget

Capital Project Type	FY 2021-22 Budget
Infrastructure (e.g., Network, Server, Storage, Security)	$4,702,000
Applications Management (e.g., Provider Data Management System, Upgrade Core Facets Systems, Provider to Provider eConsult application, Claims Auditing Software)	$3,380,000
Applications Development (e.g., New Human Capital Management System, Business Continuity Plan Software, Service Desk Software for Employee Operational Requests)	$4,775,000
Total	**$12,857,000**

- Represents nearly 87.4% of total Capital Budget
- Addresses information technology infrastructure needs
- Supports internal operations
- Ensures compliance with state and federal requirements

Note: Project details can be found in Attachment A: Fiscal Year 2021-22 Capital Budget by Project

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505 Building Improvements

Capital Project Type	FY 2021-22 Budget
New Member Services Entrance and Lobby Improvements for Enhanced Security	$625,000
Office Suite Renovation and Improvements	$478,000
New Roof Membrane Continuation	$100,000
Capital Lease for Copiers	$75,000
Enhanced HVAC Ionization Filter to Treat Airborne Viruses	$75,000
Cooling Tower Continuation	$40,000
IDF Room HVAC Unit Replacement	$25,000
Recording Studio for Education, Training, Outreach, and Marketing	$10,000
Total	**$1,428,000**

- Represents 9.7% of total Capital Budget

PACE Center Budget

Capital Project Type	FY 2021-22 Budget
Electronic Storage Expansion	$123,000
Interior Light Repairs	$75,000
Work Station Renovation	$57,000
Conference Rooms 110 and 109 Furniture and Analog Audio Visual Systems Upgrade	$50,000
Conference Room Table Upgrades	$44,000
Upgrade Phone Systems to Add Redundancy	$35,000
Upgrade Employee Outdoor Patio	$20,000
Upgrade Lobby Furniture	$18,000
Total	**$422,000**

- Represents 2.9% of total Capital Budget

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Recommended Actions

- Approve the CalOptima FY 2021-22 Capital Budget
- Authorize the expenditures and appropriate the funds for the items listed in Attachment A: Fiscal Year 2021-22 Capital Budget by Project
  - Items will be procured in accordance with CalOptima policies and procedures

Our Mission

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

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action to Be Taken March 5, 2020
Regular Meeting of the CalOptima Board of Directors

Consent Calendar

7. Consider Authorization of Expenditures in the CalOptima Fiscal Year 2019-20 Operating Budget for Claims Editing Solution and Recovery Services

Contact

Belinda Abeyta, Executive Director, Operations, (714) 246-8400

Recommended Actions

Recommend authorizing unbudgeted operating expenditures within the Medi-Cal program purchased services expense category in an amount not to exceed $1,395,000 from existing reserves for the following:

1. An increase of up to $645,000 to fund contingency fees for pre-payment claims editing solutions of professional services claims;
2. An increase of up to $750,000 to fund contingency fees for overpayment recoveries related to inpatient DRG and outpatient APC paid claims and non-pursuit fees.

Background/Discussion

The recommended budget adjustments for clinical editing solutions and recovery solutions are included within the Claims Administration Fiscal Year (FY) 2019-20 Operating budget as summarized below.

1. Cotiviti. Cotiviti is CalOptima's claims editing solution that identifies claim coding accuracy for providers rendering professional services. Cotiviti is a contingency contract based on a fee of 19.5% per claim based on the acceptance of the coding edit prior to the final claim payment. Cotiviti's claims editing software utilizes National Correct Coding Initiative Edits (NCCI), Medicare and Medi-Cal guidelines to determine the claim coding accuracy of professional services claims.

   CalOptima's Claims Administration Department provides guidance to Cotiviti as to which claims coding edits can be utilized for professional service claims submitted to CalOptima for payment consideration. Savings for the first six months of FY 2019-20 total $4,382,247 with contingency fees of $832,646 paid to Cotiviti. Claims Administration increased the number of claims coding edits in FY 2019-20 Q3, generating $1,110,917 in avoided overpayments from FY 2019-20 Q2.

   Claims Administration has identified four additional claims coding edits that Claims Administration will request Cotiviti to implement for professional service claims within the next 120 days increasing savings to CalOptima. Claims Administration budgeted $958,000 for contingency fees with $125,354 remaining for FY 2019-20 budget. This requested addition to budget is to cover the additional contingency fees up to $645,000.

2. Varis. Varis is CalOptima's clinical editing solutions for post-payment recoveries of overpayments of inpatient DRG and outpatient APC paid claims. Varis is a contingency contract

based on a per claim fee of 25% for inpatient and 26% for outpatient contingent upon the successful recovery of overpayments. Claims Administration budgeted $727,000 for contingency fees in the FY 2019-20 budget with $6,384 for the remaining FY 2019-20 budget.

Current trending from FY 2018- 19 to FY 2019 -20 shows a 10% year-over-year growth in recovered overpayments that would generate increased contingency fees to Varis that are not budgeted. Management recommends authorization of additional funding of up to $750,000 in contingency fees.

Fiscal Impact

The recommended actions to authorize administrative expenditures within the Medi-Cal program for contingency fees for claims editing solution and recovery services is unbudgeted. An allocation in an amount not to exceed $1,395,000 from existing reserves will fund this action. Staff anticipates that the changes to the contingency contracts will result in higher avoided and recovered overpayments in medical expenses with the level of recoveries fully offsetting the additional contingency fees.

Rationale for Recommendation

Staff recommends approval of the recommended action to ensure CalOptima continual utilization of claim editing solutions and recovery services to ensure appropriate and accurate claims payments and recoveries through June 30, 2020.

Concurrence

Gary Crockett, Chief Counsel
Board of Directors' Finance and Audit Committee

Attachment

1. Claims Administration Budget Request Presentation

/s/ Michael Schrader *2/26/2020*
Authorized Signature **Date**

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Claims Administration Budget Request

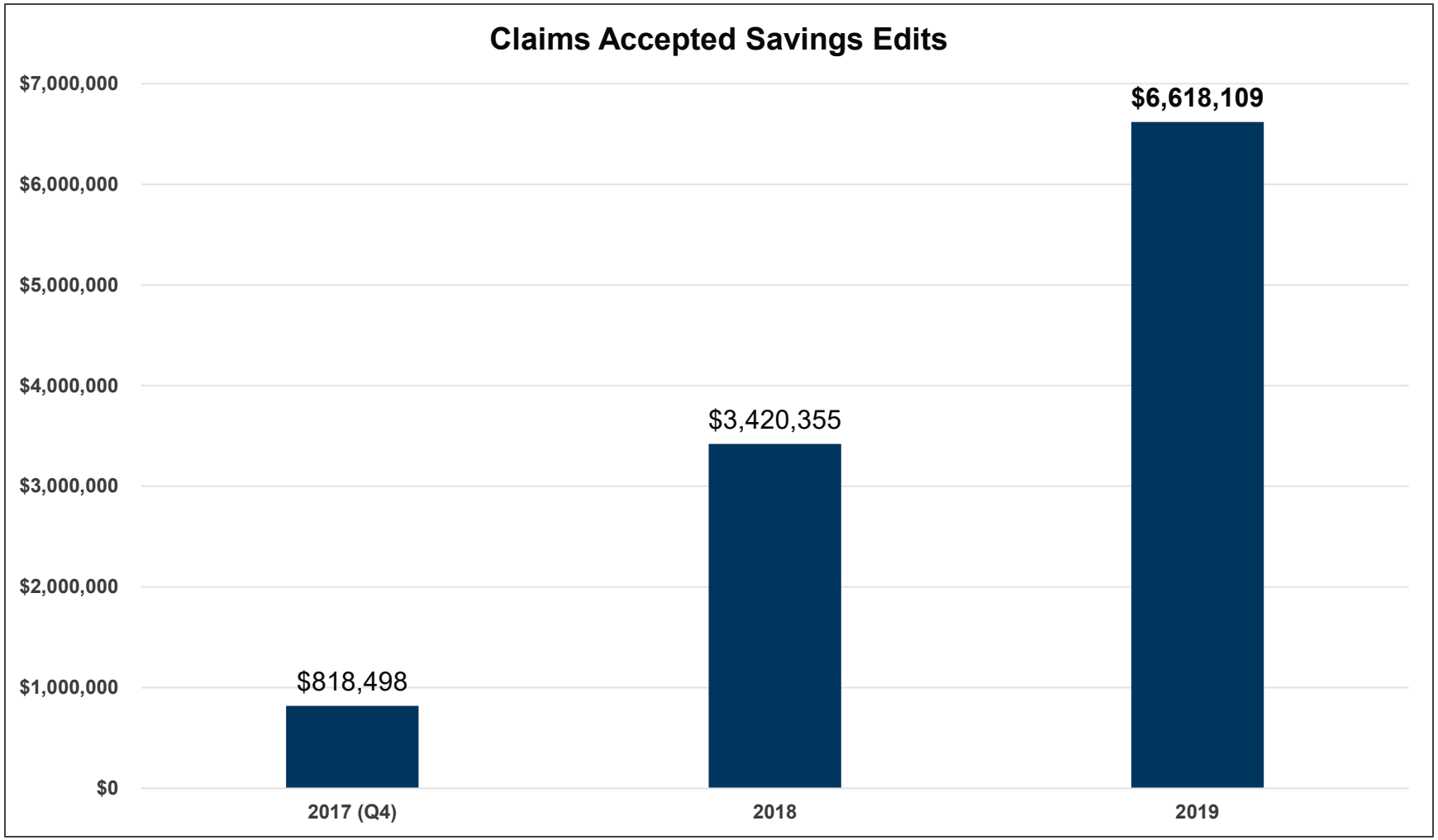
Board of Directors' Finance and Audit Committee Meeting
February 20, 2020

Belinda Abeyta
Executive Director, Operations

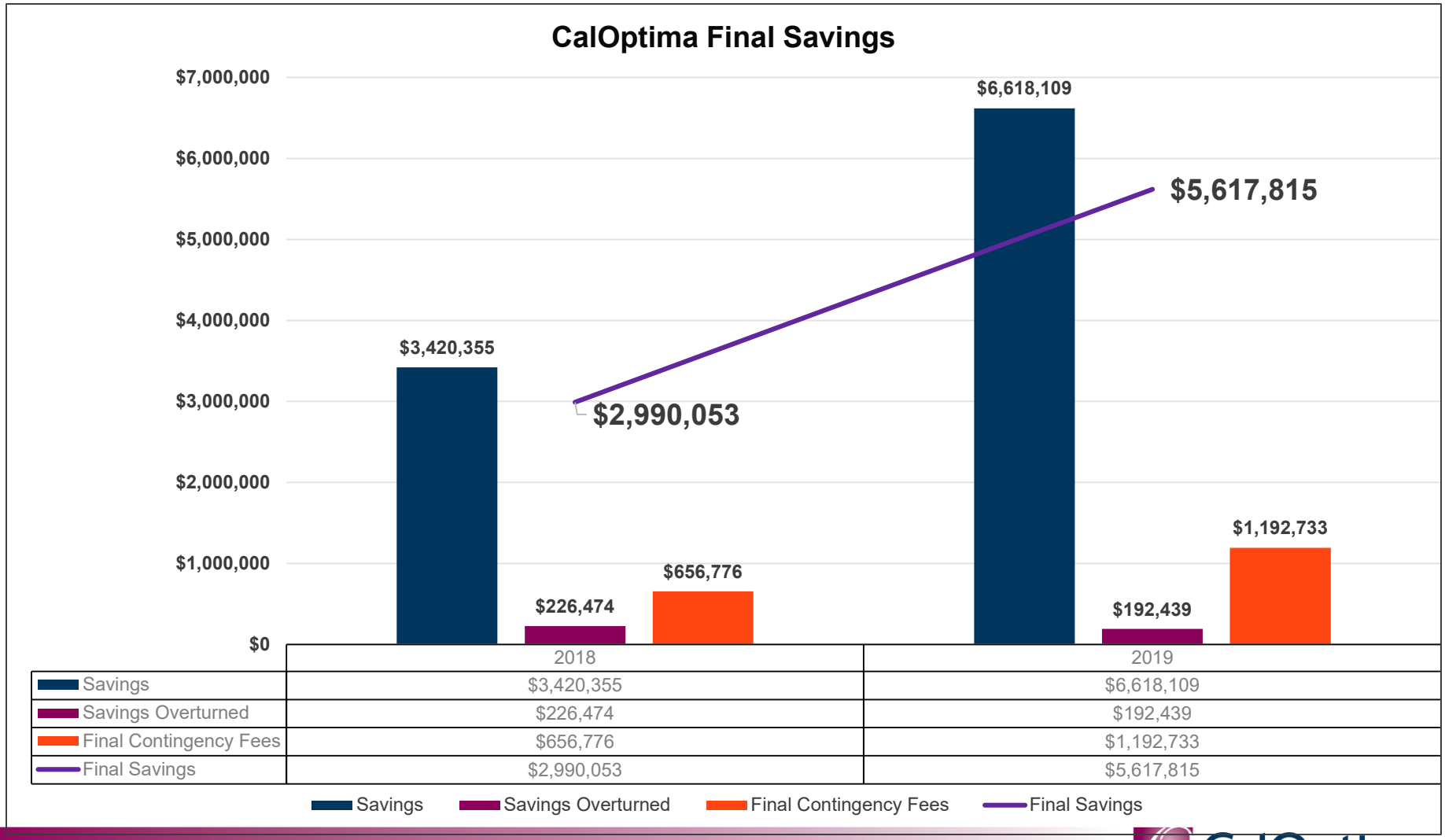
Cotiviti Background

- Cotiviti is a claims coding solution
- Provides prepayment review of professional services to identify claims coding accuracy
  - Uses National Correct Coding Initiative (NCCI) edits
  - Follows Medi-Cal and Centers for Medicare & Medicaid Services guidelines
- Charges a contingency fee for acceptance of coding recommendations

Year-Over-Year Growth



Final Savings



Top Five Coding Edits Accepted

- Unbundling
- Frequency
- Same provider
- Mutually exclusive
- Unlisted procedure code

Top Five Provider Types

- Pathology
- Hospital
- Ambulance, medical transportation
- Obstetrics/Gynecology
- Internal medicine

Next Steps

- Implement additional coding edits by June 30, 2020

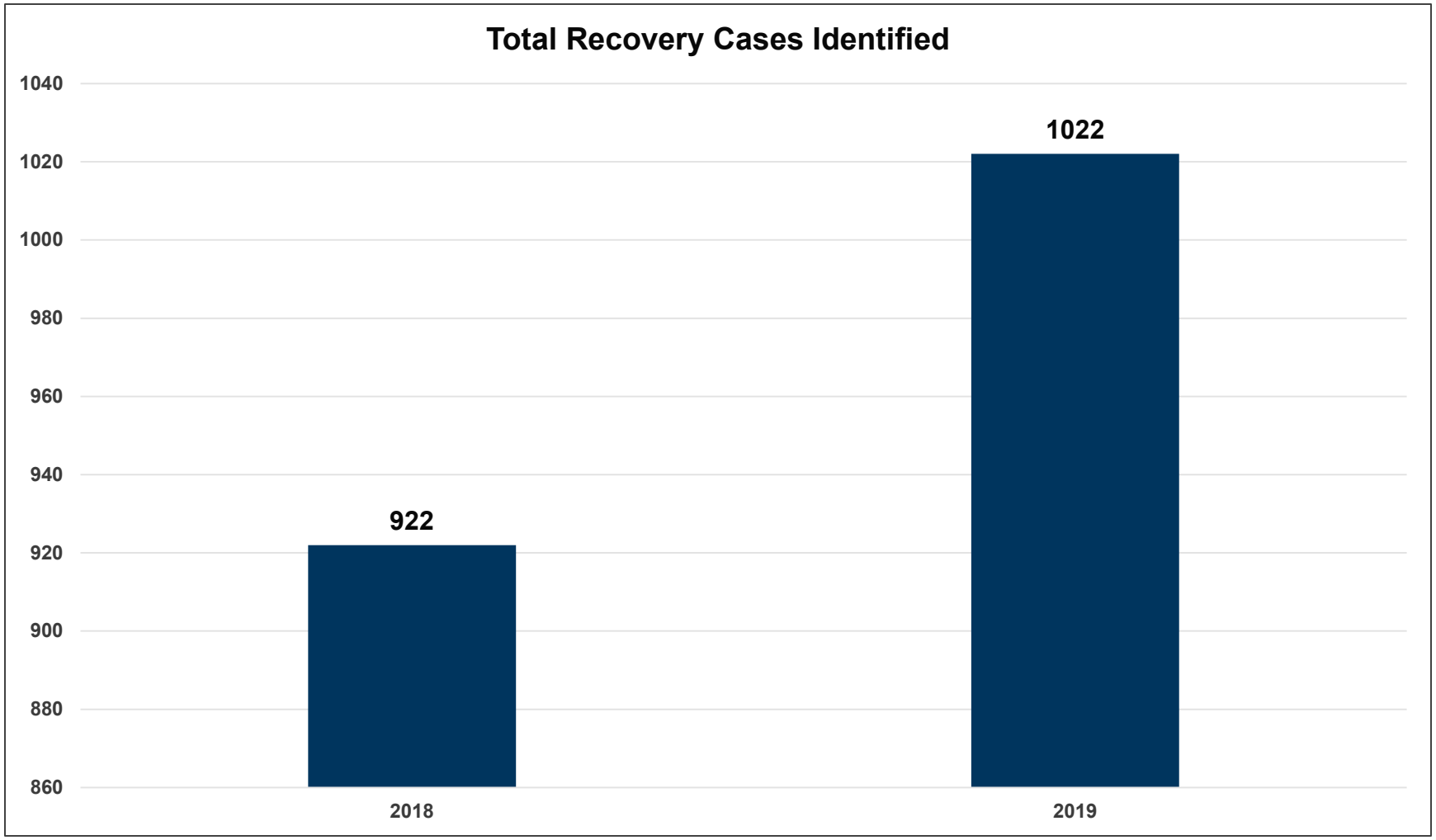
Coding Edits	Projected Savings
Multiple Treatment Reduction	$936,000
Imaging Family Reduction	$513,000
Surgical Edits	$156,000
Age	$163,000

- Identify coding edits that can be implemented within Facets

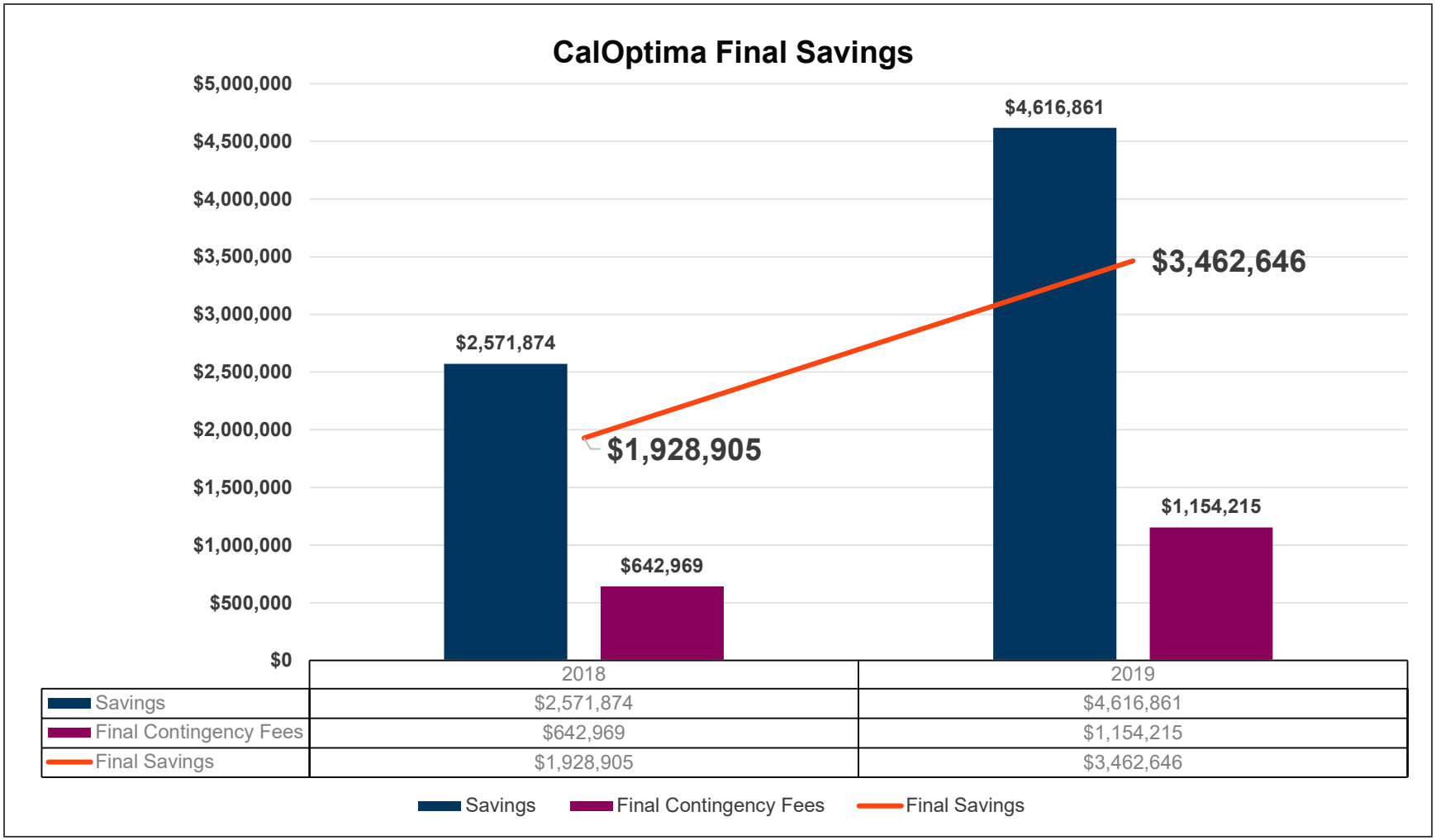
Varis Background

- Varis provides recovery identification services for overpayment of claims
  - Inpatient facility claims reimbursed at Diagnosis Related Group (DRG)
  - Outpatient facility claims reimbursed at Ambulatory Payment Classification (APC)
- Both contracted and noncontracted providers are subject to recovery identification, using medical records review
- Varis uses a fee structure
  - Contingency fee based on the overpayment recovery received
  - Recoveries can take up to a year to receive
    - Resulting contingency fees cross budget years
    - CalOptima can also incur non-pursuit fees

Year-Over-Year Growth



Final Savings



Top Five DRG Codes by Recovery

DRG Code	Description
871	Septicemia or Severe Sepsis without Mechanical Ventilation >96 Hours with Major Complications or Comorbidity
682	Renal Failure with Major Complications or Comorbidity
246	Percutaneous Cardiovascular Procedures with Drug-Eluting Stent with Major Complications or Comorbidity or 4+ Arteries or Stents
329	Major Small and Large Bowel Procedures with Major Complications or Comorbidity
207	Respiratory System Diagnosis with Ventilator Support >96 Hours or Peripheral Extracorporeal Membrane OX

Next Steps

- Continue seeking recoveries
  - 599 cases open
    - Subject to non-pursuit fees

Recommended Action

- Authorize unbudgeted expenditures within the Medi-Cal purchased services expense category in an amount not to exceed ~~$1.4~~ $1,395,000 million from existing reserves | *Rev.* 2/20/20

  for the following:
  - An increase of up to $645,000 to fund contingency fees for prepayment claims editing solutions of professional services claims
  - An increase of up to $750,000 to fund contingency fees for overpayment recoveries related to inpatient DRG and outpatient APC paid claims and non-pursuit fees

CalOptima's Mission

To provide members with access to quality health care services delivered in a cost-effective and compassionate manner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CalOptima
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Medi-Cal
A Public Agency
CalOptima
Better. Together.


OneCare (HMO SNP)
A Public Agency
CalOptima
Better. Together.


OneCare Connect
A Public Agency
CalOptima
Better. Together.


PACE
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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken December 6, 2018
Regular Meeting of the CalOptima Board of Directors

Report Item
10. Consider Extension of Contract Related to CalOptima's Core System, Facets

Contact
Len Rosignoli, Chief Information Officer, (714) 246-8400
Ladan Khamseh, Chief Operating Officer, (714) 246-8400

Recommended Action
Authorize the Chief Executive Officer, with the assistance of Legal Counsel, to extend the contract with Cognizant for the Facets software license and associated maintenance costs for three years, from July 1, 2019 through June 30, 2022.

Background
CalOptima contracts with many vendors that provide a variety of software solutions to support the overall business model. Two core Systems are central to this infrastructure while many other supporting solutions surround the core. One of those core systems is Facets. Facets handles key CalOptima operational functions including enrollment of members, health benefit configuration, provider contracts and fee schedules, claims processing and adjudication, and customer service.

Facets has been the core administrative processing system for CalOptima since April 1, 2001. This system was first developed in the 1970s, originally by a company named Erisco, and first branded as ClaimFacts. A new generation of the system was developed in the early 1990s and rebranded as Facets. Although the Facets system has been in existence a long time, it remains one of the most commonly used managed care core administrative processing systems in use today. There are 88 installations currently, covering 149 million members. There have been significant technology advances and organizational changes over time, including two acquisitions. In 2000, Erisco was acquired by TriZetto. For many years, Cognizant Technology Services was a software development partner for the Facets product. In 2014, Cognizant acquired TriZetto.

Cognizant was incorporated in 1996 and is known as one of the world's largest and leading professional services companies. As of mid-2018, Cognizant had over 250,000 employees. The acquisition of TriZetto by Cognizant complemented the service offering with extended opportunities for advanced technology development and operational support.

In 2001 when Facets was implemented at CalOptima, there were two lines of business – Medi-Cal and Healthy Families – and essentially one set of benefits, covering 249,000 members. All Health Networks accepted full risk. During the past 17 years, CalOptima's membership volume has grown to over 775,000, products such as Healthy Families were retired, new products were added, including OneCare, OneCare Connect, and PACE, and there are a variety of complex Health Network contract financial arrangements. CalOptima's business model has grown significantly more complex. As a result, CalOptima's systems, especially Facets and its interface to other systems, have had a corresponding and significant increase in

complexity. There are currently over 300 interface points between Facets and other CalOptima systems and processes.

The original contract for Facets has been extended several times. At the June 5, 2014, meeting, the Board extended the agreement and authorized payment of maintenance and support fees through June 30, 2019. Each time, the reasons for the extension were similar – Facets has been able to continue to support the CalOptima business needs; Facets is a tightly integrated system with significant complexity; the related cost and disruption of migrating to a different system was not warranted at those times.

Although CalOptima has monitored the industry and available systems over time, Management decided that a Request For Information (RFI) was warranted this year to complete a more in-depth study of available systems and to determine if changing systems or structure was indicated. The RFI was issued in August. Ten responses/proposals were received in October. The responses/proposals were evaluated by a cross-functional work group of many operational areas and Information Services. Two were eliminated as not meeting minimum qualifications. There is enough interest in learning more about at least four of the proposals/vendors to warrant moving forward with preliminary demonstrations in January 2019. Depending on the outcomes of the demonstrations, a decision will be made to either remain on the current system or to issue a more comprehensive Request for Proposal (RFP). Proposals received in response to the RFP will help to determine if CalOptima will continue with the Facets system or migrate to a different option or solution.

Discussion

A full replacement of the Facets system would likely take two years to complete after contract execution, would require a dedicated team, and will likely incur costs of several million dollars when considering fees, expenses, and labor. One of the local Medi-Cal health plans recently completed a core system change in 24 months. Considering time required for the RFP, evaluation of responses, and contract negotiation, Management is recommending that the current contract with Cognizant for Facets be extended three years, to June 30, 2022. If a system migration takes place, this will allow sufficient time to complete the RFP and implementation.

Facets is licensed by Cognizant on a perpetual basis for membership volume. What this means is that the license includes a fee based on total membership, and an active 'member' is licensed only once. CalOptima is currently licensed for 810,000 active members; adequate volume to extend through June ~~20~~30, 2022. Cognizant has committed to no increase in maintenance fees (beyond contractual Consumer Price Index increases) for this proposed three-year extension.

Rev. 12/6/18

As a result, Staff requests authorization to extend this agreement through June 30, 2022. Staff will return to the Board with the results of the conclusion of the RFP process.

Fiscal Impact

Management will include expenses for the period of July 1, 2019, through June 30, 2022, related to the recommended contract extension in future operating budgets.

Concurrence

Gary Crockett, Chief Counsel

Attachment
Contracted Entity Covered by this Recommended Board Action

/s/ Michael Schrader — *11/28/2018*
Authorized Signature — **Date**

CONTRACTED ENTITY COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
Cognizant TriZetto Software Group, Inc.	500 Frank W Burr Blvd	Teaneck	NJ	07666

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken December 6, 2018
Regular Meeting of the CalOptima Board of Directors

Report Item

11. Consider Extension of Contracts Related to CalOptima's Key Operational and Human Resource Systems

Contact

Len Rosignoli, Chief Information Officer, (714) 246-8400
Ladan Khamseh, Chief Operating Officer, (714) 246-8400

Recommended Actions

Authorize the Chief Executive Officer (CEO) to:

1. Extend the contracts with the following vendors as listed below through the dates indicated in the attachment:
    a. Altruista Guiding Care
    b. Burgess Reimbursement System
    c. Edifecs XEngine
    d. Catalyst Solutions
    e. Medecision
    f. Star MTM
    g. Ansafone
    h. Ceridian Dayforce
    i. Silk Road Open Hire and Wingspan

2. Authorize payment of maintenance and support fees to these vendors through the dates and up to the amounts indicated in the attachment, Table 1.

Background

CalOptima contracts with many vendors that provide a variety of software solutions to support the overall business model. Two core systems are central to this infrastructure while many other supporting solutions surround the core.

Within the managed care industry, this is standard practice, as no commercially-available single solution meets the demands of the industry for all functions, especially when considering the varying lines of business, government regulations, and the uniqueness of each health plan. The trend over the past ten years or more has been to utilize this approach by using a core administrative processing system surrounded by specialty solutions. CalOptima, as well as the other 15 Local Health Plans of California, and virtually all health plans, use this approach.

The two core systems for CalOptima are:

1. Cognizant Facets – This solution handles the key functions of enrollment of members, health benefit configuration, claims processing and adjudication, provider contract reimbursement, and customer service.

2. Altruista Guiding Care – This solution handles the key functions of Care Management, including Case Management, Utilization Management, Authorizations/Referrals, Disease Management, as well as Appeals & Grievances.

The systems included in this staff recommendation are:

a. Altruista Guiding Care – As mentioned above, this is one of CalOptima's two core systems. CalOptima originally contracted with Altruista in April of 2014 for a term of seven total years, including an initial term and five one-year optional renewal terms extending to 4/6/2021. The system was live as of April 2015. There are two years remaining on the current contract, supporting the decision to recommend approval to extend for those two years, to 4/6/2021. Replacement of this core system was a substantial investment in money and time. It can take years for a core system of this type to fully stabilize. There are additional features yet to be explored, including the Population Health modules. No later than during Fiscal Year (FY) 2019-2020, a Request for Information (RFI) will be issued, primarily to remain informed and evaluate the marketplace for systems of this type, to help determine how long this system will remain or when it may be considered for replacement through a Request for Proposal (RFP) process.

b. Burgess Reimbursement System – This solution provides two key function. One - it enables continuous monitoring of the hundreds of claims reimbursement Medicare fee schedules maintained by the Federal Centers for Medicare and Medicaid Services (CMS) ensuring that CalOptima's Medicare fee schedules are up-to-date as soon as Medicare makes a change. Two - it uses sophisticated algorithms to calculate the reimbursement pricing for all CalOptima Medicare related claims. In the future, this solution will be expanded to perform the same functions for the Medi-Cal fee schedules and claims pricing. This system is very tightly integrated within the Facets core system software.

c. Edifecs – XEngine – This tool supports quality for the CalOptima Facets Claims process. XEngine is a tool that validates and ensures compliance with regulatory transaction standards and streamlines operational efficiency.

d. Catalyst Solutions – This vendor provides essential supplemental maintenance services and support of the Facets system based on their depth of knowledge of Facets and the inner workings of the software.

e. Medecision - Aerial Care Coordination - This solution is the current CalOptima provider portal – more commonly known to the CalOptima provider partners as CalOptima Link. This portal enables thousands of provider office users to verify eligibility, review claims status, view patient rosters, and submit service authorization requests. This will ultimately be replaced by the new CalOptima Provider Portal.

f. Star MTM – This vendor provides the system and services to support the Pharmacy Medication Therapy Management process required by The Centers for Medicare and Medicaid Services (CMS) for both the OneCare and OneCare Connect lines of business. This process is tightly integrated within the overall administration of CalOptima's pharmacy benefit. An RFP will be issued during FY 2020-2021 to re-evaluate this service.

g. Ansafone – This vendor provides critical services supporting both CalOptima's Customer Service function and the Medical Affairs function. Ansafone provides after-hours call center support for both general customer service calls as well as more specific medical affairs calls. Ansafone also periodically conducts designed member outreach calls, as needed. An RFP for this service will be issued during FY 2018-2019 to evaluate the marketplace and to determine if CalOptima will retain the existing vendor or consider other alternatives.

h. Ceridian Dayforce – This is the primary Human Resources (HR) system handling employee benefits and payroll.

i. Silk Road Open Hire and Wingspan – Open Hire is the current HR applicant tracking and recruitment system. Wingspan is the current performance management system where all CalOptima employee performance evaluations are stored.

   These three HR systems are tightly woven into the support and management of the CalOptima employees and are mission-critical for ongoing smooth operations. CalOptima has been on these systems for nearly ten years. During FY2019-20, CalOptima will issue an RFP for these functions to evaluate the marketplace to determine if a replacement is warranted, and if a single comprehensive HR solution can be procured rather than separate systems.

Discussion

The vendors listed in the attached table represent the solutions described above with contracts expiring in 2019 or sooner.

Many of these solutions are tightly embedded/integrated into either Facets and/or Guiding Care or are mission critical to the Human Resources function. Replacing any of these solutions would require a substantial additional investment, time commitment, and significant disruption to operations.

Fiscal Impact

The CalOptima FY 2018-19 Operating Budget includes the annual fees for the listed contracted vendors related to CalOptima's core and HR systems through June 30, 2019. Management will include expenses for the recommended contract extension periods on or after July 1, 2019, in future CalOptima Operating Budgets.

Rationale for Recommendation

Extension of the contracts for these systems will ensure there is no disruption to the services provided by each of the solutions and allow continuity of operations throughout the organization and with CalOptima's member and provider community, and its employees.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. Proposed Contract Extensions – Table 1
2. Contracted Entities Covered by this Recommended Board Action

/s/ Michael Schrader — *11/28/2018*

Authorized Signature — **Date**

Attachment – Table 1 - Proposed Contract Extensions

Vendor – Solution Name	Description of Service	Original Contract Start Date	Current Contract Expires	Recommend Contract Extension Through	Comments	Annual Cost Based on Fiscal Year 2018-19 Fees
Altruista Health – Guiding Care	Core Care Management Solution	4/6/2014	4/6/2019	4/6/2021	2 years remaining on the original contract	$1,485,000
Burgess – Burgess Reimbursement System	Medicare/Medi-Cal Fee Schedules and Claims Pricing	1/1/2008	12/31/2019	6/30/2022	Tightly Integrated with Facets	$442,162
Edifecs – XEngine	Electronic transaction standardization tool	3/9/2011	12/31/2019	12/31/2021	Tightly Integrated with Facets	$90,000
Catalyst Solutions	Facets Support Services	4/21/2014	12/31/18	6/30/2022	Integral supplemental maintenance services for Facets	$35,000
Medecision – Aerial Care Coordination	Provider Portal (CalOptima Link)	3/23/2011	12/31/2019	12/31/2020	Eventually to be replaced with Provider Portal	$1,560,000
Star MTM	Pharmacy Medication Therapy Management Services	11/1/2014	3/21/2020	3/21/2022	Tightly Integrated into the Pharmacy process. Expect to issue RFP during Fiscal Year 2020-2021.	$156,000
Ephonamation.com, Inc., DBA Ansafone	After hours customer service call center; after hours medical affairs call center; member outreach.	9/1/2016	8/31/2019	8/31/2020	Tightly integrated within Customer Service and Medical Affairs. RFP to be issued during Fiscal Year 2018-2019.	$213,000
Ceridian - Dayforce	The main Human Resources System for Benefits and Payroll	6/29/2008	6/30/2019	12/31/2021	Plan to issue RFP during Fiscal Year 2019-2020	$254,000

Vendor – Solution Name	Description of Service	Original Contract Start Date	Current Contract Expires	Recommend Contract Extension Through	Comments	Annual Cost Based on Fiscal Year 2018-19 Fees
Silk Road – Open Hire and Wingspan	Human Resources Support Systems – Performance Management, Applicant Tracking	6/19/2009	6/30/2019	12/31/2021	Plan to issue RFP during Fiscal Year 2019-2020	$58,500

CONTRACTED ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
Altruista Health, Inc.	11800 Sunrise Valley Dr Suite 1000	Reston	VA	20191
Burgess Group, LLC	1701 Duke St	Alexandria	VA	22314
Edifecs, Inc.	1756 114th Ave SE	Bellevue	WA	98004
Catalyst Solutions, LLC	2353 S Broadway	Denver	CO	80210
Medecision, Inc.	550 E Swedesford Rd Building D, Suite 220	Wayne	PA	19087
Star MTM, LLC DBA Clinical Support Services	701 Seneca St	Buffalo	NY	14210
Ephonamation.com, Inc., DBA Ansafone Communications	145 E Columbine Ave	Santa Ana	CA	92707
Ceridian Corporation	3311 E Old Shakopee Rd	Minneapolis	MN	55425
SilkRoad Technology, Inc.	100 S Wacker Dr Suite 425	Chicago	IL	60606

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken September 1, 2016
Regular Meeting of the CalOptima Board of Directors

Report Item
5. Consider Extension of Contracts Related to CalOptima's Core Systems

Contact
Len Rosignoli, Chief Information Officer, (714) 246-8400
Ladan Khamseh, Chief Operating Officer, (714) 246-8400

Recommended Actions
Authorize the Chief Executive Officer (CEO) to:

1. Extend the contracts with the following vendors as listed below through the dates indicated in the attached Tables 1, 2, and 3:
    a. Burgess-Burgess Reimbursement System (Medicare/Medi-Cal Fee Schedules and Claims Pricing)
    b. Medecision (Provider Portal (CalOptima Link)
    c. Edifecs-XEngine (Claims Electronic transaction standardization tool)
    d. Microstrategy (Enterprise Business Analytics and Intelligence)
    e. Office Ally (Claims Clearinghouse)
    f. Change Healthcare (Claims Clearinghouse)
    g. HMS (Medi-Cal Cost Containment)
    h. SCIO Health Analytics-My Socrates (Third Party Liability and Subrogation Recovery Services)
    i. OptumInsight (Credit Balance Recovery Services)
    j. MCG-CareWebQI (Evidence-based Clinical Guidelines
    k. Intelli-Flex (Telephone system and supporting Customer Service applications)
    l. TW Telcom/Level III (CalOptima's carrier for telecommunications as well as Internet connectivity); and

2. Authorize payment of maintenance and support fees to these vendors through the dates and up to the amounts indicated in the attached Tables 1, 2, and 3.

Background
CalOptima contracts with many vendors that provide a variety of software solutions to support the overall business model. Two Core Systems are central to this infrastructure while many other supporting solutions surround the Core.

Within the managed care industry, this is standard practice, as no commercially-available single solution is able to meet the demands of the industry for all functions. The trend over the past ten years or more has been to utilize this approach by using the Core for what those systems handle best, and to use specialty solutions to surround the Core. CalOptima, as well as the other 15 Local Health Plans of California, and virtually all health plans, use this approach.

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At the center and in the Core for CalOptima are two systems:

- TriZetto Facets – This solution handles the key functions of enrollment of members, health benefit configuration, claims processing and adjudication, and customer service.
- Altruista Guiding Care – This solution handles the key functions of Care Management, including Case Management, Utilization Management, Authorizations/Referrals, Disease Management, and Appeals & Grievances.

Supporting Systems include:

a. Burgess Reimbursement System – This solution provides two key functions. It enables continuous monitoring of the hundreds of claims reimbursement Medicare fee schedules maintained by the Federal Centers for Medicare and Medicaid Services (CMS) ensuring that CalOptima's Medicare fee schedules are up-to-date as soon as Medicare makes a change. It also uses sophisticated algorithms to calculate the reimbursement pricing for all CalOptima Medicare related claims. In the future, this solution will be expanded to perform the same functions for the Medi-Cal fee schedules and claims pricing.
b. Medecision - Aerial Care Coordination - This solution is the current CalOptima provider portal – more commonly known to the CalOptima provider partners as CalOptima Link. This portal enables the over 5,000 provider users to verify eligibility, review claims status, view patient rosters, and submit service authorization requests.
c. Edifecs – XEngine – This tool supports quality for the CalOptima Facets Claims process. XEngine is a tool that helps to validate compliance with regulatory transaction standards and streamline operational efficiency.
d. Microstrategy – This is the current CalOptima Business Intelligence and Analytics solution. Many routine analytics processes developed within Microstrategy have become part of the standard operations of CalOptima, providing data analytics to support all business functions.
e. and f. Office Ally and Change Healthcare – These vendor solutions are known as Claims Clearinghouses. Essentially, providers in the community interact with their systems to submit claims for payment to a variety of health plans/payers. The Office Ally Clearinghouse services the vast majority of California providers. Office Ally also provides Claims Submission, Electronic Health Record, and Practice Management solutions at no cost to provider offices, including hundreds of CalOptima provider offices. Change Healthcare (formerly known as Emdeon) is the largest claims Clearinghouse in the Country. In 2015, Change Healthcare handled over 8.5 billion transactions, covering $1.7 trillion in claims.
g. Health Management Systems (HMS) – HMS is a cost containment service vendor. For CalOptima, as well as the California Department of Health Care Services (DHCS), HMS is contracted to identify, audit and recover improper Medi-Cal payments. HMS' mission is to help protect the integrity of government-sponsored health and human services programs. HMS provides similar services to 23 states including 41 state Medicaid programs.
h. SCIO Health Analytics - My Socrates – My Socrates is a subrogation service solution used to support CalOptima's Medicare Claims processing. This service handles and identifies third-party liability, for example, subrogation with motor vehicle accidents, often a contributor to total claims cost. SCIO's services reach more than 400 million medical claims and 1.3 billion prescription claims nationwide.
i. OptumInsight – For CalOptima, OptumInsight provides Credit Balance Recovery services. There is a Medicare regulation dictating that providers may not retain any overpayments. An overpayment is where a health insurer reimburses a provider in excess of what should be

reimbursed, most often caused by billing or processing errors. There are a variety of significant penalties that can be assessed if overpayments are not identified and handled appropriately. This service helps CalOptima recover overpayments and its provider partners to identify procedural and system issues that create credit balances to identify opportunities to prevent future overpayments.

j. MCG, part of the Hearst Health Network – CareWebQI – This solution is embedded and tightly integrated within the Altruista Guiding Care solution for Care Management. CareWebQI provides electronic, automated access to evidence-based best practices and clinical criteria for the support and documentation of care management decisions.

The next two solutions support the overall Information Technology Infrastructure:

k. Intelliflex – This is the vendor that provides CalOptima's Avaya telephone System. The Avaya equipment is used for all employees. In addition, Avaya Contact Center and TelStrat Call Recording services are tightly embedded into CalOptima's Customer Service Operation, helping maintain regulatory compliance and policy adherence.
l. TW Telecom / Level 3 – This is CalOptima's carrier for telecommunications as well as Internet connectivity. This vendor supports this particular area of the County.

Discussion

The vendors listed in the attached table represent the solutions described above with contracts expiring over the next six months.

Many of these solutions are tightly embedded/integrated into either Facets and/or Altruista (the Core Systems) – see Table 1. Unless Facets or Altruista were to be replaced, replacing these tightly integrated solutions is infeasible without substantial investment and significant disruption to operations. Some also represent the most viable solution considering CalOptima's operating environment. See Table 2. Those falling into this category will not enter the competitive bidding process at this time.

Other solutions are less tightly integrated, less costly, less complex to replace, and are handled by competing vendors within the marketplace. For these vendors, a competitive bidding process is planned, and the approximate date to issue the RFI or RFP is listed in Table 3.

Fiscal Impact

The CalOptima Fiscal Year 2016-17 Operating Budget includes the annual fees for the listed contracted vendors related to CalOptima's core and supporting systems through June 30, 2017. Management will include expenses for the recommended contract extension periods on or after July 1, 2017, in future CalOptima Operating Budgets.

Rationale for Recommendation

Extension of the contracts for these systems that support the Core Systems will ensure there is no disruption to the services provided by each of the solutions and allow continuity of operations throughout the organization and with CalOptima's member and provider community.

Concurrence
Gary Crockett, Chief Counsel
Chet Uma, Chief Financial Officer

Attachment
Proposed Contract Extensions

/s/ Michael Schrader — *8/25/2016*
Authorized Signature — **Date**

Attachment - Proposed Contract Extensions

Table 1 – Solutions tightly integrated with Facets and/or Altruista

Number from List, Vendor, Solution Name (if applicable)	Description of Service	Original Contract Start Date	Current Contract Expires	Recommend Contract Extension Through:	Competitive Bid Initiation (approximate):	Annual Cost Based on Fiscal Year 2016-17 Budget
a. Burgess – Burgess Reimbursement System	Medicare/Medi-Cal Fee Schedules and Claims Pricing	1/1/2008	12/31/2016	12/31/2019	N/A	$811,700
b. Medecision – Aerial Care Coordination	Provider Portal (Calopima Link)	3/23/2011	9/1/2016	12/31/2019	N/A	$1,531,935
c. Edifecs – XEngine	Claims Electronic transaction standardization tool	3/9/2011	3/30/2017	12/31/2019	N/A	$93,702
d. Microstrategy	Enterprise Business Analytics and Intelligence	9/13/2011	9/19/2016	9/19/2019	N/A	$155,000

Table 2 – Solutions defined as “most viable” based on market standards, lack of competition, or related to State consistency

Number from List, Vendor, Solution Name (if applicable)	Description of Service	Original Contract Start Date	Current Contract Expires	Recommend Contract Extension Through:	Competitive Bid Initiation (approximate):	Annual Cost Based on Fiscal Year 2016-17 Budget
e. Office Ally	Claims Clearinghouse	7/1/2004	12/31/2016	12/31/2020	N/A	$474,579
f. Change Healthcare	Claims Clearinghouse	10/12/2000	10/18/2016	12/31/2020	N/A	$94,916
g. HMS	Medi-Cal Cost Containment	5/15/2008	5/14/2017	5/14/2020	N/A	$398,646
k. Intelli-Flex	Telephone system and supporting Customer Service applications.	12/7/2009	1/1/2017	12/31/2019	N/A	$306,936

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Number from List, Vendor, Solution Name (if applicable)	Description of Service	Original Contract Start Date	Current Contract Expires	Recommend Contract Extension Through:	Competitive Bid Initiation (approximate):	Annual Cost Based on Fiscal Year 2016-17 Budget
l. TW Telecom / Level III	CalOptima's carrier for telecommunications as well as Internet connectivity.	2/15/2012	1/1/2017	12/31/2021	N/A	$720,000

Table 3 – Solutions with sufficient market competition with approximate RFP issue years listed

Number from List, Vendor, Solution Name (if applicable)	Description of Service	Original Contract Start Date	Current Contract Expires	Recommend Contract Extension Through:	Competitive Bid Initiation (approximate):	Annual Cost Based on Fiscal Year 2016-17 Budget
h. SCIO Health Analytics - My Socrates	Third Party Liability and Subrogation Recovery Services. (No cost, only contingency fee on percentage of recoveries).	2/19/2010	12/31/2016	12/31/2018	2017	Recovered in FY 2015-2016: $219,258.00 Fee (25%): $54,814.50 Net Recovery: $164,443.50
i. OptumInsight	Credit Balance Recovery Services. (No cost, only contingency fee on percentage of recoveries).	11/1/2011	12/31/2016	12/31/2018	2017	Recovered in FY 2015-2016: $44,834.00 Fee (12%): $5,380.08 Net Recovery: $39,453.92
j. MCG – CareWebQI	Evidence-based Clinical Guidelines	4/1/2008	3/31/2017	3/31/2021	2019	$641,300

Number from List, Vendor, Solution Name (if applicable)	Description of Service	Original Contract Start Date	Current Contract Expires	Recommend Contract Extension Through:	Competitive Bid Initiation (approximate):	Annual Cost Based on Fiscal Year 2016-17 Budget
l. TW Telecom / Level III	CalOptima's carrier for telecommunications as well as Internet connectivity.	2/15/2012	1/1/2017	12/31/2021	N/A	$720,000

Table 3 – Solutions with sufficient market competition with approximate RFP issue years listed

Number from List, Vendor, Solution Name (if applicable)	Description of Service	Original Contract Start Date	Current Contract Expires	Recommend Contract Extension Through:	Competitive Bid Initiation (approximate):	Annual Cost Based on Fiscal Year 2016-17 Budget
h. SCIO Health Analytics - My Socrates	Third Party Liability and Subrogation Recovery Services. (No cost, only contingency fee on percentage of recoveries).	2/19/2010	12/31/2016	12/31/2018	2017	Recovered in FY 2015-2016: $219,258.00 Fee (25%): $54,814.50 Net Recovery: $164,443.50
i. OptumInsight	Credit Balance Recovery Services. (No cost, only contingency fee on percentage of recoveries).	11/1/2011	12/31/2016	12/31/2018	2017	Recovered in FY 2015-2016: $44,834.00 Fee (12%): $5,380.08 Net Recovery: $39,453.92
j. MCG – CareWebQI	Evidence-based Clinical Guidelines	4/1/2008	3/31/2017	3/31/2021	2019	$641,300

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken October 7, 2021
Regular Meeting of the CalOptima Board of Directors

Report Item
17. Consider Authorizing Kaiser Foundation Health Plan, Inc.'s Collaboration in Mutually Identified Quality Initiatives Including Participation in CalOptima's Quality Improvement Committee

Contacts
Emily Fonda, Chief Medical Officer (714) 246-8887
Marie Jeannis, Executive Director, Quality & Population Health Management (714) 246-8591

Recommended Actions
Authorize the Chief Executive Officer (CEO)to request that Kaiser Foundation Health Plan, Inc. (Kaiser) collaborate with CalOptima on mutually identified quality initiatives through the following:

1. Participating in CalOptima's Quality Improvement Committee (QIC) on a quarterly basis (minimum); and
2. Collaboration on areas of focus with sharing of best practices and strategies. This collaboration will occur a minimum of quarterly or more often as needed. The areas of focus include:
    a. Poorly Controlled Diabetes
    b. Lead Screening in Children
    c. Prenatal and Postpartum Care
    d. Well Child Visits
    e. Member Experience
    f. COVID-19 Vaccination Response Plan.

Background
On June 3, 2021, the CalOptima Board of Directors (Board) directed staff to extend Kaiser's contract under the current capitation model, subject to the development and inclusion of specific quality improvement goals, that support Members' overall quality of care. In response to the Board's directive, CalOptima staff has worked with Kaiser to amend the contract and added the following language:

- "6.23 QUALITY INITIATIVE PARTICIPATION---HMO shall fully participate in those CalOptima quality elements/initiatives as may, from time to time, be adopted by the CalOptima Board of Directors and be mutually agreed upon by HMO and CalOptima, including the timely submission of all data and reports associated with such quality initiatives, to improve overall health outcomes."

To support the contract amendment and quality initiative goals, staff proposes additional collaboration with Kaiser focused on mutually agreed upon key quality strategic measures which include both clinical quality measures and member experience measures.

Staff notes that Kaiser is a fully delegated health network, and as such has its own quality program.

Discussion
As part of CalOptima's oversight responsibilities, management proposes to request Kaiser's participation in CalOptima's QIC meetings effective the fourth quarter of 2021.
Kaiser's participation in the QIC will allow greater collaboration between the two entities, an opportunity to share prevailing practices, and result enhanced services for our members.

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CalOptima and Kaiser representatives met on August 13, 2021 and discussed opportunities to collaborate on mutually identified goals. Kaiser agreed to participate in CalOptima's QIC meetings and collaborate on areas of focus with sharing of best practices and strategies.

The QIC is the foundation of the QI program and is accountable to the Quality Assurance Committee (QAC). Quality initiatives identified through the QIC will be reported up to the QAC for strategic direction and recommendations. QAC routinely receives progress reports from the QIC describing improvement actions taken, progress in meeting objectives and quality performance results achieved. The QAC also makes recommendations to the Board for annual approval with modifications and appropriate resource allocations of the QI Program.

The purpose of the QIC is to assure that all QI activities are performed, integrated, and communicated internally and to the contracted delegated entities to achieve the result of improved care and services for members. The QIC oversees the performance of delegated functions by its delegated partners and their contracted provider and practitioner partners. The QIC provides overall direction for the continuous improvement process and evaluates whether activities are consistent with CalOptima's strategic goals and priorities. It supports efforts to ensure that an interdisciplinary and interdepartmental approach is taken, and adequate resources are committed to the program. It monitors compliance with regulatory and accrediting body standards relating to QI Projects (QIP), activities, and initiatives. In addition, and most importantly, it makes certain that members are provided optimal quality of care. HEDIS activities and interventions are reviewed, approved, processed, monitored and reported through the QIC. The QIC also recommends strategies for quality initiatives and current QI work plan activities to CalOptima's delegated partners.

To assist CalOptima in continuing to deliver positive outcomes and quality care for our members, staff proposes Kaiser's attendance at the QIC on a quarterly basis beginning next quarter, and to periodically report on the status of Kaiser's quality programs and initiatives. The QIC reports to the QAC of the Board of Directors and provides progress reports on quality initiatives and quality performance results achieved. The QAC provides additional strategic direction and guidance. Kaiser's QIC activities and participation will be included in the staff's management report for the QAC. The QAC Kaiser Management Report would be separate from the current QIC report and would provide progress reports on CalOptima and Kaiser mutual collaborative efforts and initiatives.

In addition, CalOptima proposes Kaiser to collaborate on mutually identified areas of focus. The areas of focus include:

1. Poorly Controlled Diabetes
2. Blood Lead Screening in Children
3. Prenatal and Postpartum Care
4. Well Child Visits
5. Member Experience
6. COVID-19 Vaccination Response Plan.

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Through a Kaiser specific quality meeting, CalOptima and Kaiser will collaborate on mutually identified quality initiatives to understand and identify health inequities or disparities. Quality initiatives will target areas such as comprehensive diabetes care (particularly focusing on members with poor HbA1c control), blood lead screening for children, prenatal and postpartum care, well child visits, improved member experience, and vaccination plan for COVID-19.

In support of the Board's directive to include quality initiative requirements, staff recommends authorization to request Kaiser's participation in QIC meetings and collaboration on mutually identified quality initiatives and sharing best practices.

Staff will return to the Board with further recommendations on any additional Kaiser-specific deliverables and/or performance metrics as needed.

Fiscal Impact
The recommended action to request Kaiser to collaborate with CalOptima on mutually identified quality initiatives is operational in nature and has no additional fiscal impact beyond what was incorporated in the CalOptima Fiscal Year 2021-22 Operating Budget approved by the CalOptima Board of Directors on June 3, 2021. The existing funding under the Kaiser contract is inclusive of funding for participation and collaboration on quality initiatives.

Rationale for Recommendation
Staff recommends Board authorization of these actions to ensure continued quality care for our members and support greater collaboration between CalOptima and Kaiser.

Concurrence
Gary Crockett, Chief Counsel

Attachments
1. Entities Covered by this Recommended Action

/s/ Richard Sanchez *9/30/2021*
Authorized Signature **Date**

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ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
Kaiser Foundation Health Plan, Inc.	393 E Walnut St.	Pasadena	CA	91188

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken October 7, 2021
Regular Meeting of the CalOptima Board of Directors

Report Item

18. Consider Approving an Exemption to the Required Submission of the Seniors and Persons with Disabilities (SPD) Tracking Log (Medi-Cal) Report for Kaiser Foundation Health Plan, Inc.

Contacts

Emily Fonda, Chief Medical Officer, (714) 246-8887
Tracy Hitzeman, Executive Director Clinical Operations, (714) 246-8549

Recommended Actions

1. Approve an exemption for Kaiser Foundation Health Plan, Inc. (Kaiser) to the SPD Tracking Log (Medi-Cal) reporting requirement in Kaiser's Delegation Agreement; and
2. Approve modification of CalOptima Policy HH.2003 Health Network and Delegated Entity Reporting, removing the SPD Tracking Log (Medi-Cal) from required Kaiser reports.

Background/ Discussion

Kaiser participates in CalOptima's Medi-Cal program as a delegated subcontractor under the HMO health network model. As with a number of other health networks, Kaiser has been part of CalOptima's provider network for over 20 years. It offers a full-service HMO network that has grown to approximately 50,000 CalOptima members, or approximately 6% of CalOptima's total Medi-Cal membership.

The health network contracts include a Delegation Agreement that delineates administrative services each network is responsible for performing. The agreement is required under the terms of CalOptima's Medi-Cal contract with the Department of Health Care Services (DHCS), as well as for CalOptima's National Committee for Quality Assurance (NCQA) accreditation.

Kaiser provides health care services under a unique integrated model. As a result, Kaiser's contract contains a provision allowing it to request a change or exemption from a CalOptima policy and/or reporting requirement, when appropriate to address its unique integrated model. Kaiser is precluded from requesting an exemption solely for operational convenience or if the exemption would adversely impact compliance with regulatory or audit requirements or interfere with CalOptima's delegation oversight activities. The exemption review process incorporates input and analysis from operational and compliance experts prior to preliminary approval, and is subject to approval by CalOptima's Board of Directors.

CalOptima created and implemented a Personal Care Coordinator (PCC) role in 2014 to increase CalOptima and Health Network (HN) compliance with CMS care management requirements, and to improve care coordination and efficiency. As a result of the positive impact to the OneCare program, in May 2015, the PCC role was added to CalOptima and the HN care delivery structure for the Medi-Cal Seniors and Persons with Disabilities (SPD) population.

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Because Kaiser's care management and coordination is structured as an integrated model, the addition of PCCs was not needed, or part of a contractual requirement. Kaiser provides care for their SPD Members through this model in accordance with DHCS requirements.

As part of the regular annual review and update of CalOptima's Policy HH.2003 Health Network and Delegated Entity Reporting, Attachment A: Timely and Appropriate Submission Grid — Master and Attachment B: Timely and Appropriate Submission Grid — Supplemental Attachment, staff included the SPD Tracking Log. This report contributes data on Personal Care Coordinator (PCC) member assignment used in the monitoring and oversight of care coordination activities for Seniors and Persons with Disabilities. As Kaiser does not have staff in this role, the SPD Tracking Log report should not have been on their list of required reports.

Kaiser submitted a request for exemption from the SPD Tracking Log monthly submission. The report exemption request was reviewed and approved by CalOptima's Health Network Relations and Clinical Operations departments. The Compliance Committee determined that the proposed exemption and related policy change are acceptable, subject to Board approval. This exemption request is now being brought to the Board for consideration.

Fiscal Impact
The recommended actions to approve a reporting exemption for Kaiser and to make conforming changes to CalOptima Policy HH.2003 is operational in nature and has no fiscal impact.

Rationale for Recommendation
The SPD Tracking Log is not applicable to Kaiser, therefore an exemption is recommended for approval.

Concurrence
Gary Crockett, Chief Counsel

Attachments
1. Entities Covered by this Recommended Action
2. CalOptima Policy HH.2003: Health Network and Delegated Entity Reporting, which includes:
   - CalOptima Policy HH.2003Attachment A: Timely and Appropriate Submission Grid — Master
   - CalOptima Policy HH.2003Attachment B: Timely and Appropriate Submission Grid — Supplemental Attachment

/s/ Richard Sanchez *09/29/2021*
Authorized Signature **Date**

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CONTRACTED ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Medical Group	Address	City	State	Zip Code
	Kaiser Foundation Health Plan, Inc.	393 E Walnut Street	Pasadena	CA	91188

Policy:	HH.2003
Title:	**Health Network and Delegated Entity Reporting**
Department:	Network Operations
Section:	Health Network Relations
CEO Approval:	*/s/ Richard Sanchez 06/09/2021*
Effective Date:	10/01/1998
Revised Date:	06/03/2021
Applicable to:	☒ Medi-Cal ☒ OneCare ☒ OneCare Connect ☐ PACE ☐ Administrative

I. PURPOSE

This policy outlines the process for submission and evaluation of reports that a Health Network or Delegated Entity is required to submit to CalOptima.

II. POLICY

A. Each Health Network or Delegated Entity shall be responsible for submission of reports to CalOptima, as required by CalOptima or as specified in its contract, the Report Binder (including but not limited to, the Report Grid and the Report Grid Supplement), or CalOptima's policies and procedures.

B. The Report Grid and Report Grid Supplement are distributed to Health Networks and Delegated Entities in the Report Binder.

C. The Report Binder shall contain the following:

1. Report Grid;
2. Report Grid Supplement;
3. Report Templates; and
4. Letter Templates.

D. Each responsible CalOptima department shall be accountable for:

1. Identifying required reports;
    a. Reports must list all applicable regulatory, contractual, and policy citations and include all required data elements.
2. Creating and maintaining the Table of Authorities for each report;
3. Creating templates and all applicable reporting formats, instructions, and technical guidelines;
4. Monitoring submission and timeliness of reports;

5. Notifying Health Networks and Delegated Entities of missing, incorrect, or late reports;

6. Notifying Health Network Relations of unsuccessful follow-up attempts; and

7. Escalating issues of continued noncompliance to the Office of Compliance.

E. CalOptima's Health Network Relations Department shall be responsible for:

1. Maintaining and updating the Report Binder, in consultation with CalOptima departments and the Office of Compliance;

2. Distributing the Report Binder to Health Networks and Delegated Entities quarterly, or more frequently if needed; and

3. Contacting Health Networks and Delegated Entities if a CalOptima department is not successful with its follow-up attempts.

F. The Office of Compliance shall be responsible for taking appropriate corrective actions in response to reported issues of noncompliance, in accordance with CalOptima Policies HH.2005Δ: Corrective Action Plan and HH.2002Δ: Sanctions.

III. PROCEDURE

A. Identification of Reporting Requirements

1. Each responsible CalOptima department shall, on an ongoing basis:

a. Monitor regulatory, statutory, and/or contract requirements to determine impact on Health Network or Delegated Entity reporting requirements; and

b. With the assistance of the Office of Compliance, review the Report Binder to:

i. Update or correct existing reports;

ii. Identify new reports and associated regulatory, contractual, and policy citations to support new reports;

iii. Update or create Report Grid requirements, Report Templates, Table of Authorities, data dictionary, data elements, and/or instructions; and

iv. Notify the Health Network Relations Department of changes to the Report Binder.

B. Distribution of Report Binder

1. The Health Network Relations Department shall, quarterly, and as necessary:
a. Distribute the Report Binder to departments to review Health Network or Delegated Entity reporting requirements;

i. CalOptima departments shall have ten (10) business days to review the Report Binder and submit changes or updates to the Health Network Relations Department.

b. Collect updates to Report Grid requirements, Report Templates, data dictionaries, Tables of Authorities, Report Grid Supplement, and instructions to compile into the Report Binder, as submitted by departments;

c. Review department updates for completeness and eliminate duplicate or overlapping reports, with consultation from the responsible CalOptima department; and

d. Distribute the Report Binder to Health Networks and Delegated Entities on the first (1st) business day of each calendar quarter.

i. CalOptima's Health Network Relations Department shall provide Health Networks and Delegated Entities with an attestation to complete upon distribution of the updated Report Binder.

ii. Health Networks and Delegated Entities shall submit the signed attestation to the CalOptima Health Network Relations Department within five (5) business days, acknowledging receipt of the updated Report Binder.

C. Reporting Procedures

1. A Health Network or Delegated Entity shall submit reports in the time, manner, and file format specified by CalOptima or identified in its contract, the Report Binder (including, but not limited to, the Report Grid and the Report Grid Supplement), or CalOptima's policies and procedures.

2. If a Health Network or Delegated Entity report contains Protected Health Information (PHI), the Health Network or Delegated Entity shall submit the report to CalOptima via:

a. CalOptima's secure FTP site; or

b. Secure electronic mail, as specified by the specific report instructions.

3. Each responsible department shall:

a. Monitor or audit, as applicable, a Health Network or Delegated Entity's submission of required reports and compliance with requirements of the Health Network contract, the Report Binder and CalOptima's policies and procedures;

b. Make two (2) documented attempts to contact the Health Network or Delegated Entity to address missing, incorrect, or late submission;

c. Notify Health Network Relations Department if a Health Network or Delegated Entity does not respond after two (2) follow-up attempts; and

d. Report continued noncompliance to the Office of Compliance.

4. The Health Network Relations Department, upon receipt of notification from the responsible department of unsuccessful attempts to contact the Health Network or Delegated Entity, shall:

a. Contact the Health Network or Delegated Entity to obtain the missing report(s) and, if necessary, escalate the issue to the Health Network's senior management; and

b. Work with the department and Health Network or Delegated Entity to correct any content, formatting, or submission issues, if applicable.

5. The Office of Compliance, upon receipt of notification from the responsible department of a Health Network or Delegated Entity's continued noncompliance, shall take appropriate action in accordance with CalOptima Policies HH.2005Δ: Corrective Action Plan and HH.2002Δ: Sanctions.

IV. ATTACHMENT(S)

A. Timely and Appropriate Submission Grid ("Report Grid")
B. Timely and Appropriate Submission Grid - Supplemental Attachment ("Report Grid Supplement")

V. REFERENCE(S)

A. CalOptima Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
B. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal
C. CalOptima Three-Way Contract with the Centers for Medicare & Medicaid Services (CMS) and the Department of Health Care Services (DHCS) for Cal MediConnect
D. CalOptima Health Network Service Agreement
E. CalOptima Policy HH.2002Δ: Sanctions
F. CalOptima Policy HH.2005Δ: Corrective Action Plan

VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency
04/29/2016	Department of Health Care Services (DHCS)
01/31/2018	Department of Health Care Services (DHCS)

VII. BOARD ACTION(S)

Date	Meeting
12/03/2020	Regular Meeting of the CalOptima Board of Directors
06/03/2021	Regular Meeting of the CalOptima Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	10/01/1998	HH.2003	Health Network Reporting	Medi-Cal
Revised	12/01/1999	HH.2003	Health Network Reporting	Medi-Cal
Revised	10/01/2002	HH.2003	Health Network Reporting	Medi-Cal
Revised	07/01/2004	HH.2003	Health Network Reporting	Medi-Cal
Revised	01/01/2007	HH.2003	Health Network Reporting	Medi-Cal
Revised	12/01/2015	HH.2003	Health Network Reporting	Medi-Cal OneCare OneCare Connect
Revised	09/01/2016	HH.2003	Health Network Reporting	Medi-Cal OneCare OneCare Connect

Action	Date	Policy	Policy Title	Program(s)
Revised	12/01/2017	HH.2003	Health Network Reporting	Medi-Cal OneCare OneCare Connect
Revised	11/01/2018	HH.2003	Health Network Reporting	Medi-Cal OneCare OneCare Connect
Revised	05/01/2019	HH.2003	Health Network Reporting	Medi-Cal OneCare OneCare Connect
Revised	12/03/2020	HH.2003	Health Network Reporting	Medi-Cal OneCare OneCare Connect
Revised	06/03/2021	HH.2003	Health Network Reporting	Medi-Cal OneCare OneCare Connect

IX. GLOSSARY

Term	Definition
Corrective Action Plan (CAP)	A plan delineating specific identifiable activities or undertakings that address and are designed to correct program deficiencies or problems identified by formal audits or monitoring activities by CalOptima, the Centers of Medicare & Medicaid Services (CMS), Department of Health Care Services (DHCS), or designated representatives. FDRs and/or CalOptima departments may be required to complete CAPs to ensure compliance with statutory, regulatory, or contractual obligations and any other requirements identified by CalOptima and its regulators.
Delegated Entity	For purposes of this policy, a delegated entity is contracted with CalOptima to provide dental, fitness/gym, behavioral health, or vision benefits to eligible CalOptima Members.
Health Network	For purposes of this policy, a Physician-Hospital Consortia (PHC), Physician Medical Group (PMG), or a Shared Risk Group (SRG) under a shared risk contract, or health care service plan, such as a Health Maintenance Organization (HMO) that contracts with CalOptima to provide Covered Services to Members assigned to that Health Network.
Letter Templates	For the purposes of this policy, regulatory letter templates issued by regulatory agencies to be used by Health Networks and Delegated Entities for member communications, as required by applicable contractual, policy, and regulatory requirements.
Report Template	A blank form of each report also including instructions and file layout and/or data dictionary.
Sanction	Action taken by CalOptima including, but not limited to, restrictions, limitations, monetary fines, termination, or a combination thereof, based on a delegate's, subcontractor's, or any Capitated Network partner's failure to comply with statutory, regulatory, contractual, CalOptima policy, or other requirements related to the CalOptima programs.
Table of Authorities	For the purposes of this policy, a document that outlines all applicable regulatory, contractual, and policy citations that support the required reports outlined in the Report Grid.
Timely and Appropriate Submission Binder ("Report Binder")	A soft copy document that identifies all reports required of Health Networks to meet CalOptima's operational and regulatory compliance; contains the Report Grid and Report Templates, as well as a data certification statement.
Timely and Appropriate Submission Grid ("Report Grid")	A matrix of reports required by CalOptima, including report names, descriptions, responsible department, naming conventions, frequencies, submission methods and file formats, as set forth in Attachment A of this Policy.
Timely and Appropriate Submission Grid - Supplemental Attachment ("Report Grid Supplement")	A supplemental document to the Report Grid that includes detailed report descriptions, data elements and citations for all required reports, as set forth in Attachment B of this Policy.

CalOptima Policy HH.2003 - Attachment A: Timely and Appropriate Submission Grid - Master

Year: 2021 Release: 2 Release Date: TBD									Line of Business			Report Requirement Indicator			Report Type	
REPORT NAME	DESCRIPTION/REQUIREMENT (Refer to "FTP File Path for Template (Health Network)" for required reporting elements)	FTP FILE PATH FOR TEMPLATE (HEALTH NETWORK)	CALOPTIMA DEPARTMENT	REPORT FREQUENCY	NAMING CONVENTION	NAMING CONVENTION INSTRUCTIONS	FTP FOLDER	FILE TYPE	MEDI-CAL	ONECARE	ONECARE CONNECT	Health Networks (Except Kaiser)	Kaiser	VSP	Oversight	Reimbursement
Annual Audit	Health Networks shall participate in an annual audit conducted by CalOptima's Audit & Oversight Department by desk review and onsite. The purpose of the annual audit is to ensure that delegated functions are being performed satisfactorily for Medi-Cal OneCare and OneCare Connect lines of business if applicable. The Health Network will be evaluated based upon CalOptima policy and procedures current NCQA accreditation standards DMHC CMS and DHCS regulatory and contractual requirements.	/users/Documentation Library/HN Reporting Binder/2021 Report Templates/Audit & Oversight	Audit and Oversight	**Annually; Per process**	1_AORPT_**HN_CAT**	HN = Health network # CAT = Audit Category	hn_reporting	Zip	x	x	x	x	x	x	x	
Claims XML Universe	Health Networks shall submit a complete Claims universe for monthly review. CalOptima will select a subset of the universe and notify the Health Network of the case files required. XML version 2.0.	/users/Documentation Library/XML Version 2.0/Claims	Claims	**Monthly: 2nd of every month**	2_XMLRPT_**HN**_CLM_**YYYYMM_##**.xml	HN = Health network # MM = 2 digit month YYYY= 4 digit year	hn_reporting	XML	x	x	x	x	x	x	x	
Claims Universe Case Files	Health Networks shall submit monthly Claims universe case files selected by CalOptima from the Claims XML universe. CalOptima will perform monthly review of the case files and inform the Health Network of the results.	/users/Documentation Library/HN Reporting Binder/2021 Report Templates/Audit & Oversight	Claims	**Monthly: 10th of every month**	1_CLMRPT_**HN_MMYYYY**_CLAIMS_**LB**_FILES	HN = Health network # MM = 2 digit month YYYY= 4 digit year LB = Line of Business (MC = Medi-Cal OC = OneCare DB = OneCare Connect)	hn_reporting	PDF	x	x	x	x	x	x	x	
Credentialing Monthly Universe	Health Networks shall submit a complete Credentialing universe for monthly review. CalOptima will select a subset of the universe and notify the Health Network of the case files required.	/users/Documentation Library/HN Reporting Binder/2021 Report Templates/Audit & Oversight	Quality Improvement	**Health Networks and Kaiser Monthly: 2nd of every month VSP Quarterly: January 10, April 10, July 10, October 10**	1_QIRPT_**HN_MMYYYY**_CRED	MM = 2 digit month	hn_reporting	Excel	x	x	x	x	x	x	x	
Credentialing Universe Monthly Case Files	Health Networks shall submit monthly Credentialing universe case files selected by CalOptima from the Credentialing universe. CalOptima will perform monthly review of the case files and inform the Health Network of the results.	/users/Documentation Library/HN Reporting Binder/2021 Report Templates/Audit & Oversight	Quality Improvement	**Monthly: 10th of every month**	1_QIRPT_**HN_MMYYYY**_CRED_FILES	HN = Health network # MM = 2 digit month YYYY= 4 digit year	hn_reporting	PDF	x	x	x	x	x	x	x	
Notice of Medicare Non-Coverage (NOMNC) Log (OneCare & OneCare Connect)	Health Networks shall submit a monthly NOMNC log. CalOptima will select a subset from the log and notify the Health Network of the case files required.	/users/Documentation Library/HN Reporting Binder/2021 Report Templates/Audit & Oversight	Utilization Management	**Monthly: 2nd of every month**	1_UMRPT_**HN_MMYYYY**_NOMNC_LB	HN = Health network # MM = 2 digit month YYYY= 4 digit year LB = Line of Business (OC = OneCare DB = OneCare Connect)	hn_reporting	Word		x	x	x			x	
NOMNC Files (OneCare & OneCare Connect)	Health Networks shall submit monthly NOMNC files selected by CalOptima from the NOMNC log. CalOptima will perform monthly review of the case files and inform the Health Network of the results.	/users/Documentation Library/HN Reporting Binder/2021 Report Templates/Audit & Oversight	Utilization Management	**Monthly: 10th of every month**	1_UMRPT_**HN_MMYYYY**_NOMNC_FILES_LB	HN = Health network # MM = 2 digit month YYYY= 4 digit year LB = Line of Business (OC = OneCare DB = OneCare Connect)	hn_reporting	PDF		x	x	x			x	
Provider Dispute Resolution (PDR) XML Universe	Health Networks shall submit a complete PDR universe for monthly review. CalOptima will select a subset of the universe and notify the Health Network of the case files required.	/users/Documentation Library/HN Reporting Binder/2021 Report Templates/Audit & Oversight	Claims	**Monthly: 2nd of every month**	1_XMLRPT_**HN**_PDR_**YYYYMM**_##.xml	HN = Health network # MM = 2 digit month YYYY= 4 digit year	hn_reporting	XML	x	x	x	x	x	x	x	
PDR Universe Case Files	Health Networks shall submit monthly PDR universe case files selected by CalOptima from the PDR XML Universe. CalOptima will perform monthly review of the case files and inform the Health Network of the results.	/users/Documentation Library/HN Reporting Binder/2021 Report Templates/Audit & Oversight	Claims	**Monthly: 10th of every month**	1_CLMPRT_**HN_MMYYYY**_PDR_**LB**_FILES	HN = Health network # CIN = Member CIN MM = 2 digit month YYYY= 4 digit year LB = Line of Business (MC = Medi-Cal OC = OneCare DB = OneCare Connect)	hn_reporting	PDF	x	x	x	x	x	x	x	
Provider Directory Universe Case Files	Health Networks shall submit Provider Directory universe case files selected by CalOptima annually from the Provider Directory universe. CalOptima will perform an annual review of the case files and inform the Health Network of the results.	/users/Documentation Library/HN Reporting Binder/2021 Report Templates/Audit & Oversight	Provider Relations/PDMS	**Annually, per request**	1_HMRPT_**HN**_PD_**QTYYYY**	HN = Health network reporting # QT = 2 digit Quarter # YYYY = 4 digit year	hn_reporting	PDF (zip)	x	x	x	x			x	
Utilization Management (UM) XML Universe	Health Networks shall submit a complete UM universe for monthly review. CalOptima will select a subset of the universe and notify the Health Network of the case files required. XML version 2.1.	/users/Documentation Library/XML Version 2.1/Authorizations	Utilization Management	**Monthly: 2nd of every month**	2_XMLRPT_**HN**_UM_**YYYYMM**_##.xml	HN = Health network # MM = 2 digit month YYYY= 4 digit year	hn_reporting	XML	x	x	x	x	x		x	
UM Universe Case Files	Health Networks shall submit monthly UM universe case files selected by CalOptima from the UM XML universe. CalOptima will perform monthly review of the case files and inform the Health Network of the results.	/users/Documentation Library/HN Reporting Binder/2021 Report Templates/Audit & Oversight	Utilization Management	**Monthly: 10th of every month**	1_UMRPT_**HN_MMYYYY_LB**_Files	HN = Health network # CIN = Member CIN MM = 2 digit month YYYY= 4 digit year LB = Line of Business (MC = Medi-Cal OC = OneCare DB = OneCare Connect)	hn_reporting	PDF	x	x	x	x	x		x	

CalOptima Policy HH.2003 - Attachment A: Timely and Appropriate Submission Grid - Master

Year: 2021 Release: 2 Release Date: TBD									Line of Business			Report Requirement Indicator			Report Type	
REPORT NAME	DESCRIPTION/REQUIREMENT (Refer to "FTP File Path for Template (Health Network)" for required reporting elements)	FTP FILE PATH FOR TEMPLATE (HEALTH NETWORK)	CALOPTIMA DEPARTMENT	REPORT FREQUENCY	NAMING CONVENTION	NAMING CONVENTION INSTRUCTIONS	FTP FOLDER	FILE TYPE	MEDI-CAL	ONECARE	ONECARE CONNECT	Health Networks (Except Kaiser)	Kaiser	VSP	Oversight	Reimbursement
Behavioral Health Comprehensive Diagnostic Exam (CDE) Report - Kaiser	Kaiser shall submit the Behavioral Health CDE Report containing behavioral health services data.	/users/Documentation Library/HN Reporting Binder/2021 Report Templates/Behavioral Health/	Behavioral Health	**Monthly: 15th of every month**	1_BHRPT_**HN**_CalOptima.CDE.**MM.YYYY**	HN = Health network reporting # YYYY= 4 digit year MM = 2 digit month	hn_reporting	Excel	x				x		x	
Mental Health Grievances and Appeals (Medi-Cal) - Kaiser	Kaiser shall submit the Medi-Cal Expansion (MCE) DHCS Report containing mental health grievances and appeals data.	/users/Documentation Library/HN Reporting Binder/2021 Report Templates/Behavioral Health/	Behavioral Health	**Quarterly; January 20, April 20, July 20, October 20**	Mental Health Reporting Template.xlsx Send via email to behavioralhealth@caloptima.org		Secure email	Excel	x				x		x	
Case Management Log	Health Networks shall submit monthly Case Management log which tracks case management referral activities based on data and referral sources members in various levels of care management (from complex to service coordination) and "add on" services. Health Networks shall submit monthly Case Management Files selected by CalOptima from the Monthly Case Management Log. CalOptima will perform monthly review of the Case Management Files and inform the Health Network of the results.	/users/Documentation Library/HN Reporting Binder/2021 Report Templates/Case Management	Case Management	**Monthly: 15th of every month**	1_CMRPT_**HN_MMYYYY**_CM	HN = Health network reporting # MM = 2 digit month YYYY= 4 digit year	hn_reporting	Excel	x			x	x		x	
Case Management Files	Health Networks shall submit monthly Case Management Files selected by CalOptima from the Monthly Case Management Log. CalOptima will perform monthly review of the Case Management Files and inform the Health Network of the results.	/users/Documentation Library/HN Reporting Binder/2021 Report Templates/Case Management	Case Management	**Monthly: 1 week after CalOptima request**	Secure email to Case Management.	N/A	N/A	PDF	x			x	x		x	
Continuity of Care (Whole-Child Model)	Health Networks shall submit weekly report of Continuity of Care (COC) for Whole -Child Model (WCM) members that includes COC requests and the outcome received during the previous month.	/users/Documentation Library/HN Reporting Binder/2021 Report Templates/Case Management	Case Management	**Weekly; every Tuesday by 10 am for the prior week's activity**	1_WCMMC_**HN_YYYYMMDD**_COC	HN = Health network reporting # MM = 2 digit month DD - 2 digit day YYYY= 4 digit year	Managed_HN_Reporting/ WCM/Inbound	Excel	x			x	x		x	
Enhanced Monitoring Report (WCM)	Health Networks shall submit quarterly Enhanced Monitoring Report for WCM members.	/users/Documentation Library/HN Reporting Binder/2021 Report Templates/Case Management	Case Management Regulatory Affairs	**Quarterly; 2nd day after the end of the quarter**	1_WCMMC_**HN_YYYYMMDD**_Enhanced.xlsx	HN = Health network reporting # YYYY= 4 digit year MM = 2 digit month DD - 2 digit day	Managed_HN_Reporting/ WCM/Inbound	Excel	x			x	x		x	
Health Homes Program (HHP) Enrollment and Disenrollment Report	Health Networks shall submit monthly report of all HHP enrollments and disenrollments as of the last day of the prior reporting month.	/users/Documentation Library/HN Reporting Binder/2021 Report Templates/Case Management	Case Management	**Monthly: 10th of every month**	**HN**_HHP_Enro lment.csv	HN = Health network reporting #	Managed_HN_Reporting/ HHP/Inbound	Excel	x			x	x		x	
HHP Finalized Engagement List (FEL) Return File	Health Networks shall submit monthly report of FEL return file that includes HHP engagement outcomes.	/users/Documentation Library/HN Reporting Binder/2021 Report Templates/Case Management	Case Management	**Monthly: 10th of every month**	**HN**_HHP_ReturnFEL	HN = Health network reporting #	Managed_HN_Reporting/ HHP/Inbound	Excel	x			x	x		x	
HHP Services	Health Networks shall submit monthly report of HHP services that includes prior reporting month's HHP service activities.	/users/Documentation Library/HN Reporting Binder/2021 Report Templates/Case Management	Case Management	**Monthly: 10th of every month**	1_HHPServices_**HN_YYYYMM**.csv	HN = Health network reporting # YYYY= 4 digit year MM = 2 digit month DD - 2 digit day	Managed_HN_Reporting/ HHP/Inbound	Excel	x			x	x		x	
Implementation Audit (OneCare Connect)	Health Networks shall submit monthly report of Implementation Audit that includes documentation of implementation hospitalization key event and non-hospitalization key event. This report is part of CalOptima's requirement for Personal Care Coordinator (PCC) funding.	/users/Documentation Library/HN Reporting Binder/2021 Report Templates/Case Management	Case Management	**Ongoing, per process**	**HN_Member CIN**_OCC_Review_**MMYYYY**	HN = Health network reporting # Member_CIN = Member CIN YYYY = 4 digit year MM = 2 digit month	OCC/RevisedMOC/Inboun d	PDF			x	x			x	
Implementation Audit (OneCare)	Health Networks shall submit monthly report of Implementation Audit that includes documentation of implementation hospitalization key event and non-hospitalization key event. This report is part of CalOptima's requirement for PCC funding.	/users/Documentation Library/HN Reporting Binder/2021 Report Templates/Case Management	Case Management	**Ongoing, per process**	**HN_Member CIN**_OC_Review_**MMYYYY**	HN = Health network reporting # Member_CIN = Member CIN YYYY = 4 digit year MM = 2 digit month	OC/RevisedMOC/Inbound	PDF		x		x			x	
Implementation Audit (Seniors and Persons with Disabilities (SPD))	Health Networks shall submit monthly report of Implementation Audit that includes documentation of implementation hospitalization key event and non-hospitalization key event. This report is part of CalOptima's requirement for PCC funding.	/users/Documentation Library/HN Reporting Binder/2021 Report Templates/Case Management	Case Management	**Ongoing, per process**	**HN_Member CIN**_Review_**MMYYYY**	HN = Health network reporting # Member_CIN = Member CIN YYYY = 4 digit year MM = 2 digit month	MediCal/RevisedMOC/Inb ound	PDF	x			x	x		x	
Organ Transplant - Kaiser	Kaiser shall submit monthly report of members engaged in the organ transplant process.	/users/Documentation Library/HN Reporting Binder/2021 Report Templates/Case Management	Case Management	**Monthly: 15th of every month**	1_CMRPT_04_**MMYYYY**_OT	MM = 2 digit month YYYY= 4 digit year	hn_reporting	Excel	x				x		x	
Annual Redetermination Files	Health Networks shall submit reports of Annual Redetermination files for WCM members most recent (within the past year). The report is due no later than 60 calendar days prior to annual redetermination.	/users/Documentation Library/HN Reporting Binder/2021 Report Templates/Case Management	Case Management (MOC)	**Ongoing, per process**	**HN_MEMBERCIN**_WCM_AR_**MMDDYYYY**	HN = Health network reporting # MEMBER CIN = CIN # MM = 2 digit month DD = 2 digit day YYYY= 4 digit year	WCM Revised MOC/Inbound	PDF	x			x	x		x	
Individual Care Plan/Health Action Plan (ICP/HAP) bundle	Health Networks shall submit report of individual bundles with completed HAP. A HAP bundle will be returned after a member has completed a health needs assessment (HNA) and enrolled in CalOptima's HHP and due between 85 and 90 calendar days from HHP enrollment date.	/users/Documentation Library/HN Reporting Binder/2021 Report Templates/Case Management	Case Management (MOC)	**Ongoing, per process**	HN#_CIN_HHP_MMDDYYYY	HN=Health network reporting # C N-MM=2 digit month DD-2 digit day YYYY=4 digit year (MMDDYYY=date ICP/HAP completed)	HN#HNname/MediCal/HH P MOC/Inbound	PDF	x			x	x		x	

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CalOptima Policy HH.2003 - Attachment A: Timely and Appropriate Submission Grid - Master

Year: 2021 Release: 2 Release Date: TBD									Line of Business			Report Requirement Indicator			Report Type	
REPORT NAME	DESCRIPTION/REQUIREMENT (Refer to "FTP File Path for Template (Health Network)" for required reporting elements)	FTP FILE PATH FOR TEMPLATE (HEALTH NETWORK)	CALOPTIMA DEPARTMENT	REPORT FREQUENCY	NAMING CONVENTION	NAMING CONVENTION INSTRUCTIONS	FTP FOLDER	FILE TYPE	MEDI-CAL	ONECARE	ONECARE CONNECT	Health Networks (Except Kaiser)	Kaiser	VSP	Oversight	Reimbursement
Interdisciplinary Care Plan (ICP) Bundle (OneCare Connect)	Health Networks shall submit report of individual bundles with ICT minutes and ICP. This report is part of CalOptima's requirement for PCC funding. An ICT bundle will be returned within 45 calendar days of health risk assessment (HRA) completion date for all members completing an HRA.	/users/Documentation Library/HN Reporting Binder/2021 Report Templates/Case Management	Case Management (MOC)	**Ongoing, per process**	**HN_MEMBERCIN**_ICP_**MMDDYYYY**	HN = Health network reporting # MEMBER CIN = CIN # MM = 2 digit month DD = 2 digit day YYYY= 4 digit year	OCC/RevisedMOC/Inbound	PDF			x	x			x	
Interdisciplinary Care Team (ICT) Bundle (Medi-Cal)	Health Networks shall submit report of individual bundles with ICT minutes and ICP. This report is part of CalOptima's requirements for PCC funding. An ICT bundle will be returned for members completing an HRA with a CML of care coordination or complex. Bundles shall be returned within 145 calendar days for basic care management and 60 calendar days for complex or care coordination levels.	/users/Documentation Library/HN Reporting Binder/2021 Report Templates/Case Management	Case Management (MOC)	**Ongoing, per process**	**HN_MEMBERCIN**_SPD_ICT_**MMDDYYYY**	HN = Health network reporting # MEMBER CIN = CIN # MM = 2 digit month DD = 2 digit day YYYY= 4 digit year	SPD/RevisedMOC/Inbound	PDF	x			x	x		x	
ICT Bundle (OneCare)	Health Networks shall submit report of individual bundles with ICT minutes and ICP. This report is part of CalOptima's requirements for PCC funding. An ICT bundle will be returned for all members completing an HRA. Bundles shall be returned within 145 calendar days for basic care management and 60 calendar days for complex or care coordination levels.	/users/Documentation Library/HN Reporting Binder/2021 Report Templates/Case Management	Case Management (MOC)	**Ongoing, per process**	**HN_MEMBER CIN**_ICT_**MMDDYYYY**	HN = Health network reporting # MEMBER CIN = CIN # MM = 2 digit month DD = 2 digit day YYYY= 4 digit year	OneCare/RevisedMOC/Inbound	PDF		x		x			x	
Long Term Care (LTC) ICP Bundle (OneCare Connect)	Health Networks shall submit report of individual bundles with ICT minutes and ICP. This report is part of CalOptima's requirements for PCC funding. An ICT bundle will be returned for all members residing in Long Term Care that have completed an HRA. Bundles shall be returned within 45 calendar days of HRA completion.	/users/Documentation Library/HN Reporting Binder/2021 Report Templates/Case Management	Case Management (MOC)	**Ongoing, per process**	**HN_MEMBERCIN**_LTC_ICP_**MMDDYYYY**	HN = Health network reporting # MEMBER CIN = CIN # MM = 2 digit month DD = 2 digit day YYYY= 4 digit year	OCC/RevisedMOC/Inbound	PDF			x	x			x	
Pediatric ICT Bundle (Medi-Cal)	Health Networks shall submit report of individual bundles with ICT minutes and ICP. This report is part of CalOptima's requirements for PCC funding. An ICT bundle will be returned for all members residing in Long Term Care that have completed an HRA. Bundles shall be returned within 145 calendar days for basic care management and 60 days for complex or care coordination levels.	/users/Documentation Library/HN Reporting Binder/2021 Report Templates/Case Management	Case Management (MOC)	**Ongoing, per process**	**HN_MEMBERCIN**_SPD_PEDS_ICT_**MMDDYYYY**	HN = Health network reporting # MEMBER CIN = CIN # MM = 2 digit month DD = 2 digit day YYYY= 4 digit year	SPD/RevisedMOC/Inbound	PDF	x			x	x		x	
Model of Care (MOC) SPD Tracking Log (Medi-Cal)	Health Networks shall submit monthly report of PCC assignment for all current SPD members. This report is part of CalOptima's requirements for PCC funding.	/users/Documentation Library/HN Reporting Binder/2021 Report Templates/Case Management	Case Management (MOC)	**Monthly: 6th of every month**	**HN**271**CCYYMMDD**	HN = Health network reporting # CCYY= 4 digit year MM = 2 digit month DD = 2 digit day	SPD Revised MOC/Inbound	Pipe delimited text file	x			x	x		x	
MOC Tracking Log (OneCare Connect)	Health Networks shall submit monthly report of PCC assignment for all current OCC members. This report is part of CalOptima's requirements for PCC funding.	/users/Documentation Library/HN Reporting Binder/2021 Report Templates/Case Management	Case Management (MOC)	**Monthly: 6th of every month**	**HN**871**CCYYMMDD**	HN = Health network reporting # CCYY= 4 digit year MM = 2 digit month DD = 2 digit day	OCC/RevisedMOC/Inbound	Pipe delimited text file			x	x			x	
MOC Tracking Log (OneCare)	Health Networks shall submit monthly report of PCC assignment for all current OC members. This report is part of CalOptima's requirements for PCC funding.	/users/Documentation Library/HN Reporting Binder/2021 Report Templates/Case Management	Case Management (MOC)	**Monthly: 6th of every month**	**HN**571**CCYYMMDD**	HN = Health network reporting # CCYY= 4 digit year MM = 2 digit month DD = 2 digit day	OneCare/RevisedMOC/Inbound	Pipe delimited text file		x		x			x	
MOC WCM Tracking Log (Medi-Cal)	Health Networks shall submit monthly report of PCC assignment for all current WCM members. This report is part of CalOptima's requirements for PCC funding.	/users/Documentation Library/HN Reporting Binder/2021 Report Templates/Case Management	Case Management (MOC)	**Monthly: 6th of every month**	**HN**275**CCYYMMDD**	HN = Health network reporting # CCYY= 4 digit year MM = 2 digit month DD = 2 digit day	WCM Revised MOC/Inbound	Pipe delimited text file	x			x			x	
Network Staff Legend File	Health Networks shall submit monthly report of Network Staff Legend File that includes all PCC staff the percentage of time each staff person spends on each program and Care Coordinator (CC) staff information (OCC only). This report is part of CalOptima's requirements for PCC funding.	/users/Documentation Library/HN Reporting Binder/2021 Report Templates/Case Management	Case Management (MOC)	**Monthly: 6th of every month**	**HN**429**YYYYMMDD**	HN = Health network reporting # YYYY = 4 digit year MM = 2 digit month DD = 2 digit day	/RevisedMOC/Inbound	Pipe delimited text File	x	x	x	x			x	
WCM ICP Bundle (Medi-Cal)	Health Networks shall submit report of individual bundles with ICT minutes and ICP. This report is part of CalOptima's requirements for PCC funding. An ICT bundle will be returned for members completing an HRA with a CML of care coordination or complex. Bundles sha l be returned within 90 days of HRA completion.	/users/Documentation Library/HN Reporting Binder/2021 Report Templates/Case Management	Case Management (MOC)	**Ongoing, per process**	**HN_MEMBERCIN**_WCM_ICT_**MMDDYYYY**	HN = Health network reporting # MEMBER CIN = CIN # MM = 2 digit month DD = 2 digit day YYYY= 4 digit year	WCM Revised MOC/Inbound	PDF	x			x	x		x	
DHCS WCM Report - Kaiser	Kaiser shall submit monthly report of WCM authorizations care coordination and grievances/appeals. The grievance and appeal sections apply to Kaiser due to delegation of member grievances and appeals.	/users/Documentation Library/HN Reporting Binder/2021 Report Templates/Case Management	Case Management GARS Utilization Management	**Monthly: 15th of every month** **First Submission: 10/15/19 (Jul, August, September 2019 data), monthly thereafter**	1_WCMMC_04_**YYYYMM**_DHCS	HN = Health network reporting # YYYY= 4 digit year MM = 2 digit month	Managed_HN_Reporting/ WCM/Inbound	Excel	x				x		x	

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Year: 2021 Release: 2 Release Date: TBD									Line of Business			Report Requirement Indicator			Report Type	
REPORT NAME	DESCRIPTION/REQUIREMENT (Refer to "FTP File Path for Template (Health Network)" for required reporting elements)	FTP FILE PATH FOR TEMPLATE (HEALTH NETWORK)	CALOPTIMA DEPARTMENT	REPORT FREQUENCY	NAMING CONVENTION	NAMING CONVENTION INSTRUCTIONS	FTP FOLDER	FILE TYPE	MEDI-CAL	ONECARE	ONECARE CONNECT	Health Networks (Except Kaiser)	Kaiser	VSP	Oversight	Reimbursement
Population Health Management (PHM) Program Description - Kaiser	Kaiser shall develop a PHM program description and submit to CalOptima for review.	/users/Documentation Library/HN Reporting Binder/2021 Report Templates/Case Management	Case Management and Population Health Management	**Annually: February 15**	2_CMRPT_DMRPT_04_Annual**YYYY**_CMPD	HN = Health network # YYYY = 4 digit year	hn_reporting	PDF or Word	x				x		x	
DHCS WCM Report	Health Networks shall submit monthly report of WCM authorizations and care coordination.	/users/Documentation Library/HN Reporting Binder/2021 Report Templates/Case Management	Case Management Utilization Management	**Monthly: 15th of every month** **First submission: 10/15/19 (Jul, Aug, Sep '19 data), monthly thereafter**	1_WCMMC_**HN_YYYYMM**_DHCS	HN = Health network reporting # YYYY= 4 digit year MM = 2 digit month	Managed_HN_Reporting/ WCM/Inbound	Excel	x			x			x	
Claims Third Party Liability (TPL) (Medi-Cal)	Health Networks shall submit monthly report of potential TPL data to CalOptima for reporting to DHCS.	/users/Documentation Library/HN Reporting Binder/2021 Report Templates/Claims Reporting	Claims	**Monthly: 30th of every month**	1_CLMRPT_**HN_MMYYYY**_TPL	HN = Health network reporting # MM = 2 digit month YYYY= 4 digit year	hn_reporting	Excel & PDF	x			x	x		x	
Claims TPL (OneCare Connect)	Health Networks shall submit monthly report of potential TPL data to CalOptima for reporting to DHCS.	/users/Documentation Library/HN Reporting Binder/2021 Report Templates/Claims Reporting	Claims	**Monthly: 30th of every month**	1_CLMRPT_**HN_MMYYYY**_TPL_DB	HN = Health network reporting # MM = 2 digit month YYYY= 4 digit year	hn_reporting	Excel & PDF			x	x			x	
DHCS Post-Payment Recovery Report (Medi-Cal Only)	Health Networks shall submit monthly report of post-payment recovery data for other health coverage (OHC) claims to CalOptima.	/users/Documentation Library/HN Reporting Binder/2021 Report Templates/Claims Reporting	Claims	**Monthly: 3rd business day of every month**	1_MCPPR_XX_YYYYPP_SS	HN = Health network reporting # MM = 2 digit month YYYY = 4 digit year	hn_reporting	Text F le	x			x	x		x	
Customer Service Call Log Universe	Health Networks shall submit quarterly Customer Service Call Log Universe for monitoring of Health Network Member Services/Customer Service staff in the ident fication of grievances and the appropriate handling of a grievance. CalOptima Customer Service will meet quarterly with the Health Networks to provide feedback of monitoring.	/users/Documentation Library/HN Reporting Binder/2021 Report Templates/Customer Service	Customer Service	**Quarterly: January 7, April 7, July 7, October 7**	MC: 1_CSRPT_**HN**_CS_MC_**QQYYYY** OC: 1_CSRPT_**HN**_CS_OC_**QQYYYY** OCC: 1_CSRPT_**HN**_CS_OCC_**QQYYYY**	HN = Health network # QQ = 2 digit quarter (Q1 etc) YYYY= 4 digit year	hn_reporting	Excel	x	x	x	x	x		x	
Health Network Dashboard	Health Networks shall submit report of call center statistics for monthly review.	/users/Documentation Library/HN Reporting Binder/2021 Report Templates/Customer Service	Customer Service	**Monthly: 15th of every month**	2_HMRPT_CSRPT_**HN_MMYYYY**_Dashboard	HN = Health network # MM = 2 digit month YYYY= 4 digit year	hn_reporting	Excel	x	x	x	x	x	x	x	
Interpreter Services Utilization Report	Health Networks shall submit quarterly report of interpreter services utilization for CalOptima members assigned to their Health Networks.	/users/Documentation Library/HN Reporting Binder/2021 Report Templates/Customer Service	Customer Service	**Quarterly: January 30, April 30, July 30, October 30**	2_CSRPT_QIRPT_**HN_QTYYYY**_CCS_2019	HN = Health network reporting # QT = 2 digit Quarter # YYYY = 4 digit year	hn_reporting	Excel	x	x	x	x	x	x	x	
DHCS NMT/NEMT Report - Kaiser	Kaiser shall submit monthly report of DHCS Non-Medical Transportation (NMT)/Non-Emergency Medical Transportation (NEMT). The grievance and appeals sections apply to Kaiser due to delegation of member grievances and appeals.	/users/Documentation Library/HN Reporting Binder/2021 Report Templates/Customer Service	Customer Service GARS	**Monthly: 27th of every month**	2_CSRPT_GARSRPT_04_NMT-NEMT_**MMYYYY**	MM = 2 digit month YYYY= 4 digit year	hn_reporting	Excel	x				x		x	
Annual Audited Financial Statements	Health Networks shall submit annual audited financial statements of the organization (PHC and SRG only).	/users/Documentation Library/HN Reporting Binder/2021 Report Templates/Finance	Finance	**Annual submission due 120 days after organization's fiscal year ends**	1_FINRPT_**HN**_Annual**YYYY**_AAFS	HN = Health network reporting # YYYY = 4 digit year	hn_reporting	PDF or Excel	x	x	x	x			x	
Incurred But Not Reported (IBNR) Documentation	Health Networks shall annually submit IBNR documentation which can be included in the Annual Audited Financial Statements or submitted as a separate report.	/users/Documentation Library/HN Reporting Binder/2021 Report Templates/Finance	Finance	**Annual submission due 120 days after organization's fiscal year ends**	1_FINRPT_**HN**_Annual**YYYY**_IBNR or submitted with Annual Audited Financial Statements	HN = Health network reporting # YYYY = 4 digit year	hn_reporting	PDF or Excel	x	x	x	x			x	
Medical Loss Ratio (MLR)	Health Networks shall submit interim and final reports of the Health Network MLR.	/users/Documentation Library/HN Reporting Binder/2021 Report Templates/Finance	Finance	**Interim: January - June due August 15.** **Interim: January - December due February 15** **Final: Annual submission of all 12 months due June 30**	1_FINRPT_**HN_SemiAnnualYYYY**_MLR 1_FINRPT_**HN_AnnualYYYY**_MLR 1_FINRPT_**HN_FinalYYYY**_MLR	HN = Health network reporting # YYYY= 4 digit year	hn_reporting	Excel (using most current AFRF)	x		x	x			x	
Risk Bearing Organization (RBO) Report	Health Networks shall submit quarterly and annual RBO reports that include financial data submitted to the Department of Managed Health Care (DMHC) by the Health Networks (PHC and SRG only).	/users/Documentation Library/HN Reporting Binder/2020 Report Templates/Finance	Finance	**Annual submission due 150 days after the fiscal year ends.** **Quarterly: February 15, May 15, August 15, November 15**	1_FINRPT_**HN**_Annual**YYYY**_DMHC (Annua) 1_FINRPT_**HN_QTYYYY**_DMHC (Quarterly)	HN = Health network reporting # YYYY= 4 digit year QT = 2 digit Quarter #	hn_reporting	PDF or Excel	x	x	x	x			x	
Total Business Reports	Health Networks shall submit quarterly unaudited financial statements of the PHC and SRG organization.	/users/Documentation Library/HN Reporting Binder/2021 Report Templates/Finance	Finance	**Quarterly: February 15, May 15, August 15, November 15**	1_FINRPT_**HN_QTYYYY**_TBFS	HN = Health network reporting # QT = 2 digit Quarter # YYYY = 4 digit year	hn_reporting	PDF or Excel	x	x	x	x			x	
DHCS Quarterly Report - Kaiser	Kaiser shall submit quarterly report of member grievances and appeals received within the quarter. Report includes a breakdown of grievance and appeal types by categories specified by DHCS template. This report applies to Kaiser due to delegation of member grievances and appeals.	/users/Documentation Library/HN Reporting Binder/2021 Report Templates/GARS	GARS	**Quarterly: January 23, April 23, July 23, October 23**	1_GARSRPT_04_**QTYYYY**_DHCS	HN = Health network reporting # QT = 2 digit Quarter # YYYY = 4 digit year	hn_reporting	Excel	x				x		x	

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Year: 2021 Release: 2 Release Date: TBD									Line of Business			Report Requirement Indicator			Report Type	
REPORT NAME	DESCRIPTION/REQUIREMENT (Refer to "FTP File Path for Template (Health Network)" for required reporting elements)	FTP FILE PATH FOR TEMPLATE (HEALTH NETWORK)	CALOPTIMA DEPARTMENT	REPORT FREQUENCY	NAMING CONVENTION	NAMING CONVENTION INSTRUCTIONS	FTP FOLDER	FILE TYPE	MEDI-CAL	ONECARE	ONECARE CONNECT	Health Networks (Except Kaiser)	Kaiser	VSP	Oversight	Reimbursement
Grievances Volume Report - Kaiser	Kaiser shall submit quarterly report of member grievance volume/aggregate data. This report applies to Kaiser due to delegation of member grievances and appeals.	/users/Documentation Library/HN Reporting Binder/2021 Report Templates/GARS	GARS	**Quarterly: January 23, April 23, July 23, October 23**	1_GARSRPT_HMO04_QQYYYY_VOL	QT = 2 digit Quarter # YYYY = 4 digit year	hn_reporting	Excel	x				x		x	
Community-Based Adult Services (CBAS) Report - Kaiser	Kaiser shall submit quarterly CBAS reports that include CBAS services and assessment grievance and appeals and call center complaints. The grievance and appeal sections apply to Kaiser due to delegation of member grievances and appeals.	/users/Documentation Library/HN Reporting Binder/2021 Report Templates/GARS	GARS Customer Service Long Term Services and Supports	**Quarterly: January 23, April 23, July 23, October 23**	3_GARSRPT_CSRPT_LTSSRPT_HMO04_**QTYYYY**_CBAS	QT = 2 digit Quarter # YYYY = 4 digit year	Incoming	Text F le	x				x		x	
DHCS Data Cert fication Statement	Health Networks shall submit a completed and signed Data Certification Statement on Health Network's letterhead that data information and documentation submitted to CalOptima monthly are accurate complete and truthful.	/users/Documentation Library/HN Reporting Binder/2021 Report Templates/HNR	HNR	**Monthly: 25th of every month**	1_AORPT_**HN**_Data Certification_**MMYYYY**	HN = Health network #	hn_reporting	PDF	x			x	x	x	x	
Health Network Newly Contracted Provider Training Report	Health Networks shall submit quarterly report of educational training of all newly contracted providers. Required training must be conducted within ten (10) working days and completed within thirty (30) calendar days from the provider's placement on active status. Health Networks shall obtain a signed acknowledgment notice from providers upon completion of training.	/users/Documentation Library/HN Reporting Binder/2021 Report Templates/HNR	HNR	**Quarterly: January 25, April 25, July 25, October 25**	1_HMRPT_**HN_QTYYYY**_NCT	HN = Health network reporting # QT = 2 digit Quarter # YYYY = 4 digit year	hn_reporting	Excel	x	x	x	x	x	x	x	
Primary Care Provider (PCP) Upload File	Health Networks shall submit bi-monthly report of Medi-Cal Member PCP assignment/changes.	/users/Documentation Library/HN Reporting Binder/2021 Report Templates/HNR	HNR	**Bi-monthly: 10th and 25th of every month**	**HN**204**JJJ**	HN = Health network reporting # JJJ = Julian Date	hn_reporting	Excel	x			x			x	
DHCS Supplemental Data – Kaiser	Kaiser shall submit monthly report of Behavioral Health Treatment (BHT) and Hepatitis C (Hep C) supplemental data for CalOptima's Consolidated Supplemental File submission to DHCS.	/users/Documentation Library/HN Reporting Binder/2021 Report Templates/IS	IS	**Monthly; 15th of every month**	CalOptima_KSR_PRD_Supplementals_[yyyymm].txt	YYYY= 4 digit year MM = 2 digit month	Incoming	Text F le	x				x		x	
Vision Service Plan (VSP) Provider Roster	VSP shall submit monthly report of VSP providers for the print and online provider directories.	/users/Documentation Library/HN Reporting Binder/2021 Report Templates/PDMS	PDMS	**Monthly: 15th of every month**	VSP_Medicaid_CA_Orange_County_Provider_Listing_ **YYYYMMDD**	HN = Health network reporting # CCYY= 4 digit year MM = 2 digit month DD = 2 digit day		Excel	x					x	x	
Health Education Calendar - Kaiser	Kaiser is required to submit its Health Education Calendar semi-annually for review and auditing.	/users/Documentation Library/HN Reporting Binder/2021 Report Templates/Population Health Management	Population Health Management	**Semi-Annually: January 31 and July 31**	1_DMRPT_04_**MMYYYY**_HECALENDAR	HN = Health network reporting # MM = 2 digit month YYYY= 4 digit year	hn_reporting	Excel	x				x		x	
Health Education Individual Encounters - Kaiser	Kaiser is required to submit its Health Education Calendar semi-annually for review and auditing.	/users/Documentation Library/HN Reporting Binder/2021 Report Templates/Population Health Management	Population Health Management	**Semi-Annually January 31 and July 31**	1_DMRPT_04_**MMYYYY**_HEIE	HN = Health network reporting # MM = 2 digit month YYYY= 4 digit year	hn_reporting	Word	x				x		x	
Health Education Other Encounters - Kaiser	Kaiser is required to submit Health Education Other Encounters semi-annually for review and auditing.	/users/Documentation Library/HN Reporting Binder/2021 Report Templates/Population Health Management	Population Health Management	**Semi-Annually January 31 and July 31**	1_DMRPT_04_**MMYYYY**_HEOE	HN = Health network reporting # MM = 2 digit month YYYY= 4 digit year	hn_reporting	Word	x				x		x	
Perinatal Support Services (PSS) Encounters - Kaiser	Kaiser shall submit monthly Comprehensive Perinatal Service Program (CPSP)/PSS data to support CalOptima's oversight and quality improvement efforts.	/users/Documentation Library/HN Reporting Binder/2021 Report Templates/Population Health Management	Population Health Management	**Monthly: 15th of every month**	1_DMRPT_04_**MMYYYY**_PSS_Services	HN = Health network reporting # MM = 2 digit month YYYY= 4 digit year	hn_reporting	Excel	x				x		x	
Access and Availability Report - Kaiser	Kaiser shall submit annual analysis of data to measure performance against standards for access including behavioral health (BH) access standards.	/users/Documentation Library/HN Reporting Binder/2021 Report Templates/Quality Analytics	Quality Analytics	**Annually: February 15**	1_MDMRPT_04_Annual**YYYY**_Access	YYYY = 4 digit year	hn_reporting	Excel or Word or PDF	x				x		x	
Quality Improvement (QI) Evaluation (Previous Year) - Kaiser	Kaiser shall perform an annual evaluation of their QI work plan/program and submit to CalOptima for review.	/users/Documentation Library/HN Reporting Binder/2020 Report Templates/Quality Improvement	Quality Improvement	**Annually: February 15**	1_QIRPT_**HN**_Annual**YYYY**_QIE	HN = Health network # YYYY = 4 digit year	hn_reporting	PDF or Word	x				x		x	
QI Program - Kaiser	Kaiser shall develop an annual QI report and submit to CalOptima for review.	/users/Documentation Library/HN Reporting Binder/2021 Report Templates/Quality Improvement	Quality Improvement	**Annually: February 15**	1_QIRPT_**HN**_Annual**YYYY**_QIP	HN = Health network # YYYY = 4 digit year	hn_reporting	PDF or Word	x				x		x	
QI Work Plan - Kaiser	Kaiser shall report progress towards QI program goals semi-annually.	/users/Documentation Library/HN Reporting Binder/2021 Report Templates/Quality Improvement	Quality Improvement	**Semi-Annually: February 15 and August 15**	1_QIRPT_**HN**_SemiAnnual**YYYY**_QI	HN = Health network # YYYY = 4 digit year	hn_reporting	Excel	x				x		x	
QI Work Plan Current Year (Initial) - Kaiser	Kaiser shall develop an annual quality improvement work plan that outlines goals and initiatives for the new year. The initial work plan must be submitted to CalOptima for review.	/users/Documentation Library/HN Reporting Binder/2021 Report Templates/Quality Improvement	Quality Improvement	**Annually: February 15 (for new year)**	1_QIRPT_**HN**_Annual**YYYY**_QICY	HN = Health network # YYYY = 4 digit year	hn_reporting	Excel	x				x		x	
Report of Findings and Actions Taken as a Result of QI Activities - Kaiser	Kaiser shall submit quarterly report of any findings or actions taken as a result of QI activities.	/users/Documentation Library/HN Reporting Binder/2021 Report Templates/Quality Improvement	Quality Improvement	**Quarterly**	1_QIRPT_HN_QTYYYY_QI Findings	HN = Health network # YYYY = 4 digit year	hn_reporting	PDF	x				x		x	

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REPORT NAME	DESCRIPTION/REQUIREMENT (Refer to "FTP File Path for Template (Health Network)" for required reporting elements)	FTP FILE PATH FOR TEMPLATE (HEALTH NETWORK)	CALOPTIMA DEPARTMENT	REPORT FREQUENCY	NAMING CONVENTION	NAMING CONVENTION INSTRUCTIONS	FTP FOLDER	FILE TYPE	MEDI-CAL	ONECARE	ONECARE CONNECT	Health Networks (Except Kaiser)	Kaiser	VSP	Oversight	Reimbursement
Authorization Utilization Report	Health Networks shall submit quarterly report of open authorizations if a claim was received and the date the claim was paid (if applicable). Unused authorization reporting shall include the claims status for each referral authorized during the measurement period.	/users/Documentation Library/HN Reporting Binder/2021 Report Templates/Utilization Mgmt	Utilization Management	**Quarterly:** **Q3 2020 - February 15, 2021** **Q4 2020 - May 15, 2021** **Q1 2021 - August 15, 2021** **Q2 2021 - November 15, 2021**	1_UMRPT_**HN_QTYYYY**_AUTH	HN = Health network reporting # QT = 2 digit quarter YYYY= 4 digit year	hn_reporting	Excel	x			x	x		x	
Dental Anesthesia Report	Health Networks shall submit quarterly report of the monthly totals of dental general anesthesia requests approvals and denials for adults and children with and without developmental disability (DD).	/users/Documentation Library/HN Reporting Binder/2021 Report Templates/Utilization Mgmt	Utilization Management	**Quarterly:** **15th of the month after the end of the quarter**	1_UMRPT_**HN_QTYYYY**_DA	HN = Health network reporting # QT = 2 digit Quarter # YYYY = 4 digit year	hn_reporting	Excel	x			x	x		x	
UM Evaluation (Previous Year)	Health Networks shall perform an annual evaluation on their UM work plan/program and submit to CalOptima for review.	/users/Documentation Library/HN Reporting Binder/2021 Report Templates/Utilization Mgmt	Utilization Management	**Annually:** **February 15**	2_UMRPT_AORPT_**HN**_Annual**YYYY**_UME	HN = Health network # YYYY = 4 digit year	hn_reporting	PDF or Word	x	x	x	x	x		x	
UM Program	Health Networks shall develop a UM program description and submit to CalOptima for review.	/users/Documentation Library/HN Reporting Binder/2021 Report Templates/Utilization Mgmt	Utilization Management	**Annually:** **February 15**	2_UMRPT_AORPT_**HN**_Annual**YYYY**_UMP	HN = Health network # YYYY = 4 digit year	hn_reporting	PDF or Word	x	x	x	x	x		x	
UM Work Plan	Health Networks shall report progress towards UM program goals semi-annually.	/users/Documentation Library/HN Reporting Binder/2021 Report Templates/Utilization Mgmt	Utilization Management	**Semi-Annually:** **February 15 and August 15**	2_UMRPT_AORPT_**HN**_SemiAnnual**YYYY**_UMCY	HN = Health network # YYYY = 4 digit year	hn_reporting	Excel	x	x	x	x	x		x	
UM Work Plan Current Year (Initial)	Health Networks shall develop an annual UM work plan that outlines goals and initiatives for the new year. The initial work plan must be submitted to CalOptima for review.	/users/Documentation Library/HN Reporting Binder/2021 Report Templates/Utilization Mgmt	Utilization Management	**Annually:** **February 15 (for new year)**	2_UMRPT_AORPT_**HN**_Annual**YYYY**_UMCY	HN = Health network # YYYY= 4 digit year	hn_reporting	Excel	x	x	x	x	x		x	
Out-of-Network (OON) Requests	Health Networks shall submit quarterly report of OON requests from all enrolled members (except for COC) and approvals by specialty type.	/users/Documentation Library/HN Reporting Binder/2021 Report Templates/Utilization Mgmt	Utilization Management	**Quarterly:** **January 25, April 25, July 25, October 25**	1_UMRPT_**HN_QTYYYY**_OON	HN = Health network reporting # QT = 2 digit Quarter # YYYY = 4 digit year	hn_reporting	Excel	x			x	x		x	
Kaiser WCM Claim Detail	Kaiser shall submit monthly report of WCM claims payment information.	/users/Documentation Library/HN Reporting Binder/2021 Report Templates/Claims Reporting	Claims	**Monthly:** **15th of every month**	Kaiser_ClaimDetail_MMDDYY	DD = 2 digit day MM = 2 digit month YYYY = 4 digit year	incoming	Excel	x				x			x
Preclusion List Report for Member Notifications Only	Health Networks shall submit monthly report of impacted members ut lizing services from a provider who is on the preclusion list. CalOptima Customer Service then notices impacted members on behalf of all Health Networks.	/users/Documentation Library/HN Reporting Binder/2021 Report Templates/Customer Service	Customer Service	**Monthly:** **10th of every month**	2_CSRPT_HNRPT_**HN**_PreclusionList_**YYYYMM**	HN = Health network reporting # YYYY= 4 digit year MM = 2 digit month	hn_reporting	Excel	x	x	x	x	x	x		x
Directed Payments File	Health Networks shall submit monthly Directed Payment adjustment report for qualifying services.	/users/Documentation Library/HN Reporting Binder/2021 Report Templates/HNR	HNR	**Monthly:** **10th of every month**	1_HNRPT_DirectedPayment_**HN_YYYYMM**.csv	HN = Health network reporting # YYYY= 4 digit year MM = 2 digit month DD - 2 digit day	hn_reporting	Excel	x			x	x			x
Kaiser WCM Rx Detail	Kaiser shall submit monthly report of WCM Rx payment information.	/users/Documentation Library/HN Reporting Binder/2021 Report Templates/Pharmacy Management	Pharmacy	**Monthly:** **15th of every month**	WCM04RXCCYYMMDD	MM = 2 digit month YYYY = 4 digit year	incoming	Excel	x				x			x
FDR Compliance Attestation	The First Tier Downstream and Related Entity (FDR) Compliance Attestation is completed by a l CalOptima FDRs. It requests for attestation to the compliance program elements and if there is offshore use of any protected heath information (PH) then FDRs are to complete the offshore subcontracting attestation.	https://www.caloptima.org/ /media/F les/CalOptimaOrg/508/Vendors/ComplianceFDRs/2020-08_CalOptimaFDRProgramAttestation_508.ashx	Office of Comp iance	**Initial upon contracting; Annually thereafter**	FDR Compliance Attestation	N/A	email to compliance@caloptima.org	PDF	x	x	x	x	x	x	x	
Claims Timeliness Report	Health Networks shall submit a monthly claims payment performance (timeliness) report.	/users/Documentation Library/HN Reporting Binder/2021 Report Templates/Claims Reporting	Claims	**Monthly** **15th of every month** **Quarterly** **January 30, April 30, July 30, October 30**	1_CLMRPT_**HN_MMYYYY**_MTR_**LOB** (Monthly) 1_CLMRPT_**HN_QTYYYY**_MTR_**LOB** (Quarterly)	HN = Health network reporting # MM = 2 digit month QT = 2 digit quarter # YYYY= 4 digit year LOB=MC OC DB	hn_reporting	Excel	x	x	x	x	x	x	x	
274 Provider Directory - Kaiser	Kaiser is required to submit managed care provider data in a national standard transaction in compliance with the Accredited Standards Committee (ASC) X12N 274 version 4050X109 Implementation Guide and the most recent DHCS 274 Companion Guide.	/users/Documentation Library/HN Reporting Binder/2021 Report Templates/PDMS	PDMS	**Monthly** **2nd of every month**	**HN**274**YYYYMMDD**	HN = Health network reporting # YYYY= 4 digit year MM = 2 digit month DD - 2 digit day	274/inbound/	Text F le	x				x		x	
Provider Termination Quarterly Report	Monitor adherence to CalOptima's Delegation Agreement for NCQA MED 1: Medicaid Benefits and Services Element H: Notification of Termination of a Practitioner or Practice Group and monitor Kaiser to ensure written notification is issued to affected members within 15 calendar days after receipt or issuance of the termination notice.	/users/Documentation Library/HN Reporting Binder/2021 Report Templates/Customer Service	Provider Relations/PDMS	**Monthly: 15th of the month with all manadatory fields populated** **Quarterly:** **10th of the month following the end of each quarter**	1_HNRPT_TermSubmission_**QQYYYY_HN**	QQ = 2 digit caledar quarter (e.g. 01 = Quarter 1 JAN-MAR) HN = Health Network YYYY= 4 digit year reporting #	hn_reporting	Excel	x			x	x		x	

CalOptima Policy HH.2003 - Attachment A: Timely and Appropriate Submission Grid - Master

Year: 2021 Release: 2 Release Date: TBD									Line of Business			Report Requirement Indicator			Report Type	
REPORT NAME	DESCRIPTION/REQUIREMENT (Refer to "FTP File Path for Template (Health Network)" for required reporting elements)	FTP FILE PATH FOR TEMPLATE (HEALTH NETWORK)	CALOPTIMA DEPARTMENT	REPORT FREQUENCY	NAMING CONVENTION	NAMING CONVENTION INSTRUCTIONS	FTP FOLDER	FILE TYPE	MEDI-CAL	ONECARE	ONECARE CONNECT	Health Networks (Except Kaiser)	Kaiser	VSP	Oversight	Reimbursement
UM Retrospective Appeal Universe	Monitor the Health Networks' handling of first level UM Provider Appeals.	/users/Documentation Library/HN Reporting Binder/2021 Report Templates/GARS	GARS	**Quarterly: 10th of the month following the end of each quarter**	1_GARSRPT_Retro Auth Appeals_**HN_YYYYMMDD**	HN = Health network reporting # YYYY= 4 digit year MM = 2 digit month DD - 2 digit day	hn_reporting	Excel	x	x	x	x	x		x	
Semi-Annual Site Visit Report - Kaiser	The report captures sites that received an Initial or Periodic FSR/MRR.	/users/Documentation Library/HN Reporting Binder/2021 Report Templates/Quality Improvement	Quality Improvement	**Semi-Annually: February 15 and August 15**	1_QIRPT_04_**MMDDYYYY**_FSR Semi Annual Report	YYYY= 4 digit year MM = 2 digit month DD - 2 digit day	hn_reporting	Excel	x				x		x	
Kaiser Pharmacy Monitoring Report	Monitor Kaiser's compliance with requirements related to pharmacy benefits information and updates.	/users/Documentation Library/HN Reporting Binder/2021 Report Templates/Pharmacy Management	Pharmacy	**Semi-Annually: April 1 and October 1**	Kaiser_Pharmacy_Monitoring_Report_**MMYYYY**.pdf	YYYY= 4 digit year MM = 2 digit month	Email to CalOptima Pharmacy Management Department	PDF	x				x		x	
Medi-Cal Continuity of Care (COC)	Monitor health network compliance with DHCS Continuity of Care requirements.	/users/Documentation Library/HN Reporting Binder/2021 Report Templates/Utilization Mgmt	Utilization Management	**Monthly: 1st Tuesday of each month**	1_COCMC_**HN_YYYYMMDD**.xls	HN = Health network reporting # YYYY= 4 digit year MM = 2 digit month DD - 2 digit day	Manged_HN_Reporting/COCMC/Inbound	Excel	x			x	x		x	

CalOptima Policy HH.2003 – Attachment B: Timely and Appropriate Submission Grid – Supplemental Attachment

REPORT NAME	DESCRIPTION/REQUIREMENT	CITATION	REPORT FREQUENCY	LINE OF BUSINESS			REPORT REQUIREMENT INDICATOR		
				Medi-Cal	OneCare	OneCare Connect	Health Networks (Except Kaiser)	Kaiser	VSP
Annual Audit	Health Networks shall participate in an annual audit conducted by CalOptima's Audit & Oversight Department by desk review and onsite. The purpose of the annual audit is to ensure that delegated functions are being performed satisfactorily for CalOptima's Medi-Cal, OneCare, and OneCare Connect lines of business, if applicable. The Health Network will be evaluated based upon CalOptima policy and procedures, current NCQA accreditation standards, DMHC, CMS and DHCS regulatory and contractual requirements. The deliverables may include road mapped audit tools for the areas reviewed, supporting policies, and procedures, evidence of staff training, committee minutes, attestations, desktop procedures, and other documentation identified throughout the course of the audit for the following areas, as applicable: • Access & Availability • Care Delivery Model • Claims • Compliance • Credentialing • Cultural & Linguistics • Customer Service • Encounters • Information Systems • Mailroom Process • Marketing • Medi-Cal Addendum • Member Grievances & Appeals • Network Management • Provider Network Contracting • Provider Relations • Quality Improvement • Sub-Contractual • Translation Services • Utilization Management • Whole Child Model	CalOptima Policy GG.1619: Delegation Oversight Cal MediConnect 3-Way Contract, Section 2.2.4 DHCS Medi-Cal Contract, Exhibit A, Attachment 6, Provision 13 Medicare Managed Care Manual, Chapter 11, Section 110.2 APL 17-004: Sub-Contractual Relationships and Delegation	Annually: per process	X	X	X	X	X	X
Claims XML Universe	Health Networks shall submit a complete Claims XML universe for monthly review. CalOptima will select a subset of the universe and notify the Health Network of the case files required. XML version 2.0. The report includes the following: • Claim version (the version number of the xml specification), as of date (the date the xml specification was released), entry ID (incremental numeric count used as a unique identifier in CalOptima's file loading process) • CalOptima Line of Business (LOB) • Claim number, form type, bill type in UB04, admission code, place of service name and code • Authorization number • Was claim adjusted and clean • Whole Child Model (WCM) principal procedure code, principal procedure code date, other procedure code dates, type of services, patient discharge status, condition codes, diagnostic related grouping (DRG) – (UB04 forms), Division of Financial Responsibility (DOFR), expense type	APL 17-004: Sub-Contractual Relationships and Delegation CalOptima Policy GG.1619: Delegation Oversight CalOptima Policy HH.2015: Health Network Claims Processing Cal MediConnect 3-Way Contract, Sections: 2.2.4 5.1.9 5.1.9.2 5.1.10	Monthly: 2nd of every month	X	X	X	X	X	X

REPORT NAME	DESCRIPTION/REQUIREMENT	CITATION	REPORT FREQUENCY	LINE OF BUSINESS			REPORT REQUIREMENT INDICATOR		
				Medi-Cal	OneCare	OneCare Connect	Health Networks (Except Kaiser)	Kaiser	VSP
	• Beneficiary name, Client Identification Number (CIN), threshold language • Requestor type, receipt date and time • Date and time of additional information requested (AIR) • Billing provider name, provider national provider identification (NPI), Tax ID, specialty, contracted status • Rendering provider name, NPI, Tax ID, specialty, contracted status • Medical necessity denials • Date and time claim received, loaded in system, decision made, claim redirected • Payment information method, number, print date and time, transfer date and time • Mail date and time of written notification to member and provider • Decision maker name, title and credentials • International Classification of Diseases (ICD) entry type, code, description, primary entry for Whole Child Model (WCM) present on admission and admitting • Date of service • Billed revenue code, description, Current Procedural Terminology (CPT), Healthcare Common Procedure Code (HCPC) descriptions, modifier and modifier description, units and amount • Paid revenue code, description, and CPT/HCPC • Paid CPT/HCPC description, modifier, modifier description, units, amount, withhold amount, interest amount, adjustment code, adjustment code description • Paid reason for CPT/HCPC change • Decision type and decision denial reason	DHCS Medi-Cal Contract, Exhibit A, Attachment 8, Provision 4 Medicare Managed Care Manual Chapter 11, Section 110.2 Title 42, Code of Federal Regulations (CFR), Sections: 422.520 (a) 447.45 (d)							

CalOptima Policy HH.2003 – Attachment B: Timely and Appropriate Submission Grid – Supplemental Attachment

REPORT NAME	DESCRIPTION/REQUIREMENT	CITATION	REPORT FREQUENCY	LINE OF BUSINESS			REPORT REQUIREMENT INDICATOR		
				Medi-Cal	OneCare	OneCare Connect	Health Networks (Except Kaiser)	Kaiser	VSP
Claims Universe Case Files	Health Networks shall submit monthly Claims universe case files selected by CalOptima from the Claims XML universe. CalOptima will perform monthly review of the case files and inform the Health Network of the results. Case files include the following: <u>Paid Claims:</u> • Copy of claim and receipt date (if electronic claim, a print screen showing date of receipt), and date claim is entered in health network system (acknowledgement date) • Authorization, if applicable • Remittance advice (RA) or explanation of payment/explanation of benefit (EOB) with interest if applicable • Proof of check clearing (bank statements or copy of cancelled check) <u>Denied/Contested Claims:</u> • Copy of claim and received date (if electronic claim, a print screen showing received date), and date claim is entered in health network system (acknowledgement date) • Eligibility print screen if contested/denied for eligibility • System notes pertaining to claim • If applicable, denial letters for member liability denials and any supporting documents used to determine the denial • RA/EOB with interest, if applicable <u>Adjustments:</u> • Copy of original claim and receipt date (if electronic claim, a print screen showing date of receipt) • Original RA/EOB showing payment or denial • Date of discovery that adjustment occurred (customer service call, internal audit, project, refund check, etc.) • Reason for adjustment (system notes, eligibility or retrospective eligibility screen, etc.) • All information/documentation for claim development (i.e., emergency room report, medical records) including applicable dates of request and receipt, and reason for claims development • RA/EOB with applicable interest • Proof of check clearing (bank statements or copy of cancelled check) for adjusted claim	APL 17-004: Sub-Contractual Relationships and Delegation CalOptima Policy GG.1619: Delegation Oversight CalOptima Policy HH.2015: Health Network Claims Processing Cal MediConnect 3-Way Contract, Sections: 2.2.4 5.1.9 5.1.9.2 5.1.10 DHCS Medi-Cal Contract, Exhibit A, Attachment 8, Provision 4 Medicare Managed Care Manual, Chapter 11, Section 110.2 Title 42, CFR, Sections: 422.520 (a) 447.45 (d)	Monthly: 10th of every month	X	X	X	X	X	X

REPORT NAME	DESCRIPTION/REQUIREMENT	CITATION	REPORT FREQUENCY	LINE OF BUSINESS			REPORT REQUIREMENT INDICATOR		
				Medi-Cal	OneCare	OneCare Connect	Health Networks (Except Kaiser)	Kaiser	VSP
Credentialing Monthly Universe	Health Networks shall submit a complete Credentialing universe for monthly review. CalOptima will select a subset of the universe and notify the Health Network of the case files required. The report includes the following: • Health Network name, reporting month and year • Whether there are initially credentialed (IC), recredentialed (RC), or terminated (TM) practitioners on the report • Data ID (IC/RC/TM) • CalOptima program (Medi-Cal, OneCare, OneCare Connect) • Individual practitioner name, license number and type • Contract type and primary contracted specialty • Current and previous credentialing decision dates • Whether board certified, board certified specialty, initial board certification issue date, and board certification expiration date • Current facility site review date • Current, signed attestation date • Termination date and reasons for termination • Date Change Termination (CT) form was submitted	NCQA Standards, Credentialing/Recredentialing: CR3 CR4 APL 17-004: Sub-Contractual Relationships and Delegation APL 19-004: Provider Credentialing/Recredentialing and Screening/Enrollment CalOptima Policy GG.1605: Delegation Oversight of Credentialing and Recredentialing Activities CalOptima Policy GG.1650: Credentialing and Recredentialing of Practitioners CalOptima Policy GG.1619: Delegation Oversight Cal MediConnect 3-Way Contract, Sections: 2.2.4 2.10.5 2.16.3.3 DHCS Medi-Cal Contract, Exhibit A, Attachment 4, Provisions: 6 12 Medicare Managed Care Manual: Chapter 6, Section 60.3 Chapter 11, Section 110.2	<u>Health Networks and Kaiser</u> Monthly: 2nd of every month <u>VSP</u> Quarterly: January 10, April 10, July 10, October 10	X	X	X	X	X	X
Credentialing Universe Monthly Case Files	Health Networks shall submit monthly Credentialing universe case files selected by CalOptima from the Credentialing universe. CalOptima will perform monthly review of the case files and inform the Health Network of the results. Case files include the following: <u>Initial Credentialing</u> • Initial credentialing approval form (signed by Medical Director/Authorized Representative) or credentialing approval letter • File checklist • Application with all pertinent information for the review (including, at a minimum, attestation and data release authorization) • License verification • Copy of DEA certificate or verification of DEA registration • Work history, and education and training verification • Board certification verification, as applicable	NCQA Standards, Credentialing/Recredentialing: CR3 CR4 APL 17-004: Sub-Contractual Relationships and Delegation APL 19-004: Provider Credentialing/Recredentialing and Screening/Enrollment CalOptima Policy GG.1605: Delegation Oversight of Credentialing and Recredentialing Activities	Monthly: 10th of every month	X	X	X	X	X	X

REPORT NAME	DESCRIPTION/REQUIREMENT	CITATION	REPORT FREQUENCY	LINE OF BUSINESS			REPORT REQUIREMENT INDICATOR		
				Medi-Cal	OneCare	OneCare Connect	Health Networks (Except Kaiser)	Kaiser	VSP
	• Hospital admitting privileges, if applicable; otherwise, provide documentation of coverage • Copy of current malpractice/professional liability policy • National Practitioner Data Bank query • State sanctions or restriction on licensure verification • Medicare/Medicaid sanction verification • Office of Inspector General (OIG) review • System for Award Management (SAM) review • Medi-Cal Suspended and Ineligible review • Medicare opt-out review • CMS Preclusion List review • Current Facility Site Review, if applicable • Evidence of Medi-Cal screening and enrollment (required for all Medi-Cal network practitioners) • Supervising Physician and Mid-Level Clinician Agreement for physician assistants and nurse practitioners <u>Recredentialing</u> • Recredentialing approval form (signed by Medical Director/Authorized Representative) or recredentialing approval letter • Previous recredentialing approval form (signed by Medical Director/Authorized Representative) or recredentialing approval letter • File checklist • Performance monitoring documentation • Application with all pertinent information for the audit (including, at a minimum, attestation and data release authorization) • License verification • Copy of DEA certificate or verification of DEA registration • Board certification verification, as applicable • Hospital admitting privileges, if applicable; otherwise, provide documentation of coverage • Copy of current malpractice/professional liability policy • National Practitioner Data Bank query • State sanctions or restriction on licensure verification • Medicare/Medicaid sanction verification • Office of Inspector General (OIG) review • System for Award Management (SAM) review • Medi-Cal Suspended and Ineligible review • Medicare opt-out review • CMS Preclusion List review • Current Facility Site Review, if applicable • Evidence of Medi-Cal screening and enrollment (required for all Medi-Cal network practitioners) • Supervising Physician and Mid-Level Clinician Agreement for physician assistants and nurse practitioners	CalOptima Policy GG.1650: Credentialing and Recredentialing of Practitioners CalOptima Policy GG.1619: Delegation Oversight Cal MediConnect 3-Way Contract, Sections: 2.2.4 2.10.5 2.16.3.3 DHCS Medi-Cal Contract, Exhibit A, Attachment 4, Provisions: 6 12 Medicare Managed Care Manual: Chapter 6, Section 60.3 Chapter 11, Section 110.2							
Notice of Medicare Non-Coverage (NOMNC) Log (OneCare & OneCare Connect)	Health Networks shall submit a monthly NOMNC log. CalOptima will select a subset from the log and notify the Health Network of the case files required. The report includes the following: • Member identifier, medical record number, and facility service type • Date of termination request/notice and date of actual termination	CalOptima Policy GG.1619: Delegation Oversight Cal MediConnect 3-Way Contract, Sections: 2.2.4 2.11.9 Medicare Managed Care Manual, Chapter 11, Section 110.2	Monthly: 2nd of every month		**X**	**X**	**X**		

REPORT NAME	DESCRIPTION/REQUIREMENT	CITATION	REPORT FREQUENCY	LINE OF BUSINESS			REPORT REQUIREMENT INDICATOR		
				Medi-Cal	OneCare	OneCare Connect	Health Networks (Except Kaiser)	Kaiser	VSP
	• Date the termination request/notice was given to member/member's representative, and date member/member's representative signed for receipt • Date of discharge	Title 42, CFR, Sections: 405.1200 (b)(1) & (2) 422.624 (b)(1) and (2)							
NOMNC Files (OneCare & OneCare Connect)	Health Networks shall submit monthly NOMNC files selected by CalOptima from the NOMNC log. CalOptima will perform monthly review of the case files and inform the Health Network of the results. NOMNC files include the following: • Service Type: Skilled Nursing Facility (SNF), home health (including psychiatric home health), or comprehensive outpatient rehabilitation facility services • Date of termination request • Date of actual termination (including date, time and name of provider making the request) • Date of termination request/notification to the member/member's representative (must be made no later than two (2) days before the termination of services) • Member/member's representative notified of appeal rights • Date of termination request/notification signed by the member/member's representative • Copy of signed NONMC letter • Date of discharge If member is incapable of providing a signature and member's representative is not present at the time of the termination request, the following is required: • Documentation indicating the date the provider spoke with the member's representative (date of the conversation is the date of receipt of the notice) • Proof of letter mailed on same date of call made to member's representative • If provider is unable to reach member's representative by phone, provide proof of the following: o Certified mail receipt with return receipt request o Date someone at the representative's address signs or refuses to sign the letter o Ensure facility compliance of placing dated copy of the certified mail receipt in the Member's medical file	CalOptima Policy GG.1619: Delegation Oversight Cal MediConnect 3-Way Contract, Sections: 2.2.4 2.11.9 Medicare Managed Care Manual, Chapter 11, Section 110.2 Title 42, CFR, Sections: 405.1200 (b)(1) & (2) 422.624 (b)(1) and (2)	Monthly: 10th of every month		X	X	X		
Provider Dispute Resolution (PDR) XML Universe	Health Networks shall submit a complete PDR universe for monthly review. CalOptima will select a subset of the universe and notify the Health Network of the case files required. XML version 1.0. The report includes the following: • Entry ID and line of business (Medi-Cal, OneCare, OneCare Connect) • Unique ID number used to track authorization request • Date and time for the following: the PDR request was received, the PDR acknowledgement letter was sent to the provider, and the final decision was made on the PDR • Check number used to pay overturned PDR request, and date and time check was mailed • Date and time the written notification was provided to the provider • Name and title of the decision maker of the PDR request	APL 17-004: Sub-Contractual Relationships and Delegation CalOptima Policy GG.1619: Delegation Oversight CalOptima Policy MA.9009: Non-Contracted Provider Payment Disputes Cal MediConnect 3-Way Contract, Section 2.2.4 DHCS Medi-Cal Contract, Exhibit A, Attachment 7, Provision 2	Monthly: 2nd of every month	X	X	X	X	X	X

REPORT NAME	DESCRIPTION/REQUIREMENT	CITATION	REPORT FREQUENCY	LINE OF BUSINESS			REPORT REQUIREMENT INDICATOR		
				Medi-Cal	OneCare	OneCare Connect	Health Networks (Except Kaiser)	Kaiser	VSP
	• Whether additional information was requested to process PDR, date additional information was requested, and date additional information was received • Billing provider's name, NPI number, tax ID number, specialty, and whether contracted • Claim number of the original claim being appealed, and decision date and time of the original claim being appealed • Member's name, CIN, and preferred language • ICD type and diagnosis code • Start date and end date of services rendered • Billed revenue code, CPT/HCPC code, and modifier • Billed units and billed amount • Paid amount (excluding interest), withhold amount, and paid interest amount • Decision type (upheld means denial of payment and overturned means original decision overturned for payment), and upheld/overturned reason • Adjustment code and description	Health and Safety Code (HSC), Section 1367: (h)(1) (2) Medicare Managed Care Manual, Chapter 11, Section 110.2 Title 28, California Code of Regulations (CCR), Section 1300.71.38: (b) (c) (d)							
PDR Universe Case Files	Health Networks shall submit monthly PDR universe case files selected by CalOptima from the PDR XML universe. CalOptima will perform monthly review of the case files and inform the Health Network of the results. Case files include the following: • Copy of original claim, and received date (if electronic claim, a print screen showing received date) • Original RA/EOB showing payment or denial • Provider dispute request along with pertinent documents submitted, and date received • All information/documentation for PDR development (i.e., emergency room report, medical records), including applicable dates of request and receipt, and reason for PDR development • Acknowledgement letter, and resolution letter sent to provider • EOB showing payment with applicable interest, if original decision of payment denial is overturned • Proof of check clearing (bank statements or copy of cancelled check) if payment is issued	APL 17-004: Sub-Contractual Relationships and Delegation CalOptima Policy GG.1619: Delegation Oversight CalOptima Policy MA.9009: Non-Contracted Provider Payment Disputes Cal MediConnect 3-Way Contract, Section 2.2.4 DHCS Medi-Cal Contract, Exhibit A, Attachment 7, Provision 2 HSC, Section 1367: (h)(1) (2) Medicare Managed Care Manual, Chapter 11, Section 110.2 Title 28, CCR, Section 1300.71.38: (b) (c) (d)	Monthly: 10th of every month	X	X	X	X	X	X

REPORT NAME	DESCRIPTION/REQUIREMENT	CITATION	REPORT FREQUENCY	LINE OF BUSINESS			REPORT REQUIREMENT INDICATOR		
				Medi-Cal	OneCare	OneCare Connect	Health Networks (Except Kaiser)	Kaiser	VSP
Provider Directory Universe Case Files	Health Networks shall submit Provider Directory universe case files selected by CalOptima annually from the Provider Directory universe. CalOptima will perform an annual review of the case files and inform the Health Network of the results. The Provider Directory file review is based on a signed and dated provider attestation that includes the following: • Provider name, California license number, and gender • Address (office locations), office days and hours, day phone number, and after-hours phone number • Administrative email address, or office fax number (if no administrative email available) • Languages spoken by provider and staff • Primary specialty (i.e. dermatology, internal medicate, etc.) • Accepting new patients (i.e., open or closed panel), and age restrictions • Medical group affiliations, health network affiliations, and facility affiliation (i.e., hospital) • Special services (i.e. California Children's Services and/or Child Health and Disability Prevention (CHDP) • Programs (i.e. Medi-Cal, OneCare, OneCare Connect) • Provider type in this network (i.e. Primary Care Provider, Specialist) • Provider Type 1 NPI (if applicable), Type 2 NPI (if applicable), taxonomy, and Tax ID number • Validation statement: "A provider's failure to validate and attest to the accuracy of their Provider directory data may result in panel closure, suppression from the provider directory, and/or delay of payment." • Designated space for printed name, signature and date for the provider office manager or equivalent staff	APL 17-004: Sub-Contractual Relationships and Delegation CalOptima Health Network Contract, Section 7.10 CalOptima Policy EE.1101: Additions, Changes, and Terminations to CalOptima Provider Information, CalOptima Provider Directory, and Web-based Directory CalOptima Policy GG.1619: Delegation Oversight Cal MediConnect 3-Way Contract, Sections: 2.2.4 2.17.5.11 DHCS Medi-Cal Contract, Exhibit A, Attachment 13, Provision 4.D.4 HSC, Section 1367.27 Medicare Managed Care Manual, Chapter 11, Section 110.2 Title 42, CFR, Section 438.10 (h)	Annually, per request	X	X	X	X		

REPORT NAME	DESCRIPTION/REQUIREMENT	CITATION	REPORT FREQUENCY	LINE OF BUSINESS			REPORT REQUIREMENT INDICATOR		
				Medi-Cal	OneCare	OneCare Connect	Health Networks (Except Kaiser)	Kaiser	VSP
Utilization Management (UM) XML Universe	Health Networks shall submit a complete UM universe for monthly review. CalOptima will select a subset of the universe and notify the Health Network of the case files required. XML version 2.1. The report includes the following: • Version, as of date, entry identification (ID), and line of business (LOB) for this authorization • ID number used to track the authorization request (AR), and type of AR • Whether authorization is for Part B or physician administered drugs and/or administration • Whether authorization is for visits/services which require a care plan in coordination with PCP, and continued care from a specialist • Method AR was received, and authorization number related to AR • CMS place of service code and name • Type of services: behavioral health services, long term services and supports, substance use services, or other types of services (specified by Health Network) • Member name, CIN, and preferred language • AR requestor (member/ member's representative, contracted/non-contracted provider, service/care coordinator) • Date and time the Appointment of Representative (AOR) was received by delegate (unless no AOR form submitted or Medi-Cal LOB) • Whether additional information was requested to process authorization, and if so, date the request was sent and date information was received • Requesting provider/group/facility name, NPI, tax ID number, and whether contracted • Requested provider/group/facility name, NPI, tax ID number, specialty, and whether contracted • Approved provider/group/facility name, NPI, tax ID number, specialty, and whether contracted • Date and time of decision, and whether decision was processed as "Medical Necessity" or otherwise (Covered Benefit) • Date and time service authorization/approval was entered in Health Network's system (date and time authorization was effective), and authorization expiration date • Date and time AR was received, whether AR was requested as expedited, and whether AR was processed under the expedited timeframe • If AR was requested under expedited timeframe, whether Health Network determined the request did not meet expedited criteria and instead process the AR under the standard timeframe • If a request to expedite was made after the original request, identify requestor of subsequent request to expedite • Whether a timeframe extension was taken • Date and time for the following: the member was notified of extension, the provider was notified of extension, the written notification to the member was printed, the written notification to the member entered the mail stream, the attempted oral notification(s) to the member, and the oral notification was provided to the member • The method used to initially notify the requesting provider of the decision of authorization request • Date and time for the following: the initial notification was provided to the requesting provider, the written notification to the provider was printed, and the written notification to the provider entered the mail stream • Whether the review was completed by a physician or other appropriate health care professional • Name, job title, and credentials of the decision maker of the AR • Whether the primary ICD code was related to the AR, and ICD diagnosis code and short description • Code type (revenue or CPT or HCPC or CDT) and code of the requested service, description of the CPT/HCPC/CDT code, and number of requested units • Code type (revenue or CPT or HCPC or CDT) and code of the approved service, description of the CPT/HCPC/CDT code, and number of approved units • Determination of the requested service • Reason for the denial or modification of the requested service	NCQA Standards, Utilization Management, UM5 APL 17-004: Sub-Contractual Relationships and Delegation CalOptima Policy GG.1541: Utilization Management Delegation CalOptima Policy GG.1619: Delegation Oversight Cal MediConnect 3-Way Contract, Sections: 2.2.4 2.11.6.3 2.11.7 2.11.9 DHCS Medi-Cal Contract, Exhibit A, Attachment 5, Provisions: 2 3 Medicare Managed Care Manual, Chapter 11, Section 110.2 Title 42, CFR, Sections: 422.572(a) & (b) 422.568 (b)(1) Medicare Part C Reporting Requirements, Section VI	Monthly: 2nd of every month	X	X	X	X	X	

REPORT NAME	DESCRIPTION/REQUIREMENT	CITATION	REPORT FREQUENCY	LINE OF BUSINESS			REPORT REQUIREMENT INDICATOR		
				Medi-Cal	OneCare	OneCare Connect	Health Networks (Except Kaiser)	Kaiser	VSP
UM Universe Case Files	Health Networks shall submit monthly UM universe case files selected by CalOptima from the UM XML universe. CalOptima will perform monthly review of the case files and inform the Health Network of the results. UM case files include the following documentation: <u>Medi-Cal</u> • Approval file checklist includes all medical records attached to file and transaction log • Denial file checklist includes denial letter with attached language assistance program (LAP), all medical records attached to the file and transaction log • Modification file checklist includes modification letter with attached LAP, all medical records attached to the file and transaction log <u>OneCare</u> • Approval file checklist includes approval letter with attached LAP, all medical records attached to the file, transaction log, and provider notification fax, if available • Denial file checklist includes denial letter, all medical records attached to the file and transaction log <u>OneCare Connect</u> • Approval field checklist includes approval letter with attached LAP, all medical records attached to file, transaction log, and provider notification fax, if available • Denial file checklist includes denial letter, all medical records attached to the file, transaction log, and provider notification fax, if available	NCQA Standards, Utilization Management, UM5 APL 17-004: Sub-Contractual Relationships and Delegation CalOptima Policy GG.1541: Utilization Management Delegation CalOptima Policy GG.1619: Delegation Oversight Cal MediConnect 3-Way Contract, Sections: 2.2.4 2.11.6.3 2.11.7 2.11.9 DHCS Medi-Cal Contract, Exhibit A, Attachment 5, Provisions: 2 3 Medicare Managed Care Manual, Chapter 11, Section 110.2 Title 42, CFR, Sections: 422.572(a) & (b) 422.568 (b)(1)	Monthly: 10th of every month	X	X	X	X	X	
Behavioral Health Comprehensive Diagnostic Exam (CDE) Report - Kaiser	Kaiser shall submit the Behavioral Health CDE Report containing behavioral health services data. The report includes the following: • Plan code, name, county and reporting period • Number of CDE referrals • Number of referrals determined appropriate for CDE • Number of CDE completed • Number of CDE appointments scheduled within and outside timely access • Number of CDE not scheduled but offered appointment • Number of CDE with appointment not yet scheduled • Comments	DHCS Medi-Cal Contract, Exhibit A, Attachment 4, Provision 6	Monthly: 15th of each month	X				X	
Mental Health Grievances and Appeals (Medi-Cal) - Kaiser	Kaiser shall submit the Mental Health Report, containing mental health grievances and appeals data. The report includes the following:	DHCS Medi-Cal Contract, Exhibit A, Attachment 4, Provision 6	Quarterly: January 20, April 20, July 20, October 20	X				X	

REPORT NAME	DESCRIPTION/REQUIREMENT	CITATION	REPORT FREQUENCY	LINE OF BUSINESS			REPORT REQUIREMENT INDICATOR		
				Medi-Cal	OneCare	OneCare Connect	Health Networks (Except Kaiser)	Kaiser	VSP
	• Plan code, name, county, reporting quarter and total number of members • Number of referrals: by Specialty Mental Health Plan (SMHP) to Managed Care Plan (MCP), by MCP to SMHP within the county, to MCP mental health provider, by MCP to SMHP outside the county including outside county code • Number of grievances received for the following: psychotherapy (evaluation and treatment), outpatient services, laboratory/supplies, access to SMHP, authorization/referral to SMHP, medication/pharmacy, and all others including a description • Number of grievances: resolved within thirty days, pending less than 30 days, pending more than 30 days and resolved from a previous reporting period • Number of mental health continuity of care (COC) approvals, average number of days taken to approve requests and the average number of sessions COC requests were approved for • Average number of days taken to deny requests • Number of denials for care relationship not established, quality of care, rate disagreement, provider refusal to work with plan and all others including a description • Number of COC requests in process and comments								
Case Management Log	Health Networks shall submit monthly Case management log, which tracks case management referral activities based on data and referral sources, members in various levels of care management (from complex to service coordination), and "add on" services. Health Networks shall submit monthly Case Management Files selected by CalOptima from the Monthly Case Management Log. CalOptima will perform monthly review of the Case Management Files and inform the Health Network of the results. The report includes the following: • Member name, CIN, date of birth, and program • Diagnosis and ICD-10 code (qualifying member for case management) • Referral/data source to case management, date opened, and date closed • Case management level, status change reason, and complex case trigger • Additional programs to which member has been referred • Special program to which member is enrolled, or any special needs of member	DHCS Medi-Cal Contract, Exhibit A: Attachment 4, Provision 6 Attachment 11, Provision 1 Attachment 11, Provision 2 APL 17-004: Subcontractual Relationships and Delegation NCQA Standards, Population Health Management: PHM5 PHM7	Monthly: 15th of every month	X			X	X	
Case Management Files	Health Networks shall submit monthly Case Management Files selected by CalOptima from the Monthly Case Management Log. CalOptima will perform monthly review of the Case Management Files and inform the Health Network of the results. The report includes the following: • Identification date for Complex Case Management • Nursing Assessment • Care Notes • Care Plan	DHCS Medi-Cal Contract, Exhibit A: Attachment 4, Provision 6 Attachment 11, Provision 1 Attachment 11, Provision 2 APL 17-004: Subcontractual Relationships and Delegation NCQA Standards, Population Health Management: PHM5 PHM7	Monthly: 1 week after CalOptima request	X			X	X	
Continuity of Care (Whole-Child Model)	Health Networks shall submit weekly report of COC for Whole -Child Model (WCM) members that includes COC requests and the outcome received during the previous month. The report includes the following: • Requestor type, date of request, and request type	APL 18-023: California Children's Services Whole Child Model Program (Supersedes APL 18-011) DHCS Medi-Cal Contract, Exhibit A: Attachment 4, Provision 6	Weekly: Every Tuesday by 10 am for the prior week's activity	X			X	X	

REPORT NAME	DESCRIPTION/REQUIREMENT	CITATION	REPORT FREQUENCY	LINE OF BUSINESS			REPORT REQUIREMENT INDICATOR		
				Medi-Cal	OneCare	OneCare Connect	Health Networks (Except Kaiser)	Kaiser	VSP
	• Member name and CIN • COC begin processing date and date of decision • COC completion date (including member notification) and COC expiration date • Requested provider NPI and provider type • Decision outcome, denial reason, and explanation of other reasons • Next steps taken for incomplete requests	Attachment 11, Provision 10							
Enhanced Monitoring Report (WCM)	Health Networks shall submit quarterly Enhanced Monitoring Report for WCM members. The report includes the following: Health Networks (including Kaiser): • Describe any challenges with care coordination and Health Network's role in overcoming barriers • Describe any disruption with pharmacy needs, the steps, and the timeline Health Network is taking to ensure COC with prescriptions • For each of the four (4) rare subspecialists (pediatric dermatology, pediatric developmental and behavioral medicine, oral and maxillofacial surgery, and transplant hepatology), describe the number of out-of-network requests that have occurred during the reporting period and outcomes Kaiser Only: • Describe any challenges with completing assessments, specifically with high risk members, and the impact on the development of the ICP • Identify any barriers to conducting pediatric health risk assessments and actions the Health Network is taking to improve completion	APL 18-023: California Children's Services Whole Child Model Program (Supersedes APL 18-011) DHCS Medi-Cal Contract, Exhibit A: Attachment 4, Provision 6 Attachment 11, Provision 10	Quarterly: 2nd day after the end of the quarter	X			X	X	
Health Homes Program (HHP) Enrollment and Disenrollment Report	Health Networks shall submit monthly report of all HHP enrollments and disenrollments as of the last day of the prior reporting month. The report includes the following: • Member name, CIN, and date of birth • Whether HHP enrolled member was externally referred • HHP disenrollment date and reason • Whether member is homeless/at risk for homelessness, or received housing services during reporting period • Whether member was homeless at any point during enrollment in HHP • Whether member is no longer homeless as of the last day of reporting period • File create date	DHCS HHP Program Guide CalOptima Policy GG.1331: Health Homes Program (HHP) Services and Care Management CalOptima Policy GG.1350: Health Homes Program (HHP) Member Eligibility	Monthly: 10th of every month	X			X	X	
HHP Finalized Engagement List (FEL) Return File	Health Networks shall submit monthly report of FEL return file that includes HHP engagement outcomes. The Health Network response file includes the following: • Excluded because not eligible-well managed: Y/N • Excluded because declined to participate: Y/N • Excluded because of unsuccessful engagement: Y/N • Excluded because of duplicative program: Y/N • Excluded because of unsafe behavior or environment: Y/N • Excluded because not enrolled in Medi-Cal at MCP: Y/N	DHCS HHP Program Guide CalOptima Policy FF.4001: Special Payments Health Homes Program Supplemental Payment for Capitated Health Networks CalOptima Policy GG.1331: Health Homes Program (HHP) Services and Care Management	Monthly: 10th of every month	X			X	X	

REPORT NAME	DESCRIPTION/REQUIREMENT	CITATION	REPORT FREQUENCY	LINE OF BUSINESS			REPORT REQUIREMENT INDICATOR		
				Medi-Cal	OneCare	OneCare Connect	Health Networks (Except Kaiser)	Kaiser	VSP
	• Enrollment date (if applicable)	CalOptima Policy GG.1350: Health Homes Program (HHP) Member Eligibility							
HHP Services	Health Networks shall submit monthly report of HHP services that includes prior reporting month's HHP service activities. The report includes the following: • Claim line ID • Health Network ID, claim number, claim line number • Member name and CIN • Date of service and service provided • Claim or encounter received date • Whether an adjustment, and previous claim number • Rendering provider name and NPI • Billing provider name, NPI, and Tax ID • Billed CPT code and modifier, and primary diagnosis • Units billed and provider billed amount • Paid amount, and adjustment code • Fee-for-service or capitated claim • Check or EFT transaction number • Optional user defined fields	DHCS HHP Program Guide CalOptima Policy FF.4001: Special Payments Health Homes Program Supplemental Payment for Capitated Health Networks CalOptima Policy GG.1331: Health Homes Program (HHP) Services and Care Management CalOptima Policy GG.1350: Health Homes Program (HHP) Member Eligibility	Monthly: 10th of every month	X			X	X	
Implementation Audit (OneCare Connect)	Health Networks shall submit monthly report of Implementation Audit that includes documentation of implementation, hospitalization key event, and non-hospitalization key event. This report is part of CalOptima's requirement for Personal Care Coordinator (PCC) funding. The report includes the following: • Implementation documentation: Interdisciplinary care team (ICT) notes/minutes, final individualized care plan (ICP) signed, and clinical assessments/case management notes • Hospitalization key events: Transition of care documentation, dictated discharge summary, hospital discharge instructions, and hospital case management notes • Non-hospitalization key events: Case management notes	Cal MediConnect 3-Way Contract, Sections: 2.2.4 2.5 2.8 DPL 15-001: ICP and ICT Requirements, Section A. Care Plans Medicare-Medicaid Capitated Financial Alignment Model Reporting Requirements: California-Specific Reporting Requirements, Sections: CA1.5 CA1.6 CY2020 Medicare-Medicaid Plans (MMP) Core Reporting Requirements	Ongoing, per process			X	X		
Implementation Audit (OneCare)	Health Networks shall submit monthly report of Implementation Audit that includes documentation of implementation, hospitalization key event, and non-hospitalization key event. This report is part of CalOptima's requirement for PCC funding. The report includes the following: • Implementation documentation: Interdisciplinary care team (ICT) notes/minutes, final individualized care plan (ICP) signed, and clinical assessments/case management notes	OneCare 2018 Model of Care (MOC), MOC 2, Element C, Section 4 Medicare Managed Care Manual, Chapter 5	Ongoing, per process		X		X		

REPORT NAME	DESCRIPTION/REQUIREMENT	CITATION	REPORT FREQUENCY	LINE OF BUSINESS			REPORT REQUIREMENT INDICATOR		
				Medi-Cal	OneCare	OneCare Connect	Health Networks (Except Kaiser)	Kaiser	VSP
	• Hospitalization key events: Transition of care documentation, dictated discharge summary, hospital discharge instructions, and hospital case management notes • Non-hospitalization key events: Case management notes								
Implementation Audit (Seniors and Persons with Disabilities (SPD))	Health Networks shall submit monthly report of Implementation Audit that includes documentation of implementation, hospitalization key event, and non-hospitalization key event. This report is part of CalOptima's requirement for PCC funding. The report includes the following: • Implementation documentation: Interdisciplinary care team (ICT) notes/minutes, final individualized care plan (ICP) signed, and clinical assessments/case management notes • Hospitalization key events: Transition of care documentation, dictated discharge summary, hospital discharge instructions, and hospital case management notes • Non-hospitalization key events: Case management notes	APL 17-012: Care Coordination Requirements for Managed Long-Term Services and Supports	Ongoing, per process	X			X	X	
Organ Transplant – Kaiser	Kaiser shall submit monthly report of members engaged in the organ transplant process. The report includes the following: • Member name, CIN, and date of birth • Transplant related diagnosis and transplant type • DHCS-approved transplant center where member will be transplanted • Date the Health Network notified CalOptima of member's potential transplant status • Current transplant phase and the date the phase began • Date member is listed for transplant at DHCS-approved transplant center • Date member was last contacted regarding case management/coordination care issues • Date the transplant case is closed and reason for case closure • Case manager name • Additional comments to clarify report	APL 17-004 Subcontractual Relationship and Delegation: Monitoring Subcontracted and Delegated Functions Cal MediConnect 3-Way Contract, Section 2.2.4	Monthly: 15th of every month	X				X	
Annual Redetermination Files	Health Networks shall submit reports of Annual Redetermination files for WCM members most recent (within the past year). The report is due no later than 60 calendar days prior to annual redetermination. The report includes the following: • Report(s) from specialists/subspecialists substantiating the member's continued/ongoing treatment for their identified CCS condition(s) to support CCS annual redetermination. • WCM face sheet that includes the member's name, Health Network, CIN, age, date of birth, CCS condition, and redetermination date.	APL 18-023: California Children's Services Whole Child Model Program (Supersedes APL 18-011) DHCS Medi-Cal Contract, Exhibit A: Attachment 4, Section 6 Attachment 11, Section 10	Ongoing, per process	X			X	X	
Individual Care Plan/Health Action Plan (ICP/HAP) bundle	Health Networks shall submit report of individual bundles with completed HAP. A HAP bundle will be returned after a member has completed a health needs assessment (HNA) and enrolled in CalOptima's HHP, and due between 85 and 90 calendar days from HHP enrollment date. The report includes the following:	Medi-Cal Health Homes Program Guide APL 18-012: Health Homes Program Requirements	Ongoing, per process	X			X	X	

REPORT NAME	DESCRIPTION/REQUIREMENT	CITATION	REPORT FREQUENCY	LINE OF BUSINESS			REPORT REQUIREMENT INDICATOR		
				Medi-Cal	OneCare	OneCare Connect	Health Networks (Except Kaiser)	Kaiser	VSP
	• Final signed HAP/ICP that include documentation of an initial CML and any changes in CML since the member's enrollment, and address the member's identified needs and barriers to accessing care, community-based support referrals, transitional care if the member was hospitalized or required outpatient treatment, health promotion referrals as appropriate, and self-management skills. • Completed HNA that identifies members experiencing homelessness and any referrals to housing services, and member's voice in planning and decision making including their stated goals. • Clinical assessments/case management notes								
Interdisciplinary Care Plan (ICP) Bundle (OneCare Connect)	Health Networks shall submit report of individual bundles with ICT minutes and ICP. This report is part of CalOptima's requirements for PCC funding. An ICT bundle will be returned within 45 calendar days of health risk assessment (HRA) completion date for all members completing an HRA. The report includes the following: • ICT minutes, participants invited according to member's needs, and ICT attendees • Case management notes summarizing discussions, follow up items, and parties responsible for follow up • Documentation that the final ICP was distributed to invited participants, including the PCP and the member • Member-friendly ICP in member's preferred language and format • Copy of the final ICP signed by the PCP	Medicare-Medicaid Capitated Financial Alignment Model Reporting Requirements: California-Specific Reporting Requirements, Sections: CA 1.1 - CA 1.5 OneCare Connect 2018 Model of Care, MOC 2, Element C, Section 4 Cal MediConnect 3-Way Contract, Sections: 2.2.4 2.5 2.8 Medicare Managed Care Manual, Chapter 5, Sections: 20.2.1 2.C and D DPL 15-001: ICP and ICT Requirements	Ongoing, per process			X	X		
Interdisciplinary Care Team (ICT) Bundle (Medi-Cal)	Health Networks shall submit report of individual bundles with ICT minutes and ICP. This report is part of CalOptima's requirements for PCC funding. An ICT bundle will be returned for members completing an HRA with a CML of care coordination or complex. Bundles shall be returned within 145 calendar days for basic care management and 60 calendar days for complex or care coordination levels. The report includes the following: • ICT minutes, participants invited according to member's needs, and ICT attendees • Case management notes summarizing discussions, follow up items, and parties responsible for follow up • Documentation that the final ICP was distributed to invited participants, including the PCP and the member • Member-friendly ICP in member's preferred language and format • Copy of the final ICP signed by the PCP	APL 17-012: Care Coordination Requirements for Managed Long-Term Services and Supports	Ongoing, per process	X			X	X	
ICT Bundle (OneCare)	Health Networks shall submit report of individual bundles with ICT minutes and ICP. This report is part of CalOptima's requirements for PCC funding. An ICT bundle will be returned for all members completing an HRA. Bundles shall be returned within 145 calendar days for basic care management and 60 calendar days for complex or care coordination levels. The report includes the following:	OneCare 2018 Model of Care (MOC), MOC 2, Element C, Section 4 Medicare Managed Care Manual, Chapter 5	Ongoing, per process		X		X		

REPORT NAME	DESCRIPTION/REQUIREMENT	CITATION	REPORT FREQUENCY	LINE OF BUSINESS			REPORT REQUIREMENT INDICATOR		
				Medi-Cal	OneCare	OneCare Connect	Health Networks (Except Kaiser)	Kaiser	VSP
	• ICT minutes, participants invited according to member's needs, and ICT attendees • Case management notes summarizing discussions, follow up items, and parties responsible for follow up • Documentation that the final ICP was distributed to invited participants, including the PCP and the member • Member-friendly ICP in member's preferred language and format • Copy of the final ICP signed by the PCP								
Long Term Care (LTC) ICP Bundle (OneCare Connect)	Health Networks shall submit report of individual bundles with ICT minutes and ICP. This report is part of CalOptima's requirements for PCC funding. An ICT bundle will be returned for all members residing in Long Term Care that have completed an HRA. Bundles shall be returned within 45 calendar days of HRA completion. The report includes the following: • ICT minutes, participants invited according to member's needs, and ICT attendees • Case management notes summarizing discussions, follow up items, and parties responsible for follow up • Final ICP that includes assessments, interventions, and goals set by the facility • Documentation that the final ICP was distributed to invited participants, including the PCP and the member • Member-friendly ICP in member's preferred language and format • Copy of the final ICP signed by the PCP	OneCare Connect 2018 Model of Care (MOC), MOC 2, Element C, Section 4 Cal MediConnect 3-Way Contract, Sections: 2.2.4 2.5 2.8 DPL 15-001: ICP and ICT Requirements CY 2020 Medicare-Medicaid Plan (MMP) Core Reporting Requirements, Section 3.2	Ongoing, per process			X	X		
Pediatric ICT Bundle (Medi-Cal)	Health Networks shall submit report of individual bundles with ICT minutes and ICP. This report is part of CalOptima's requirements for PCC funding. An ICT bundle will be returned for all members residing in Long Term Care that have completed an HRA. Bundles shall be returned within 145 calendar days for basic care management and 60 days for complex or care coordination levels. The report includes the following: • ICT notes/minutes, participants invited according to member's needs, and ICT attendees • Clinical Assessments/Case management notes summarizing discussions, follow up items, and parties responsible for follow up • Documentation that the final ICP was distributed to invited participants, including the PCP and the member • Copy of Care Planning Letter sent to Member with date mailed and preferred language and format • Copy of the final ICP signed by the PCP	APL 18-023: California Children's Services Whole Child Model Program (Supersedes APL 18-011) APL 17-012: Care Coordination Requirements for Managed Long-Term Services and Supports	Ongoing, per process	X			X	X	
Model of Care (MOC) SPD Tracking Log (Medi-Cal)	Health Networks shall submit monthly report of PCC assignment for all current SPD members. This report is part of CalOptima's requirements for PCC funding. The report includes the following: • Member name and CIN • PCC number • Care Management Level (CML) • Reason for change in CML (if changed) Note: If the member is both WCM and SPD, they will only be counted/included under WCM for PCC funding and performance monitoring, and the member will not be counted/included under SPD as long as they are also WCM.	DHCS Medi-Cal Contract, Exhibit A, Attachment 11, Provision 2	Monthly: 6th of every month	X			X	X	

REPORT NAME	DESCRIPTION/REQUIREMENT	CITATION	REPORT FREQUENCY	LINE OF BUSINESS			REPORT REQUIREMENT INDICATOR		
				Medi-Cal	OneCare	OneCare Connect	Health Networks (Except Kaiser)	Kaiser	VSP
MOC Tracking Log (OneCare Connect)	Health Networks shall submit monthly report of PCC assignment for all current OCC members. This report is part of CalOptima's requirements for PCC funding. The report includes the following: • Member name and CIN • PCC number • Care Management Level (CML) • Reason for change in CML (if changed)	Cal MediConnect 3-Way Contract, Sections: 2.5.2.7 2.5.2.7.1	Monthly: 6th of every month			X	X		
MOC Tracking Log (OneCare)	Health Networks shall submit monthly report of PCC assignment for all current OC members. This report is part of CalOptima's requirements for PCC funding. The report includes the following: • Member name and CIN • PCC number • Care Management Level (CML) • Reason for change in CML (if changed)	Title 42, CFR, Section 422.101(f)	Monthly: 6th of every month		X		X		
MOC WCM Tracking Log (Medi-Cal)	Health Networks shall submit monthly report of PCC assignment for all current WCM members. This report is part of CalOptima's requirements for PCC funding. The report includes the following: • Member name and CIN • PCC number • Care Management Level (CML) • Reason for change in CML (if changed) Note: If the member is both WCM and SPD, they will only be counted/included under WCM for PCC funding and performance monitoring, and the member will not be counted/included under SPD as long as they are also WCM.	APL 18-023: California Children's Services Whole Child Model Program (Supersedes APL 18-011)	Monthly: 6th of every month	X			X		
Network Staff Legend File	Health Networks shall submit monthly report of Network Staff Legend File that includes all PCC staff, the percentage of time each staff person spends on each program, and Care Coordinator (CC) staff information (OneCare Connect only). This report is part of CalOptima's requirements for PCC funding. The report includes the following: • Staff name, number (unique for each individual PCC or CC, phone number, and email • For OneCare Connect only, CC hire date and termination date, and whether CC performed assessments • Model of Care (MOC) training received • PCC training received and PCC staffing ratio met • Percentage of time staff person spent performing work on each program (OneCare Connect, OneCare, SPD, and WCM), and on behalf of other health plans	APL 18-023: California Children's Services Whole Child Model Program (Supersedes APL 18-011) Cal MediConnect 3-Way Contract, Sections: 2.5.2.7 2.5.2.7.1 DHCS Medi-Cal Contract, Exhibit A, Attachment 11, Provision 2 Title 42, CFR, Section 422.101(f)	Monthly: 6th of every month	X	X	X	X		

REPORT NAME	DESCRIPTION/REQUIREMENT	CITATION	REPORT FREQUENCY	LINE OF BUSINESS			REPORT REQUIREMENT INDICATOR		
				Medi-Cal	OneCare	OneCare Connect	Health Networks (Except Kaiser)	Kaiser	VSP
	• Type of licensed staff or non-licensed CC staff • Attestation from Manager/Director (name and title) to report information								
WCM ICP Bundle (Medi-Cal)	Health Networks shall submit report of individual bundles with ICT minutes and ICP. This report is part of CalOptima's requirements for PCC funding. An ICT bundle will be returned for members completing an HRA with a CML of care coordination or complex. Bundles shall be returned within 90 calendar days of HRA completion. The report includes the following: • ICT minutes, participants invited according to member's needs, and ICT attendees • Case management notes summarizing discussions, follow up items, and parties responsible for follow up • Documentation that the final ICP was distributed to invited participants, including the PCP and the member • Member-friendly ICP in member's preferred language and format • Copy of the final ICP signed by the PCP	APL 18-023: California Children's Services Whole Child Model Program (Supersedes APL 18-011)	Ongoing, per process	X			X	X	
DHCS WCM Report - Kaiser	Kaiser shall submit monthly report of WCM authorizations, care coordination and grievances/appeals. The grievance and appeal sections apply to Kaiser due to delegation of member grievances and appeals. The report includes the following: • Plan code, plan name, county, and reporting period • Number of approved authorizations and denied authorizations for the following: NICU, CCS approved PICU, CCS approved inpatient facilities and special care centers (SCC), and specialized customized DME • Number of members identified as high risk and as low risk • Number of WCM assessments completed to date for high risk members and for low risk members • Number of WCM ICP completed to date for high risk members • Number of WCM eligible members with diagnosis requiring a referral to SCC to date • Number of WCM eligible members who have been seen by SCC to date • Number of WCM member discharged from hospital to date • Number of WCM members discharged from hospital with at least one follow-up visit within 28 days after discharge date • Number of grievances received regarding the following: timely access, transportation, DME, and WCM provider • Number of other WCM grievances and summary of such grievances • Number of WCM appeals and summary of appeals	APL 18-023: California Children's Services Whole Child Model Program (Supersedes APL 18-011) DHCS Medi-Cal Contract, Exhibit A: Attachment 4 Attachment 11, Provision 10	Monthly: 15th of every month	X				X	
Population Health Management (PHM) Program Description - Kaiser	Kaiser shall develop a PHM program description and submit to CalOptima for review. The report includes the following: • Quantitative results for relevant clinical, cost/utilization and experience measures • Comparison of results with a benchmark	NCQA Standards, Population Health Management, PHM7	Annually: February 15th	X				X	

REPORT NAME	DESCRIPTION/REQUIREMENT	CITATION	REPORT FREQUENCY	LINE OF BUSINESS			REPORT REQUIREMENT INDICATOR		
				Medi-Cal	OneCare	OneCare Connect	Health Networks (Except Kaiser)	Kaiser	VSP
DHCS WCM Report	Health Networks shall submit monthly report of WCM authorizations and care coordination. The report includes the following: • Plan code, plan name, county, and reporting period • Number of approved authorizations and denied authorizations for the following: NICU, CCS approved PICU, CCS approved inpatient facilities and special care centers (SCC), and specialized customized DME • Number of members identified as high risk and as low risk • Number of WCM assessments completed to date for high risk members and for low risk members • Number of WCM ICP completed to date for high risk members • Number of WCM eligible members with diagnosis requiring a referral to SCC to date • Number of WCM eligible members who have been seen by SCC to date • Number of WCM member discharged from hospital to date • Number of WCM members discharged from hospital with at least one follow up visit within 28 days after discharge date	APL 18-023: California Children's Services Whole Child Model Program (Supersedes APL 18-011) DHCS Medi-Cal Contract, Exhibit A: Attachment 4, Provision 6 Attachment 11 Provision 10	Monthly: 15th of every month	X			X		
Claims Third Party Liability (TPL) (Medi-Cal)	Health Networks shall submit monthly report of potential TPL data to CalOptima for reporting to DHCS. The report includes the following: • Member name, ID number, date of birth, and date of death (if applicable) • Contractor's name (CalOptima) • Provider name(s), and date of service • Diagnosis code(s) and description of illness or injury • Procedure codes(s) and description of services rendered • Amount subcontractor or out-of-plan Provider billed, if applicable • Amount Other Health Coverage (OHC) paid to CalOptima, or a subcontractor, if applicable • Amounts and dates of claims CalOptima, a subcontractor, or out-of-plan Provider paid, if applicable	CalOptima Policy FF.2007: Reporting of Potential Third-Party Liability (TPL) APL 17-021: Workers' Compensation – Notice of Change to Workers' Compensation Recovery Program, Reporting and Other Requirements Cal MediConnect 3-Way Contract, Section 5.1.13.1 DHCS Medi-Cal Contract, Exhibit E, Attachment 2	Monthly: 30th of every month	X			X	X	
Claims TPL (OneCare Connect)	Health Networks shall submit monthly report of potential TPL data to CalOptima for reporting to DHCS. The report includes the following: • Member name, ID number, date of birth, and date of death (if applicable) • Contractor's name (CalOptima) • Provider name(s), and date of service • Diagnosis code(s) and description of illness or injury • Procedure code(s) and description of services rendered • Amount subcontractor or out-of-plan provider billed, if applicable • Amount Other Health Coverage (OHC) paid to CalOptima, or a subcontractor, if applicable • Amounts and dates of claims CalOptima, a subcontractor, or out-of-plan Provider paid, if applicable	CalOptima Policy FF.2007: Reporting of Potential Third-Party Liability Title 42, CFR, Sections: 405.378 411.24 422.108 423.462 CMS Memorandum to MAOs and PDPs (12/5/11), "Medicare Secondary Payment Subrogation Rights" Cal MediConnect 3-Way Contract, Section 5.1.13	Monthly: 30th of every month			X	X		

REPORT NAME	DESCRIPTION/REQUIREMENT	CITATION	REPORT FREQUENCY	LINE OF BUSINESS			REPORT REQUIREMENT INDICATOR		
				Medi-Cal	OneCare	OneCare Connect	Health Networks (Except Kaiser)	Kaiser	VSP
DHCS Post-Payment Recovery Report (Medi-Cal Only)	Health Networks shall submit monthly report of post-payment recovery data for other health coverage (OHC) claims to CalOptima. The report includes the following: • Project type (Third Part Liability "TPL") • Name of Provider billing the claim, and provider tax ID number • Claim type (What kind of claim was submitted, Facility, Professional, etc.) • Member name, date of birth, ID number, and social security number • Transaction control number (claim number) • Begin date and end date of service • Coordinated care organization bill amount (amount billed to TPL/Provider) • Coordinated care organization paid amount (amount paid to the Provider) • Bill date (date the claim was billed to the TPL) • Remit amount (amount recovered from the TPL) • Claim date of remit (date the claim was paid or denied by TPL) • Check number related to remit amount • Other insurance carrier name (name of the TPL that was billed) • Claim status (disposition of the claim, paid, denied, open, etc.) • Denial reason (the reason the claim was denied by the TPL)	APL 20-010: Cost Avoidance and Post-Payment Recovery for Other Heath Coverage	Monthly: 3rd business day of every month	X			X	X	
Customer Service Call Log Universe	Health Networks shall submit quarterly Customer Service Call Log Universe for monitoring of Health Network Member Services/Customer Service staff in the identification of grievances and the appropriate handling of a grievance. CalOptima Customer Service will meet quarterly with the Health Networks to provide feedback of monitoring. The report includes the following: • File ID number, and line of business • Member name and cardholder ID (assigned by HN to identify member) • Date and time the call was received • Category of the call and detailed description of the call • Detailed description of the outcome/resolution of the call • Date and time the call was resolved • Customer Service Representative name who handled the call • Member's language	DHCS Medi-Cal Contract, Exhibit A: Attachment 13, Provision 2 Attachment 14, Provision 1 Attachment 14, Provision 2 Health and Safety Code (HSC), Section 1368(a)(1) Title 28, CCR, Section 1300.68(a) Cal MediConnect 3-Way Contract, Section 2.14 Parts C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance NCQA Element MED12D: Providing Information to Medicaid Members in the Practitioner Directory (Kaiser)	Quarterly: January 7, April 7, July 7, October 7	X	X	X	X	X	

REPORT NAME	DESCRIPTION/REQUIREMENT	CITATION	REPORT FREQUENCY	LINE OF BUSINESS			REPORT REQUIREMENT INDICATOR		
				Medi-Cal	OneCare	OneCare Connect	Health Networks (Except Kaiser)	Kaiser	VSP
Health Network Dashboard	Health Networks shall submit report of call center statistics for monthly review. The report includes the following: • Total number of calls, average speed of answer, and average length of call in seconds • Service levels (percentage of incoming calls answered within 30 seconds) • Average speed to answer member services telephone calls with a live voice • Abandonment rate (percentage of incoming calls disconnected) • Number of calls received by call type (questions, grievance and appeals, health education requests, transportation, authorization/referral, member claims, access to services) • Number of calls by language	CalOptima Health Network Contract, Sections: 3.5 7.1 DHCS Medi-Cal Contract, Exhibit A, Attachment 13, Provision 3	Monthly; 15th of every month	X	X	X	X	X	X
Interpreter Services Utilization Report	Health Networks shall submit quarterly report of interpreter services utilization for CalOptima members assigned to their Health Networks. The report includes the following: • Requests for interpreter services by language (number of requests received, and number of requests fulfilled) • Number and percentage of telephonic interpreter services provided by the following: Contracted vendor, community-based organization (CBO), HN staff, and provider/provider staff • Number and percentage of face-to-face interpreter services provided by the following: Contracted vendor, CBO, Health Network staff, and provider/provider staff • Total cost for interpretation and/or translation services with an outside vendor or CBO (if services subcontracted)	DHCS Medi-Cal Contract, Exhibit A, Attachment 6 Cal MediConnect 3-Way Contract, Section 2.11.1.2.2	Quarterly: January 30, April 30, July 30, October 30	X	X	X	X	X	X
DHCS NMT/NEMT Report – Kaiser	Kaiser shall submit monthly report of DHCS Non-Medical Transportation (NMT)/Non-Emergency Medical Transportation (NEMT). The grievance and appeals sections apply to Kaiser due to delegation of member grievances and appeals. The report includes the following: • Plan code, plan name, county, and reporting period • Number of NMT trips by private transportation to covered services for age 20 and under, and for age 21 and above • Number of NMT trips by private transportation to non-covered services for age 20 and under, and for age 21 and above • Number of NMT trips by public transportation to covered services for age 20 and under, and for age 21 and above • Number of NMT trips by public transportation to non-covered services for age 20 and under, and for age 21 and above • Number of NMT denials • Number of NMT and NEMT calls • Number of NMT and NEMT grievances, and grievance reasons • NMT/NEMT reporting comments	APL 17-010: Non-Emergency Medical and Non-Medical Transportation Services DHCS Medi-Cal Contract, Exhibit A, Attachment 10 Welfare and Institutions Code, Section 14132	Monthly: 27th of every month	X				X	

CalOptima Policy HH.2003 – Attachment B: Timely and Appropriate Submission Grid – Supplemental Attachment

REPORT NAME	DESCRIPTION/REQUIREMENT	CITATION	REPORT FREQUENCY	LINE OF BUSINESS			REPORT REQUIREMENT INDICATOR		
				Medi-Cal	OneCare	OneCare Connect	Health Networks (Except Kaiser)	Kaiser	VSP
Annual Audited Financial Statements	Health Networks shall submit annual audited financial statements of the organization (PHC and SRG only). Audited financial statements include the following: • Letters to management, and incurred but not reported (IBNR) documentation • Consolidated corporate audited financial statements (if Health Network is part of a larger entity) • Balance sheet, statement of revenue and expenses, statement of cash flows, audit opinion, and related notes and disclosures	CalOptima Policy FF.3001: Financial Reporting	Annual submission due 120 days after organization's fiscal year ends	X	X	X	X		
Incurred But Not Reported (IBNR) Documentation	Health Networks shall annually submit IBNR documentation, which can be included in the Annual Audited Financial Statements or submitted as a separate report. The IBNR documentation includes the following: • Written policies and procedures or any related documentation of the methodology used to estimate the liability for incurred but not reported (IBNR) claims • Supporting documentation for the IBNR calculation	CalOptima Policy FF.3001 Financial Reporting	Annual submission due 120 days after organization's fiscal year ends	X	X	X	X		
Medical Loss Ratio (MLR)	Health Networks shall submit interim and final reports of the Health Network MLR. MLR submission shall utilize the most current Annual Financial Reporting Form (AFRF) provided by CalOptima. Medi-Cal Expansion and Whole Child Model reported separately from Medi-Cal (classic). SRG completes only the "P" tabs. PHC completes the "P" and "H" tabs. HMO (except Kaiser) completes the HMO template.	CalOptima Policy FF.3001: Financial Reporting	Interim: January - June due August 15 Interim: January - December due February 15 Final: Annual submission of all 12 months due June 30	X		X	X		
Risk Bearing Organization (RBO) Report	Health Networks shall submit quarterly and annual RBO reports that include financial data submitted to the Department of Managed Health Care (DMHC) by the Health Networks (PHC and SRG only). RBO submissions includes a copy of the DMHC RBO Quarterly and Annual Financial Survey Report, pursuant to 28 CCR Section 1300.75.4.3.	CalOptima Policy FF.3001: Financial Reporting	Annual submission due 150 days after the fiscal year ends Quarterly: February 15, May 15, August 15, November 15	X	X	X	X		
Total Business Reports	Health Networks shall submit quarterly unaudited financial statements of the PHC and SRG organization. Quarterly unaudited statements include balance sheet, income statement, statement of cash flows, and related disclosures.	CalOptima Policy FF.3001: Financial Reporting	Quarterly: February 15, May 15, August 15, November 15	X	X	X	X		

REPORT NAME	DESCRIPTION/REQUIREMENT	CITATION	REPORT FREQUENCY	LINE OF BUSINESS			REPORT REQUIREMENT INDICATOR		
				Medi-Cal	OneCare	OneCare Connect	Health Networks (Except Kaiser)	Kaiser	VSP
DHCS Quarterly Report - Kaiser	Kaiser shall submit quarterly report of member grievances and appeals received within the quarter. Report includes a breakdown of grievance and appeal types by categories specified by DHCS template. This report applies to Kaiser due to delegation of member grievances and appeals. The report includes the following: • Year, quarter, plan code, member CIN • Grievances by categories: Accessibility, benefits/coverage, referral, quality of care/services, and other • For the other category, grievance type(s) must be defined by HN • Whether grievance was resolved (in favor of member or HN) or unresolved	CalOptima Policy HH.1103: Health Network Member Grievance and Appeal Process DHCS Medi-Cal Contract, Exhibit A, Attachment 14, Provision 3 APL 14-013: Grievance Report Template APL 17-006: Grievance and Appeal Requirements and Revised Notice Templates and "Your Rights" Attachments	Quarterly: January 23, April 23, July 23, October 23	X				X	
Grievances Volume Report - Kaiser	Kaiser shall submit quarterly report of member grievance volume/aggregate data. This report applies to Kaiser due to delegation of member grievances and appeals. The report includes the following: • Number of the following grievance types: Coverage disputes, disputes involving medical necessity, quality of care, access to care (including appointments), quality of service, and other • Total of all grievance types	CalOptima Policy HH.1103: Health Network Member Grievance and Appeal Process DHCS Medi-Cal Contract: Exhibit A, Attachment 14, Provision 3	Quarterly: January 23, April 23, July 23, October 23	X				X	
Community-Based Adult Services (CBAS) Report - Kaiser	Kaiser shall submit quarterly CBAS reports that include CBAS services and assessment, grievance and appeals, and call center complaints. The grievance and appeal sections apply to Kaiser due to delegation of member grievances and appeals. The report includes the following: • Plan code, plan name, county, reporting quarter • Number of requests for CBAS, and number of CBAS Providers • Number of members by the following categories: received initial CBAS assessment, ineligible to receive CBAS, received enhancement case management (ECM) services, provided with CBAS, and provided with unbundled services • Average number of days between CBAS request and notice of eligibility • Number of members discharged due to: death, long term nursing facility placement, other services, moving out of the plan, choosing to leave CBAS, and transfer to a different CBAS center • Number of grievances regarding: CBAS Providers, contractor assessment/reassessment, excessive travel times to access CBAS, and other CBAS grievances • Number of CBAS appeals approved, denied, and withdrawn • Number of CBAS appeals related to: denials/limited services, denied access to requested CBAS provider, and excessive travel times to access CBAS • Number of CBAS complaint calls from member and from provider • Explanations and summary of CBAS complaints • CBAS reporting comments	CalOptima Health Network Contract, Exhibit A, Attachment 19, Provision 6	Quarterly: January 23, April 23, July 23, October 23	X				X	
DHCS Data Certification Statement	Health Networks shall submit a completed and signed Data Certification Statement on Health Network's letterhead that data, information, and documentation submitted to CalOptima monthly are accurate, complete, and truthful.	APL 17-005: Certification of Document and Data Submissions	Monthly: 25th of each month	X			X	X	X

REPORT NAME	DESCRIPTION/REQUIREMENT	CITATION	REPORT FREQUENCY	LINE OF BUSINESS			REPORT REQUIREMENT INDICATOR		
				Medi-Cal	OneCare	OneCare Connect	Health Networks (Except Kaiser)	Kaiser	VSP
	The most current template Data Certification Statement in the Report Binder shall be utilized and include the following: • Health Network name, certification month and year • Signature of Health Network CEO or CFO (or an individual who reports directly to and has delegated authority to sign for such Officer) • Signature date, job title, and Health Network department.	DHCS Medi-Cal Contract, Exhibit E, Attachment 2 CalOptima Health Network Contract, Section 7.12							
Health Network Newly Contracted Provider Training Report	Health Networks shall submit quarterly report of educational training of all newly contracted providers. Required training must be conducted within ten (10) working days and completed within thirty (30) calendar days from the provider's placement on active status. Health Networks shall obtain a signed acknowledgment notice from providers upon completion of training. The report includes the following: • Program (Medi-Cal, OneCare, OneCare Connect) • Provider name, NPI, and active status date • Date the training started and date the training was completed • Whether signed acknowledgment was received from provider • Comments/explanation of missed deadline(s)	CalOptima Policy EE.1103: Provider Education and Training DHCS Medi-Cal Contract, Exhibit A: Attachment 7, Provisions 5 Attachment 9, Provision 12 APL 11-010: Competency and Sensitivity Training Required in Serving the Needs of Seniors and Persons with Disabilities Cal MediConnect 3-Way Contract, Section 2.9.11	Quarterly: January 25, April 25, July 25, October 25	X	X	X	X	X	X
Primary Care Provider (PCP) Upload File	Health Networks shall submit bi-monthly report of Medi-Cal Member PCP assignment/changes. The report includes the following: • Member site, ID, and suffix • PCP effective date, ID, and suffix • Health Network ID and suffix • Medical center ID and suffix • Staff Vs center indicator • Pay to Tax ID number (Health Network Tax ID) • Pay to Tax ID suffix • PCP reason code • Name of individual provider, group, or clinic	CalOptima Health Network Contract, Sections: 3.12 7.1 7.11 CalOptima Health Network Contract (PHC and SRG), Section 3.10.5.4 CalOptima Policy EE.1112: Health Network Eligible Member Assignment to Primary Care Provider (PCP)	Bi-monthly: 10th and 25th of every month	X			X		
DHCS Supplemental Data – Kaiser	Kaiser shall submit monthly report of Behavioral Health Treatment (BHT) and Hepatitis C (Hep C) supplemental data for CalOptima's Consolidated Supplemental File submission to DHCS. The report includes the following: • Supplement type: AIDS, maternity, Hep-C, behavioral health treatment (BHT), Health Homes Program Physical Conditions and Substance Use Disorder (HHP-PHYS-SUD)/HHP Serious Mental Illness (HHP SMI). • Member name and CIN • Health Care Plan (HCP) code • Month of service • Member enrollment status indicator • Services rendered	DHCS Medi-Cal Contract, Exhibit B, Budget Detail and Payment Provisions, Provision 16 Technical Guidance: Consolidated Supplemental Upload Process	Monthly: 15th of every month	X				X	

REPORT NAME	DESCRIPTION/REQUIREMENT	CITATION	REPORT FREQUENCY	LINE OF BUSINESS			REPORT REQUIREMENT INDICATOR		
				Medi-Cal	OneCare	OneCare Connect	Health Networks (Except Kaiser)	Kaiser	VSP
	• Diagnosis date • Delivery date • Number of weeks for Hep-C multiplier • Indicator for correction record • Indicator for Hep-C medications: Sovaldi, Olysio, Incivek, Victrelis, Harvoni, Viekira Pak, Technivie, Zepatier, Epclusa, Viekira XR, Vosevi, Mavyret • Number of encounters								
Vision Service Plan (VSP) Provider Roster	VSP shall submit monthly report of VSP providers for the print and online provider directories. The report includes the following: • Practice name, doctor name, and provider specialty • Provider address, phone number, and county name • Non-English languages spoken by provider and/or clinical staff • Provider NPI, license number and type, special experience, and gender • Accepting new patients, and ages seen • Hours of operation from Monday through Sunday	CalOptima VSP Contract, Sections: 1.17 7.1	Monthly: 15th of every month	X					X
Health Education Calendar - Kaiser	Kaiser is required to submit evidence of its health education activities semi-annually for review and monitoring. Kaiser shall demonstrate it is making health education programs available to CalOptima members by submitting its Health Education Calendar listing available classes. The report shall include, at a minimum: • Class or program name • Location • Date and time	CalOptima Policy GG.1201: Health Education Programs DHCS Medi-Cal Contract, Exhibit A, Attachment 10, Section 8	Semi-Annually: January 31 and July 31	X				X	
Health Education Individual Encounters-Kaiser	Kaiser is required to submit evidence of its health education activities semi-annually for review and monitoring. Kaiser shall demonstrate it is making health education programs available to CalOptima members by submitting its Health Education Individual Encounters listing CalOptima members who attended Kaiser Health Education classes or programs. The report shall include, at a minimum: • Class or program • Number of members in attendance	CalOptima Policy GG.1201: Health Education Programs DHCS Medi-Cal Contract, Exhibit A, Attachment 10, Section 8	Semi-Annually: January 31 and July 31	X				X	
Health Education Other Encounters - Kaiser	Kaiser is required to submit evidence of its health education activities semi-annually for review and monitoring. Kaiser shall demonstrate it is making health education programs available to CalOptima members by submitting its Health Education Other Encounters listing CalOptima members who attended Kaiser classes or programs.	CalOptima Policy GG.1201: Health Education Programs DHCS Medi-Cal Contract, Exhibit A, Attachment 10, Section 8	Semi-Annually: January 31 and July 31	X				X	

REPORT NAME	DESCRIPTION/REQUIREMENT	CITATION	REPORT FREQUENCY	LINE OF BUSINESS			REPORT REQUIREMENT INDICATOR		
				Medi-Cal	OneCare	OneCare Connect	Health Networks (Except Kaiser)	Kaiser	VSP
	The report shall include, at a minimum: • Class or program • Number of members in attendance								
Perinatal Support Services (PSS) Encounters - Kaiser	Kaiser shall submit monthly Comprehensive Perinatal Service Program (CPSP)/PSS data to support CalOptima's oversight and quality improvement efforts. The data include the following: • Member CIN • Member DOB • Estimated Delivery Date • Participating in CPSP (Y/N) • Date CPSP Initiated	CalOptima Policy GG.1701: CalOptima Perinatal Support Services (PSS) Program DHCS Medi-Cal Contract, Exhibit A, Attachment 10, Section 7	Monthly: 15th of every month	X				X	
Access and Availability Report - Kaiser	Kaiser shall submit annual analysis of data to measure performance against standards for access, including behavioral health (BH) access standards. The report includes the following: • Analysis of availability of practitioners (primary care and specialty services, including BH services) against standards for access • Analysis of access to practitioners (primary care and specialty services, including BH services) against standards for access • Non-behavioral and behavioral health identification of gaps in network specific to geographic areas or types of practitioners or providers by using analysis related to members experience with network adequacy and analyzing requests for and utilization of out-of-network services • Identifying opportunities and prioritizing opportunities for improvement identified from analyses of availability, accessibility and member experience accessing network • Documenting at least one intervention and measure effectiveness of interventions (if applicable)	DHCS APL 20-003: Network Certification Requirements, Contractual Relationship and Delegation DHCS Proposed Annual Network Certification Policy Changes NCQA Standards, Network Management: Net 1B – 1D Net 2A – 2C Net 3A – 3C CalOptima Policy GG.1600: Access and Availability Standards CalOptima Policy MA.7007: Access and Availability Title 28, CCR, Sections: 1300.67.2 1300.67.2.1 1300.67.2.2 DHCS Medi-Cal Contract, Exhibit A: Attachment 6 Attachment 9 Cal MediConnect 3-Way Contract, Section 2 Title 42, CFR, Section 438.206-207	Annually: February 15	X				X	

REPORT NAME	DESCRIPTION/REQUIREMENT	CITATION	REPORT FREQUENCY	LINE OF BUSINESS			REPORT REQUIREMENT INDICATOR		
				Medi-Cal	OneCare	OneCare Connect	Health Networks (Except Kaiser)	Kaiser	VSP
Quality Improvement (QI) Evaluation (Previous Year) – Kaiser	Kaiser shall perform an annual evaluation of their QI work plan/program and submit to CalOptima for review. The evaluation includes the following: • A description of completed and ongoing QI activities that address quality and safety of clinical care and quality of service • Trending of measures to assess performance in the quality and safety of clinical care and quality of service • Analysis and evaluation of the overall effectiveness of the QI program and of its progress toward influencing network-wide safe clinical practices	DHCS Medi-Cal Contract, Exhibit A, Attachment 4, Provision 6 Kaiser HMO Contract, Section 6.4 NCQA Standards, Quality Improvement, QI7	Annually: February 15	X				X	
QI Program – Kaiser	Kaiser shall develop an annual QI program description and submit to CalOptima for review. The program includes description of the following: • The QI program structure • The behavioral healthcare aspects of the program • Involvement of a designated physician in the QI program • Involvement of a behavioral healthcare practitioner in the behavioral aspects of the program • Oversight of QI functions of the organization by the QI Committee • Objectives for serving a culturally and linguistically diverse membership	DHCS Medi-Cal Contract, Exhibit A, Attachment 4, Provision 6 Kaiser HMO Contract, Section 6.4 NCQA Standards, Quality Improvement, QI7	Annually: February 15	X				X	
QI Work Plan – Kaiser	Kaiser shall report progress towards quality improvement program goals semi-annually. The QI work plan includes the following: • Yearly planned QI activities and objectives • Timeframe for each activity's completion • Staff members responsible for each activity • Monitoring of previously identified issues • Evaluation of the QI program	DHCS Medi-Cal Contract, Exhibit A, Attachment 4, Provision 6 Kaiser HMO Contract, Section 6.4 NCQA Standards, Quality Improvement, QI7	Semi-Annually: February 15 and August 15	X				X	
QI Work Plan Current Year (Initial) – Kaiser	Kaiser shall develop an annual quality improvement work plan that outlines goals and initiatives for the new year. The initial work plan must be submitted to CalOptima for review. The work plan includes the following: • Yearly planned QI activities and objectives • Timeframe for each activity's completion • Staff members responsible for each activity • Monitoring of previously identified issues • Evaluation of the QI program	DHCS Medi-Cal Contract, Exhibit A, Attachment 4, Provision 6 Kaiser HMO Contract, Section 6.4 NCQA Standards, Quality Improvement, QI7	Annually; February 15 (for new year)	X				X	

REPORT NAME	DESCRIPTION/REQUIREMENT	CITATION	REPORT FREQUENCY	LINE OF BUSINESS			REPORT REQUIREMENT INDICATOR		
				Medi-Cal	OneCare	OneCare Connect	Health Networks (Except Kaiser)	Kaiser	VSP
Report of Findings and Actions Taken as a Result of QI Activities – Kaiser	Kaiser shall submit quarterly report of any findings or actions taken as a result of QI activities. The report includes the following, at a minimum: • Any action taken for medical disciplinary cause or reason (through Medical Board of California or respective Licensing Board actions) • An action taken by a Peer Review Body or other organization that results in filing of a 805 or 805.01 with Medical Board of California or appropriate licensing board/agency, and/or report with the National Practitioner Data Bank (NPDB)	DHCS Medi-Cal Contract, Exhibit A, Attachment 4, Provision 6 Kaiser HMO Contract, Section 6.4 NCQA Standards, Quality Improvement, QI7	Quarterly	X				X	
Authorization Utilization Report	Health Networks shall submit quarterly report of open authorizations, if a claim was received and the date the claim was paid (if applicable). The report includes the following: • Member name, Client Identification Number (CIN), and date of birth • Health Network name or number, and PCP name • Authorization tracking/case number • Authorization request date, approved date, effective date, and expiration date • Services requested (CPT code and description) • Diagnosis (ICD and description) • Services approved to (name of provider or health delivery organization) • Specialty of provider who is authorized for services • Whether claim was submitted and date claim was paid	DHCS Medi-Cal Contract, Exhibit A, Attachment 5, Provision 1 CalOptima Health Network Contract, Sections: 7.1 7.11 CalOptima Policy GG.1513: Health Network Utilization Management Reporting and Monitoring Requirements CalOptima Policy HH.2003: Health Network and Delegated Entity Reporting	Quarterly: Q3 2020 - February 15, 2021 Q4 2020 - May 15, 2021 Q1 2021 - August 15, 2021 Q2 2021 - November 15, 2021	X			X	X	
Dental Anesthesia Report	Health Networks shall submit quarterly report of the monthly totals of dental general anesthesia requests, approvals and denials for adults and children with and without developmental disability (DD). The report includes the following: • Member categories: age 21 and older without DD, age 21 and older with DD, age 20 and younger without DD, and age 20 and younger with DD • Reporting quarter by months: number of requests (dental general anesthesia), approvals, denials due to requested documentation not submitted, denials due to not meeting medical necessity criteria, and denials due to other reasons • Reasons for the other denials for dental general anesthesia • Dental general anesthesia reporting comments	APL 15-012: Dental Anesthesia Services - Intravenous Sedation and General Anesthesia Coverage CalOptima Health Network Contract, Sections: 7.1 7.11 CalOptima Policy GG.1513: Health Network Utilization Management Reporting and Monitoring Requirements CalOptima Policy HH.2003: Health Network and Delegated Entity Reporting	Quarterly: 15th of the month after the end of the quarter	X			X	X	
UM Evaluation (Previous Year)	Health Networks shall perform an annual evaluation on their UM work plan/program and submit to CalOptima for review. The UM Evaluation includes the following: • The UM Work Plan report with the initial work plan goals, planned activities, target dates for completion and responsible person(s), titles, key findings and analysis and interventions that include:	DHCS Medi-Cal Contract, Exhibit A, Attachment 4, Provision 6 and Attachment 5, Provision 5 NCQA Standards, Utilization Management, UM1	Annually: February 15	X	X	X	X	X	

REPORT NAME	DESCRIPTION/REQUIREMENT	CITATION	REPORT FREQUENCY	LINE OF BUSINESS			REPORT REQUIREMENT INDICATOR		
				Medi-Cal	OneCare	OneCare Connect	Health Networks (Except Kaiser)	Kaiser	VSP
	• Inpatient utilization metrics, and inpatient workplan and report • Referral metrics, and referral workplan and reports • Emergency room (ER) utilization metrics, and ER work plan and reports • Complex case management (CCM) metrics, and CCM work plan and reports • Special needs plan (SNP) metrics, and SNP work plan and reports • Experience (satisfaction) with the UM process work plan and reports • Over/under utilization and referral timeframe compliance work plan and reports • Turnaround time • Inter-rater reliability evaluation • Other UM work plans and reports • Signature and date approved								
UM Program	Health Networks shall develop a UM program description and submit to CalOptima for review. The UM Program includes a description of the following: • Written description of the program structure • Involvement of a designated senior-level physician in UM program implementation, UM activities, supervision oversight and evaluation of UM program • Behavioral healthcare aspects of the program •The program scope and process used to determine benefit coverage and medical necessity • UM Program's role in the QI program, including how the delegate collects UM information and uses it for QI activities • Information sources used to determine benefit coverage and medical necessity • The Health Network annually evaluates and updates the UM program, as necessary	DHCS Medi-Cal Contract, Exhibit A: Attachment 4, Provision 6 Attachment 5, Provision 5 NCQA Standards, Utilization Management, UM1	Annually: February 15	X	X	X	X	X	
UM Work Plan	Health Networks shall report progress towards UM program goals semi-annually. The UM Work Plan report with the initial work plan goals, planned activities, target dates for completion and responsible person (s), titles, key findings and analysis and interventions must include: • Inpatient utilization metrics, and inpatient workplan and report • Referral metrics, and referral workplan and reports • Emergency room (ER) utilization metrics, and ER work plan and reports • Complex case management (CCM) metrics, and CCM Work plan and reports • Special needs plan (SNP) metrics, and SNP work plan and reports • Experience (satisfaction) with the UM process work plan and reports • Over/under utilization and referral timeframe compliance work plan and reports • Turnaround time • Inter-rater reliability evaluation • Other UM work plans and reports • Signature and date approved	DHCS Medi-Cal Contract, Exhibit A: Attachment 4, Provision 6 Attachment 5, Provision 5	Semi-Annually: February 15 and August 15	X	X	X	X	X	
UM Work Plan Current Year (Initial)	Health Networks shall develop an annual UM work plan that outlines goals and initiatives for the new year. The initial work plan must be submitted to CalOptima for review.	DHCS Medi-Cal Contract, Exhibit A: Attachment 4, Provision 6 Attachment 5, Provision 5	Annually: February 15 (for new year)	X	X	X	X	X	

REPORT NAME	DESCRIPTION/REQUIREMENT	CITATION	REPORT FREQUENCY	LINE OF BUSINESS			REPORT REQUIREMENT INDICATOR		
				Medi-Cal	OneCare	OneCare Connect	Health Networks (Except Kaiser)	Kaiser	VSP
	The UM Work Plan report with the initial work plan goals, planned activities, target dates for completion and responsible person(s), titles, key findings and analysis and interventions that include: • Inpatient utilization metrics, and inpatient workplan and report • Referral metrics, and referral workplan and reports • Emergency room (ER) utilization metrics, and ER work plan and reports • Complex case management (CCM) metrics, and CCM work plan and reports • Special needs plan (SNP) metrics, and SNP work plan and reports • Experience (satisfaction) with the UM process work plan and reports • Over/Under utilization and referral timeframe compliance work plan and reports • Turnaround time • Inter-rater reliability evaluation • Other UM work plans and reports • Signature and date approved								
Out-of-Network (OON) Requests	Health Networks shall submit quarterly report of OON requests from all enrolled members (except for COC) and approvals by specialty type. The report includes the following: • Health Network name, and reporting quarter and year • Date of OON referral request, and referral authorization number • Member name and CIN • Specialist name, NPI, address, and specialty type • Reason for OON referral request: Provider not accepting new patients, provider or specialty not available in network, timely access to provider, or other reasons (explanation provided by Health Network) • Resolution status (approved, denied, pending)	APL 20-003: Network Certification Requirements, Network Certification Non-Compliance DHCS Medi-Cal Contract, Exhibit A, Attachment 9	Quarterly: January 25, April 25, July 25, October 25	X			X	X	
Kaiser WCM Claim Detail	Kaiser shall submit monthly report of WCM claims payment information. The report includes the following: • CalOptima claim number and line, Kaiser claim number) • Provider name, NPI and tax identification number • Member CIN and name • Claim subtype, bill type, dates of service, place of service, revenue and procedure codes, DRG code and pricing, diagnosis and units. • Kaiser amount billed and paid • CalOptima amount • Claim remittance code and description • Report month and fiscal year • Check date, number and amount	CalOptima Health Network Contract, Section 9.11 CalOptima Policy: FF.4000: Whole-Child Model - Financial Reimbursement for Capitated Health Networks	Monthly: 15th of every month	X				X	

REPORT NAME	DESCRIPTION/REQUIREMENT	CITATION	REPORT FREQUENCY	LINE OF BUSINESS			REPORT REQUIREMENT INDICATOR		
				Medi-Cal	OneCare	OneCare Connect	Health Networks (Except Kaiser)	Kaiser	VSP
Preclusion List Report for Member Notifications Only	Health Networks shall submit monthly report of impacted members utilizing services from a provider who is on the preclusion list. CalOptima shall notice impacted members on behalf of all Health Networks. The report includes the following: • Line of business (OneCare, OneCare Connect) • Member name, CIN, date of birth, address, and language • Precluded provider name and NPI • Service type (health care services, health care items, or prescriptions) • Preclusion list impacted membership attestation	HPMS Memo, 11/2/18, Preclusion List Requirements Final Rule, Vol. 83, No. 73, April 2018	Monthly: 10th of every month	X	X	X	X	X	X
Directed Payments File	Health Networks shall submit monthly Directed Payment adjustment report for qualifying services. The report includes the following: • Claim line ID • Health Network ID, claim number, and claim line number • Member name, CIN, and date of service • Clean claim or encounter received date • Whether an adjustment and previous claim number • Rendering provider name and NPI • Billing provider name, NPI, and Tax ID • Billed CPT/HCPCS code and modifier (if applicable) • Provider billed amount, and whether contracted provider claim • Claim paid amount and adjustment code (if applicable) • Whether fee-for-service or capitated claim • Directed payment amount and paid date, and check or EFT transaction number • Reimbursement disposition (reserved for CalOptima use) • Optional fields (for unique identifiers/specific to HN to help with reconciliation)	APL 19-013: Proposition 56 Hyde Reimbursement Requirements for Specified Services APL 19-015: Proposition 56 Directed Payments for Physician Services APL 19-016: Proposition 56 Directed Payments for Developmental Screening Services APL 19-018: Proposition 56 Directed Payments for Adverse Childhood Experiences Screening Services APL 20-002: Non-Contract Ground Emergency Medical Transport Payment Obligations APL 20-013: Proposition 56 Directed Payments for Family Planning Services CalOptima Policy FF.2011: Directed Payments CalOptima Health Network Contract, Attachment E-2	Monthly: 10th of every month	X			X	X	
Kaiser WCM Rx Detail	Kaiser shall submit monthly report of WCM Rx payment information. The report includes the following: • Member CIN, date of birth, and MRN (assigned by Kaiser) • Pharmacy NPI and fill date • Prescriber NPI and prescription number • Generic Code Number (GCN), National Drug Code (NDC), and brand generic flag • Drug name, quantity, days of supply, and amount paid • Eligibility for Medi-Cal and CCS • Duplicate record indicator and load date	CalOptima Health Network Contract, Section 9.11 CalOptima Policy: FF.4000: Whole-Child Model - Financial Reimbursement for Capitated Health Networks	Monthly: 15th of every month	X				X	

REPORT NAME	DESCRIPTION/REQUIREMENT	CITATION	REPORT FREQUENCY	LINE OF BUSINESS			REPORT REQUIREMENT INDICATOR		
				Medi-Cal	OneCare	OneCare Connect	Health Networks (Except Kaiser)	Kaiser	VSP
FDR Compliance Attestation	The First Tier, Downstream, and Related Entity (FDR) Compliance Attestation is completed by all CalOptima FDRs. It requests for attestation to the compliance program elements and, if there is offshore use of any protected heath information (PHI), then FDRs are to complete the offshore subcontracting attestation. The report includes the following: • Indicator for participation in CalOptima programs (Medi-Cal, OneCare, OneCare Connect and/or PACE) • Organization name • Applicability of General and HIPAA Compliance and FWA Training • Applicability of Compliance Plan and Code of Conduct Requirements • Authorized Signature, Name, Email and Date • Organization Name	CalOptima Policy: HH.2023: Compliance Training CalOptima Health Network Contract, Sections: 3.26 3.27 Compliance Program Guidelines, Section 50.3, Chapter 9 Medicare Managed Care Manual; 8/26/2008 HPMS Memo: Offshore Subcontractor data module in HPMS; 9/20/2007 HPMS Memo: Sponsor activities performed outside of the United States; 7/23/2007 HPMS Memo: Sponsor activities performed outside of the United States.	Initial upon contracting; Annually thereafter	X	X	X	X	X	X
Claims Timeliness Report	Health Networks shall submit a monthly claims payment performance (timeliness) report. The report includes the following: • Health Network name, management company name and report preparer name, title and email. • The reporting year, quarter and month(s). • The number of paid, contested and member-denied claims. • The number of claims paid within timeliness requirements. • The number of unprocessed claims on hand. • The total number of all claims received • The number of emergency room (ER) claims paid, contested and denied. • The number of ER claims paid timely. • Certification signed by principal officer, including name, title, phone and email.	CalOptima Health Network Contract, Section 2.7.8 Kaiser HMO Contract, Section 2.3.8 CalOptima VSP Contract, Section 3.8	Monthly: 15th of every month Quarterly: January 30, April 30, July 30, October 30	X	X	X	X	X	X
274 Provider Directory – Kaiser	Kaiser is required to submit managed care provider data in a national standard transaction in compliance with the Accredited Standards Committee (ASC) X12N 274 version 4050X109 Implementation Guide and the most recent DHCS 274 Companion Guide. The report includes the following: • Provider and Group name, NPI, TIN, taxonomy and effective/term date(s). • Site name, bed counts, membership min/max, demographics, language(s) spoken, schedule, ownership. • Provider name, membership min/max, demographics, language(s) spoken, schedule, telehealth status.	CalOptima Policy: HH.2003 Health Network and Delegated Entity Reporting; CalOptima Policy: EE.1101 Additions, Changes, and Terminations to Provider Information CalOptima Provider Directory and Web-based Directory; DHCS Medi-Cal Contract: Exhibit A, Attachment 3; NCQA Element MED14B: Pharmacy Directory Data; NCQA Element MED14C: Behavioral Healthcare Directory Data;	Monthly: 2nd of every month	X				X	

REPORT NAME	DESCRIPTION/REQUIREMENT	CITATION	REPORT FREQUENCY	LINE OF BUSINESS			REPORT REQUIREMENT INDICATOR		
				Medi-Cal	OneCare	OneCare Connect	Health Networks (Except Kaiser)	Kaiser	VSP
		NCQA Element MED14D: Long-Term Services and Supports Provider Directory Data							
Provider Termination Quarterly Report	Monitor adherence to CalOptima's Delegation Agreement for NCQA MED 1: Medicaid Benefits and Services, Element H: Notification of Termination of a Practitioner or Practice Group and monitor Kaiser to ensure written notification is issued to affected members within 15 calendar days after receipt or issuance of the termination notice. The report includes the following: • Termination Date • Providers Name • Provider Type • Did the Termination Result in One or More of the Annual Network Certification Components to No Longer be Compliant? (Y/N) • Impacted County • Date Member Notice was mailed • Number of Members Impacted (As of Date Notice Received) • Number of Members that were Reassigned Outside of the Time and Distance Standards • Is an Accessibility Analysis or AAS Request Being Submitted with this Report? • Enter the Number of Days' Notice the Provider gave the MCP • Enter the Provider ID • Enter the Provider NPI • Enter the Provider Termination Reason • Indicate if the Provider is CCS Paneled? (Y/N)	CalOptima Policy HH.2003: Health Network and Delegated Entity Reporting; NCQA Element MED1H: Notification of Termination of a Practitioner or Practice Group Standard	Monthly: 15th of the month with all mandatory fields populated	X			X	X	
UM Retrospective Appeal Universe	Monitor the Health Networks' handling of first level UM Provider Appeals. The report includes the following: • Member Name • ID Number (CIN) • LOB • Request Type • Date the Request was Received • Time the request was received • Was the AR requested as expedited? • Was the AR processed under the expedited timeframe? • Was a timeframe extension taken? • Procedure Codes Requested • Diagnosis Code(s), (ICD-10) • Decision Date • Decision Time • Action (Approved, Modified, Denied) • Authorization Number • Provider Notification Date	CalOptima Health Network Contract Section 4.9.7: Provider Level 1 UM Appeals	Quarterly: 10th of the month following the end of each quarter	X	X	X	X	X	

REPORT NAME	DESCRIPTION/REQUIREMENT	CITATION	REPORT FREQUENCY	LINE OF BUSINESS			REPORT REQUIREMENT INDICATOR		
				Medi-Cal	OneCare	OneCare Connect	Health Networks (Except Kaiser)	Kaiser	VSP
	• Provider Notification Time • Provider Written Notification Date • Provider Written Notification Time • Member Written Notification Date • Member Written Notification Time • Threshold Language • Was an Appeal Received (Y/N)? • Date Appeal was Received • Date of Appeal Decision • Decision (Approved, Modified, Denied) • Provider Written Appeal Notification Date								
Semi-Annual Site Visit Report - Kaiser	The report captures sites that received an Initial or Periodic FSR/MRR. The report includes the following: • Site ID • Site Address • Suite No. • City • State • Zip • County • Plan# • Health Plan Name • Site Specific Certification #1-#4 • Provider Phone # • Clinic Type • Reviewer ID	DHCS APL 20-006: Site Reviews: Facility Site Review and Medical Record Review NCQA Elements MED 3B and MED 5B	Semi-Annually: February 15 and August 15	X				X	
Kaiser Pharmacy Monitoring Report	Monitor Kaiser's compliance with requirements related to pharmacy benefits information and updates. The report includes the following: • Samples of pharmacy information as displayed on Kaiser's website and/or member portal. • Samples showing updates to pharmacy information displayed on Kaiser's website and/or member portal.	NCQA Elements ME 5A, ME 5B, ME 5C, ME 5D	Semi-Annually: April 1 and October 1	X				X	
Medi-Cal Continuity of Care (COC)	Monitor health network compliance with DHCS Continuity of Care requirements. The report includes the following: • Member CIN • COC Request Information (Record Type [Original, Resubmission, Void], Parent COC ID [If Resubmission or Void], COC Receive Date and Type) • COC Benefit Type • COC Disposition • COC Expiration Date • COC Denial Reason Indicator	DHCS Medi-Cal Contract, Exhibit A: Attachment 4, Provision 6 Attachment 11, Provision 10	Monthly: 1st Tuesday of each month	X			X	X	

REPORT NAME	DESCRIPTION/REQUIREMENT	CITATION	REPORT FREQUENCY	LINE OF BUSINESS			REPORT REQUIREMENT INDICATOR		
				Medi-Cal	OneCare	OneCare Connect	Health Networks (Except Kaiser)	Kaiser	VSP
	• Submitting and COC Provider NPIs • Provider Taxonomy								

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action to be Taken October 7, 2021
Regular Meeting of the CalOptima Board of Directors

Report Item

19. Consider Authorizing Contract and Funding with Miller Geer & Associates for External Communications Support Services

Contacts

Rachel Selleck, Executive Director, Public Affairs, (657) 900-1096
Janis Rizzuto, Director, Communications, (714) 246-8837

Recommended Actions

1. Authorize the Chief Executive Officer (CEO), with the assistance of Legal Counsel, to execute a contract with Miller Geer & Associates, effective August 1, 2021, through June 30, 2022, for external communications support services at a fixed monthly rate of $12,000; and
2. Authorize unbudgeted expenditures in an amount not to exceed $132,000 from existing reserves to fund the contract through June 30, 2022.

Background

As part of CalOptima's ongoing communications efforts, staff respond to urgent and emerging issues that require external messaging and media engagement, to mitigate any adverse impact to the agency's brand or reputation. Given the fast pace and potential need for immediate response, the CalOptima Board of Directors Ad Hoc committee, which includes Chair Andrew Do, Vice Chair Clayton Corwin, Director Scott Schoeffel and Director Clayton Chau, M.D., overseeing CalOptima's response to the Centers for Medicare & Medicaid Services audit, directed staff to engage the services of Miller Geer & Associates, a health care public relations and marketing communications firm. The Board Ad Hoc believes Miller Geer has unique capabilities to support CalOptima, including extensive contacts within both the general media as well as the specialized health care industry media, deep experience managing those relationships to benefit CalOptima, and the ability to supply services quickly and reliably upon CalOptima's request. Further, Miller Geer will engage as needed with all CalOptima parties, including staff, Board members and related consultants.

Given the urgent need identified by the Board Ad Hoc for external communications support about subjects including but not limited to regulatory audits, leadership transitions, new program implementations and pandemic response, the CalOptima Board Ad Hoc has selected Miller Geer as a sole-source vendor and recommends Board of Directors approval.

Discussion

Given the emerging need for external communications response identified by the Board Ad Hoc, CalOptima seeks to amplify staff efforts by engaging Miller Geer as a vendor contractually obligated to deliver products/services within specified and quick turnaround times. Depending on the situation, the assignment may include communications plans, talking points, media statements and the like, with deadlines based on the scope of work.

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At the direction of the Board Ad Hoc, CalOptima's Executive Director, Public Affairs and Director, Communications will be responsible for directing and monitoring Miller Geer's work, including approving all materials/services and measuring the impact of said materials/services.

The Board Ad Hoc believes that with the support of Miller Geer for external communications, CalOptima is better equipped to ensure message readiness and timely response.

Fiscal Impact

The recommended actions are unbudgeted. An appropriation of up to $132,000 from existing reserves will fund these actions through June 30, 2022.

Rationale for Recommendation

The Board Ad Hoc recommends Board authorization of a contract with Miller Geer & Associates for external communications services to support the agency's response to urgent and emerging issues and maintain the CalOptima brand and reputation.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. Entities Covered by This Recommended Board Action
2. Contract #22-10159 between CalOptima and Miller Geer & Associates

/s/ Richard Sanchez *09/29/2021*
Authorized Signature **Date**

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Attachment to the October 7, 2021 Board of Directors Meeting – Agenda Item 19

ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Legal Name	Address	City	State	Zip Code
Miller Geer and Associates	3532 Katella Ave, UNIT 110	Los Alamitos	CA	90720

CONTRACT NO. 22-10159
BETWEEN
ORANGE COUNTY HEALTH AUTHORITY, A PUBLIC AGENCY, dba
ORANGE PREVENTION & TREATMENT INTEGRATED MEDICAL ASSISTANCE, dba
CALOPTIMA
And
MILLER GEER AND ASSOCIATES
(CONTRACTOR)

THIS CONTRACT ("Contract") is made and entered into as of August 1st, 2021, by and between the Orange County Health Authority, dba CalOptima, a public agency, hereinafter referred to as "CalOptima" and Miller Geer and Associates, a Corporation, hereinafter referred to as "CONTRACTOR." CalOptima and CONTRACTOR shall be referred to herein collectively as the "Parties" or individually as a "Party."

RECITALS

A. CalOptima desires to retain a CONTRACTOR to provide Crisis Communication Support Services, as described in the Scope of Work; and

B. CONTRACTOR provides such services; and

C. CONTRACTOR represents and warrants that it has the requisite personnel and experience and is capable of performing such services; and

D. CONTRACTOR desires to perform these services for CalOptima; and

E. CalOptima and CONTRACTOR desire to enter into this Contract on the terms and conditions set forth herein below.

NOW, THEREFORE, in consideration of their mutual and respective promises, and subject to the terms and conditions hereinafter set forth, the Parties agree as follows:

1. Documents Constituting Contract. This Contract shall include the following documents ("Contract Documents"), in the order of descending precedence: (i) this Contract, inclusive of all its exhibits and attachments, and any amendments thereto. Any new terms and conditions attached to CONTRACTOR's best and final offer, proposal, invoices, or request for payment, shall not be incorporated into the Contract Documents or be binding upon CalOptima unless expressly accepted by CalOptima in writing. All documents attached to this Contract and/or referenced herein as a "Contract Document" are incorporated into this Contract by this reference, with the same force and effect as if set forth herein in their entirety. Changes hereto shall not be binding upon CalOptima except when specifically confirmed in writing by an authorized representative of CalOptima and issued in accordance with Section 17, Modifications, herein. In the event of any conflict of provisions among the documents constituting the Contract, the provisions shall prevail in the above-referenced descending order of precedence.

2. Statement of Work.

2.1 CONTRACTOR shall perform the work necessary to complete, in a manner satisfactory to CalOptima, and if applicable, to the Centers for Medicare and Medicaid Services ("CMS"), the California Department of Health Care Services ("DHCS"), and/or the California Department of Managed Health Care ("DMHC"), as applicable, the services set forth in Exhibit A entitled "Scope of Work," which is attached hereto and incorporated herein by this reference.

2.2 CONTRACTOR shall provide the personnel listed below to perform the above-specified services, which persons are hereby designated as key personnel under this Contract. No person named in this Section 2, or his/her successor approved by CalOptima, shall be removed or replaced by CONTRACTOR, nor shall his/her agreed-upon function or level of commitment hereunder be

changed without the prior written consent of CalOptima.

Name	Function/Title
Jay Geer	President
James Chisum	Vice President
Nancy Franklin	Special Consultant

3. Insurance.

3.1 Prior to undertaking performance of services under this Contract and at all times during performance hereunder, and entirely at CONTRACTOR's sole expense, CONTRACTOR shall maintain the following insurance, which shall be full-coverage insurance not subject to self-insurance provisions, and CONTRACTOR shall not of its own initiative cause such insurance to be canceled or materially changed during the term of this Contract:

3.1.1 Required Insurance:

3.1.1.1 Commercial General Liability, including Contractual liability and coverage for Independent Contractors on an occurrence basis on an ISO form GC 00 01 or equivalent covering bodily injury and property damage with the following minimum liability limits:

3.1.1.2 Per Occurrence: $1,000,000

3.1.1.3 Personal Advertising Injury: $1,000,000

3.1.1.4 Products Completed Operations: $2,000,000

3.1.1.5 General Aggregate: $2,000,000

3.1.2 Commercial Automobile Liability covering any auto, whether owned, leased, hired, or rented, on an ISO form CA 0001 or equivalent in the amount of $1,000,000 combined single limit for bodily injury or property damage.

3.1.3 Workers' Compensation and Employers' Liability Policy written in accordance with the laws of the State of California and providing coverage for all of CONTRACTOR's employees:

3.1.3.1 This policy must provide statutory coverage for Workers' Compensation.

3.1.3.2 This policy must also provide coverage for $1,000,000 Employers' Liability for each employee, each accident, and in the general aggregate.

3.1.4 Professional Liability insurance covering the CONTRACTOR's professional errors and omissions with the following minimum limits of insurance:

3.1.4.1 Per occurrence: $1,000,000

3.1.4.2 General aggregate: $2,000,000

3.1.5 Commercial crime policy covering employee theft and dishonesty, forgery and alteration, money orders and counterfeit currency, credit card fraud, wire transfer fraud, and theft of client property, with the following minimum limits of $1,000,000 per occurrence:

3.1.5.1 Cyber and Privacy Liability insurance with the following minimum limits of insurance covering claims involving privacy violations, information theft, damage to or destruction of electronic information, intentional and/or unintentional release of private information, alteration of electronic information, extortion and network security. Such coverage is required only if any products and/or services related to information technology (including hardware and/or software) are provided to Insured and for claims involving any professional services for which CONTRACTOR is engaged with Insured for such length of time as necessary to cover any and all claims.

a) Privacy and Network Liability: $1,000,000

b) Internet Media Liability: $1,000,000

c) Business Interruption & Expense: $1,000,000

d) Data Extortion: $1,000,000

e) Regulatory Proceeding: $1,000,000

f) Data Breach Notification & Credit Monitoring: $1,000,000

3.2 Prior to commencement of any work hereunder, CONTRACTOR shall furnish to CalOptima's Purchasing Department additional insured endorsements and also broker-issued Certificate(s) of Insurance showing the required insurance coverages for CONTRACTOR, and further providing that:

Certificate Requirements:

3.2.1 CalOptima's officers, officials, directors, employees, agents, and volunteers are to be covered as additional insureds with respect to liability arising out of work or operations performed by or on behalf of CONTRACTOR including materials, parts, or equipment furnished in connection with such work or operations. This provision applies to CONTRACTOR's General Liability and Auto Liability policies and must be on ISO form CG 20 10 or equivalent.

3.2.2 For any claims related to this contract, the CONTRACTOR's insurance coverage shall be primary insurance as respects to CalOptima, its officers, officials, directors, employees, agents, and volunteers. This provision applies to the CONTRACTOR's General Liability, Auto Liability and Workers' Compensation and Employers' Liability policies.

3.2.3 The Insurance Company agrees to waive all rights of subrogation against CalOptima and its elected or appointed officers, officials, directors, agents, and employees for losses paid under the terms of any policy which arise from work performed by the CONTRACTOR for CalOptima. This provision applies to the CONTRACTOR's General Liability, Auto Liability and Workers' Compensation and Employers Liability policies.

3.2.4 Insurance is to be placed with insurers with a current A.M. Best rating of no less than A-VII, unless otherwise acceptable to CalOptima.

3.2.5 CONTRACTOR shall furnish CalOptima with original certificates and amendatory endorsements affecting coverage required by this clause. All certificates and endorsements are to be received and approved by CalOptima before work commences. CalOptima reserves the right to require complete, certified copies of all required insurance policies,

including endorsements affecting the coverage required by these specifications, at any time.

3.2.6 Any deductibles or self-insured retentions must be declared to and approved by CalOptima. CalOptima may require the CONTRACTOR to purchase coverage with a lower deductible or retention or provide proof of ability to pay losses and related investigations, claim administration, and defense expenses within the retention or deductible.

3.2.7 All deductibles and retentions that the aforementioned policies contain are the responsibility of the CONTRACTOR and in no way shall CalOptima be responsible for payment of the deductibles/retentions.

3.2.8 If CONTRACTOR maintains higher limits than the minimums required above, CalOptima requires and shall be entitled to coverage for the higher limits maintained by CONTRACTOR. Any available insurance proceeds in excess of the specified minimum limits of insurance and coverage shall be available to CalOptima.

3.2.9 Thirty (30) days prior written notice of cancellation be given to CalOptima.

3.3 If CONTRACTOR fails or refuses to maintain or produce proof of the insurance required by this Section 3, CalOptima shall have the right, at its election, to terminate forthwith this Contract. Such termination shall not affect CONTRACTOR'S right to be paid for its time and materials expended prior to notification of termination. CONTRACTOR waives the right to receive compensation and agrees to indemnify CalOptima for any work performed prior to approval of insurance by CalOptima

3.4 The requirement for carrying the required insurance shall not derogate from the provisions for indemnification of CalOptima.

3.5 CONTRACTOR shall require each of its subcontractors who perform services related to this Contract, if any, to maintain insurance coverage that meets all of the requirements set forth herein.

3.6 "Occurrence," as used herein, means any event or related exposure to conditions that result in bodily injury or property damage.

4. Indemnification.

4.1 To the fullest extent permitted by law, CONTRACTOR agrees to and shall save, defend, indemnify, and hold harmless CalOptima and its respective officers, directors, agents, volunteers, consultants and employees (individually and collectively referred to as "Indemnified Parties") from and against any liability whatsoever, based or asserted upon any services of the CONTRACTOR, its officers, employees, subcontractors, agents, or representatives (individually and collectively referred to as "Indemnitors") arising out of or in any way relating to this Contract, including but not limited to property damage, bodily injury, or death or any other element of any kind or nature whatsoever arising from the performance of Indemnitors under this Contract. CONTRACTOR shall defend the Indemnified Parties in any claim or action based upon any such alleged acts or omissions, at its sole expense, which shall include all costs and fees, including, but not limited to, attorneys' fees, cost of investigation, defense, and settlement or awards. CalOptima may make all reasonable decisions with respect to its representation in any legal proceeding.

4.2 CONTRACTOR's obligation to indemnify hereunder is in addition to any liability CONTRACTOR may have to CalOptima for a breach by CONTRACTOR of any of the provisions of this Contract. Under no circumstances shall the insurance requirements and limits set forth in this Contract be construed to limit CONTRACTOR's indemnification and duty to defend obligation or other liability hereunder. The terms of this Contract are contractual and the result of negotiation between the Parties hereto. Accordingly, any rule of construction of contracts (including, without limitation,

California Civil Code Section 1654) that ambiguities are to be construed against the drafting party, shall not be employed in the interpretation of this Contract.

4.3 CONTRACTOR's duty to defend herein is wholly independent of and separate from the duty to indemnify and such duty to defend shall exist regardless of any ultimate liability of CONTRACTOR, save and except Claims arising through the sole negligence or sole willful misconduct of CalOptima.

4.4 It is expressly understood and agreed that the foregoing provisions are intended to be as broad and inclusive as permitted by the law of the State of California and that CONTRACTOR's indemnification and duty to defend obligation hereunder shall survive the expiration or earlier termination of this Contract until such time as action against the Indemnified Parties for such matter indemnified hereunder is fully and finally barred by the applicable statute of limitations, including but not limited to those set forth under the California Government Claims Act (Cal. Gov. Code §900 et seq.).

4.5 The terms of this Section shall survive the termination of this Contract.

5. Independent Contractor. CalOptima and CONTRACTOR agree that CONTRACTOR, which term shall include any and all subcontractors, and any agents or employees of the CONTRACTOR, in performance of this Contract, shall act in an independent capacity, and not as officers or employees of CalOptima. CONTRACTOR's relationship with CalOptima in the performance of this Contract is that of an independent contractor. CONTRACTOR's personnel performing services under this Contract shall be at all times under CONTRACTOR's exclusive direction and control, and shall be employees of CONTRACTOR and not employees of CalOptima. CONTRACTOR shall pay all wages, salaries and other amounts due its employees in connection with this Contract, and shall be responsible for all reports and obligations respecting them, such as social security, income tax withholding, unemployment compensation, workers' compensation, and similar matters. At CONTRACTOR's expense as described herein, CONTRACTOR agrees to defend, indemnify, and hold harmless CalOptima, its officers, agents, employees, members, subsidiaries, joint venture partners, and predecessors and successors in interest from and against any claim, action, proceeding, liability, loss, damage, cost, or expense, including, without limitation, attorneys' fees as provided herein arising out of CONTRACTOR's alleged failure to pay, when due, all such taxes and obligations (collectively referred to for purposes of this paragraph as "Employment Claim(s)"). CONTRACTOR shall pay to CalOptima any expenses or charges relating to or arising from any such Employment Claim(s) as they are incurred by CalOptima.

6. Assignments; Subcontracts.

6.1 Except as specifically permitted hereunder, CONTRACTOR may not assign, transfer, delegate or subcontract any interest herein, either in whole or in part, without the prior written consent of CalOptima, which consent may be withheld in its sole and absolute discretion. In the event CalOptima provides such prior written consent, CONTRACTOR acknowledges and agrees that such assignment, transfer, delegation, or subcontract may additionally be subject to the prior written approval of DHCS. Any assignment, transfer, delegation, or subcontract made without CalOptima's express written consent shall be deemed void.

6.2 For purposes of this Section and this Contract, assignment is: (1) the change of more than twenty-five percent (25%) of the ownership or equity interest in CONTRACTOR (whether in a single transaction or in a series of transactions); (2) the change of more than twenty-five percent (25%) of the directors or trustees of CONTRACTOR (whether in a single transaction or in a series of transactions); (3) the merger, reorganization, or consolidation of CONTRACTOR with another entity with respect to which CONTRACTOR is not the surviving entity; and/or (4) a change in the management of CONTRACTOR from management by persons appointed, elected or otherwise selected by the governing body of CONTRACTOR (e.g. the Board of Directors) to a third-party management person, company, group, team or other entity.

6.3 In the event that CONTRACTOR is allowed to subcontract for services under this Contract, and does so subcontract, then CONTRACTOR shall, upon request, provide copies of such subcontracts to CalOptima or DHCS.

7. Non-Exclusive Relationship. It is understood by the parties that this is a non-exclusive relationship between CalOptima and CONTRACTOR. CalOptima shall have the right to have any of the services that are the subject of this Contract performed by CalOptima personnel or enter into contractual arrangements with one or more contractors who can provide CalOptima with similar or like services.

8. Compliance with Applicable Law and Policies. CONTRACTOR warrants that, in the performance of this Contract, it shall, at its own expense, observe and comply with all applicable federal, state, and local laws, and CalOptima Policies relating to services under the Contract that are in effect when this Contract is signed or which may come into effect during the term of this Contract.

9. Nondiscrimination Clause Compliance.

9.1 During the performance of this Contract, CONTRACTOR and its subcontractor(s) shall not unlawfully discriminate, harass, or allow harassment, against any employee or applicant for employment because of sex, race, color, ancestry, religious creed, national origin, physical disability, including Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS), AIDS-Related Complex (ARC), mental disability, medical condition (including cancer), age (over 40), marital status, and the use of family and medical care leave and pregnancy disability leave. CONTRACTOR and subcontractor(s) shall insure that the evaluation and treatment of their employees and applicants for employment are free from discrimination and harassment. CONTRACTOR and subcontractor(s) shall comply with the provisions of the Fair Employment and Housing Act (Government Code, Section 12900 et seq. and the applicable regulations promulgated thereunder Title 2, CCR, Section 7285.0 et seq.). The applicable regulations of the Fair Employment and Housing Commission implementing Government Code, Section 12990 (a-f), set forth in Chapter 5 of Division 4, Title 2, CCR are incorporated into this Contract by reference and made a part hereof as if set forth in full. CONTRACTOR and its subcontractor(s) shall give notice of their obligations under this clause to labor organizations with which they have a collective bargaining or other agreement. CONTRACTOR shall also fully comply with the following, to the extent applicable to the services provided by CONTRACTOR under this Contract: Title VI of the Civil Rights Act of 1964, 42 USC Section 2000d (race, color, national origin); Section 504 of the Rehabilitation Act of 1973 (29 USC §794) (nondiscrimination under Federal grants and programs); Title 45 CFR Part 84 (nondiscrimination on the basis of handicap in programs or activities receiving Federal financial assistance); Title 28 CFR Part 36 (nondiscrimination on the basis of disability by public accommodations and in commercial facilities); Title IX of the Education Amendments of 1973 (regarding education programs and activities); Title 45 CFR Part 91 and the Age Discrimination Act of 1975 (nondiscrimination based on age); as well as California Government Code Section 11135 (ethnic group identification, religion, age, sex, color, physical or mental handicap); California Civil Code Section 51 (all types of arbitrary discrimination); and all rules and regulations promulgated pursuant thereto.

9.2 CONTRACTOR shall include the nondiscrimination and compliance provisions of Section 9 in all subcontracts under this Contract.

10. Prohibited Interest.

10.1 CONTRACTOR shall comply with all applicable federal, state, and local laws and regulations pertaining to conflict of interest laws, including but not limited to CalOptima's Conflict of Interest Code, the California Political Reform Act (Government Code Section 81000 et seq.) and Government Code Section 1090 et seq. (collectively, the "Conflict of Interest Laws").

10.2 CONTRACTOR covenants that, for the term of the Contract, no director, officer, or employee of CalOptima during his tenure has any interest, direct or indirect, in this Contract or the proceeds thereof. CONTRACTOR further covenants that, for the term of this Contract, and consistent with the provisions of Title 22 California Code of Regulations (CCR) Section 53600(f), no state officer or state employee shall be employed in a management or contractor position by CONTRACTOR within one year after the state office or state employee has terminated state employment.

10.3 No employee, officer or agent of CalOptima shall participate in the selection, award or administration of an agreement, or in any decision that may have foreseeable impact on CONTRACTOR if a conflict of interest, real or implied, exists. Such a conflict arises when any of the following has a financial or other interest in the firm selected for award:

10.3.1 A CalOptima employee, officer or agent;

10.3.2 Any member of the employee, officer or agent's immediate family;

10.3.3 The employee, officer or agent's domestic or business partner; and

10.3.4 An organization that employs or is about to employ any of the above.

10.4 CONTRACTOR understands that, if this Contract is made in violation of Government Code Section 1090 et seq., the entire Contract is voidable and CONTRACTOR will not be entitled to any compensation for Services performed pursuant to this Contract and CONTRACTOR will be required to reimburse CalOptima any sums paid to CONTRACTOR. CONTRACTOR further understands that, in addition to the foregoing, CONTRACTOR may be subject to criminal prosecution for a violation of Government Code Section 1090.

10.5 If CONTRACTOR hereinafter becomes aware of any facts, which might reasonably be expected to either create a conflict of interest under the Conflict of Interest laws or violate the provisions of this Section, CONTRACTOR shall immediately make full written disclosure of such acts to CalOptima. Full written disclosure shall include, without limitation, identification of all persons, entities and businesses implicated and a complete description of all relevant circumstances.

11. Disclosure of Officers, Owners, Stockholders and Creditors. On an annual basis and within thirty (30) days of any changes, CONTRACTOR shall identify the names of the following persons by listing them on Exhibit I, attached hereto and incorporated by this reference:

11.1 All officers and owners who own greater than 5% of the CONTRACTOR; and

11.2 All stockholders owning greater than 5% of any stock issued by CONTRACTOR.

11.3 All creditors of CONTRACTOR's business if such interest is over 5%.

12. Equal Opportunity.

12.1 CONTRACTOR and its Subcontractors will not discriminate against any employee or applicant for employment because of race, color, religion, sex, national origin, physical or mental handicap, disability, age or status as a disabled veteran or veteran of the Vietnam era. CONTRACTOR and its Subcontractors will take affirmative action to ensure that qualified applicants are employed, and that employees are treated during employment, without regard to their race, color, religion, sex, national origin, physical or mental handicap, disability, age or status as a disabled veteran or veteran of the Vietnam era. Such action shall include, but not be limited to the following: employment, upgrading, demotion or transfer; recruitment or recruitment advertising; layoff or termination; rates of pay or other forms of compensation; and career development opportunities and selection for training, including apprenticeship. CONTRACTOR and its Subcontractors agree to post in

conspicuous places, available to employees and applicants for employment, notices to be provided by the Federal Government or Department of Health Care Services ("DHCS"), setting forth the provisions of the Equal Opportunity clause, Section 503 of the Rehabilitation Act of 1973, and the affirmative action clause required by the Vietnam Era Veterans' Readjustment Assistance Act of 1974 (38 U.S.C. 4212). Such notices shall state CONTRACTOR and its Subcontractors' obligation under the law to take affirmative action to employ and advance in employment qualified applicants without discrimination based on their race, color, religion, sex, national origin, physical or mental handicap, disability, age or status as a disabled veteran or veteran of the Vietnam era and the rights of applicants and employees.

12.2 CONTRACTOR and its Subcontractors will, in all solicitations or advancements for employees placed by or on behalf of CONTRACTOR and its Subcontractors, state that all qualified applicants will receive consideration for employment without regard to race, color, religion, sex, national origin, physical or mental handicap, disability, age or status as a disabled veteran or veteran of the Vietnam era.

12.3 CONTRACTOR and its Subcontractors will send to each labor union or representative of workers with which it has a collective bargaining agreement or other contract or understanding a notice, to be provided by the Federal Government or the State, advising the labor union or workers' representative of CONTRACTOR and its Subcontractors' commitments under the provisions herein and shall post copies of the notice in conspicuous places available to employees and applicants for employment.

12.4 CONTRACTOR and its Subcontractors will comply with all provisions of and furnish all information and reports required by Section 503 of the Rehabilitation Act of 1973, as amended, the Vietnam Era Veterans' Readjustment Assistance Act of 1974 (38 U.S.C. 4212) and of the Federal Executive Order No. 11246 as amended, including by Executive Order 11375, 'Amending Executive Order 11246 Relating to Equal Employment Opportunity,' and as supplemented by regulation at 41 CFR part 60, "Office of the Federal Contract Compliance Programs, Equal Employment Opportunity, Department of Labor," and of the rules, regulations, and relevant orders of the Secretary of Labor.

12.5 CONTRACTOR and its Subcontractors will furnish all information and reports required by Federal Executive Order No. 11246 as amended, including by Executive Order 11375, 'Amending Executive Order 11246 Relating to Equal Employment Opportunity,' and as supplemented by regulation at 41 CFR part 60, "Office of the Federal Contract Compliance Programs, Equal Employment Opportunity, Department of Labor," and the Rehabilitation Act of 1973, and by the rules, regulations, and orders of the Secretary of Labor, or pursuant thereto, and will permit access to its books, records, and accounts by the State and its designated representatives and the Secretary of Labor for purposes of investigation to ascertain compliance with such rules, regulations, and orders.

12.6 In the event of CONTRACTOR and its Subcontractors' noncompliance with the requirements of the provisions herein or with any federal rules, regulations, or orders which are referenced herein, this Contract may be cancelled, terminated, or suspended in whole or in part, and CONTRACTOR and its Subcontractors may be declared ineligible for further federal and state contracts, in accordance with procedures authorized in Federal Executive Order No. 11246 as amended, and such other sanctions may be imposed and remedies invoked as provided in Federal Executive Order No. 11246 as amended, including by Executive Order 11375, 'Amending Executive Order 11246 Relating to Equal Employment Opportunity,' and as supplemented by regulation at 41 CFR part 60, "Office of the Federal Contract Compliance Programs, Equal Employment Opportunity, Department of Labor," or by rule, regulation, or order of the Secretary of Labor, or as otherwise provided by law.

12.7 CONTRACTOR and its Subcontractors will include the provisions of this section in every subcontract or purchase order unless exempted by rules, regulations, or orders of the Secretary of

Labor, issued pursuant to Federal Executive Order No. 11246 as amended, including by Executive Order 11375, 'Amending Executive Order 11246 Relating to Equal Employment Opportunity,' and as supplemented by regulation at 41 CFR part 60, "Office of the Federal Contract Compliance Programs, Equal Employment Opportunity, Department of Labor," or Section 503 of the Rehabilitation Act of 1973 or (38 U.S.C. 4212) of the Vietnam Era Veteran's Readjustment Assistance Act, so that such provisions will be binding upon each subcontractor or CONTRACTOR. CONTRACTOR and its Subcontractors will take such action with respect to any subcontract or purchase order as the Director of the Office of Federal Contract Compliance Programs or DHCS may direct as a means of enforcing such provisions, including sanctions for noncompliance, provided, however, that in the event CONTRACTOR and its Subcontractors become involved in, or are threatened with litigation by a subcontractor or CONTRACTOR as a result of such direction by DHCS, CONTRACTOR and its Subcontractors may request in writing to DHCS, who, in turn, may request the United States to enter into such litigation to protect the interests of the State and of the United States.

13. Standard of Performance; Warranties.

13.1 CONTRACTOR agrees to perform all work under this Contract with the requisite skill and diligence consistent with professional standards for the industry and type of work performed under this Contract, and pursuant to the governing rules and regulations of the industry.

13.2 In the event that CONTRACTOR is allowed to subcontract for services under this Contract, and does so subcontract, then CONTRACTOR represents and warrants that any individual or entity acting as a subcontractor to this Contract has the appropriate skill and expertise to perform the subcontracted work.

13.3 CONTRACTOR expressly warrants that all material and work will conform to applicable specifications, drawings, description and samples, including, without limitation, CalOptima's designs, drawings, and specifications, and will be merchantable, of good workmanship and material, and free from defect. CONTRACTOR further warrants that all material covered by this Contract, if any, which is the product of CONTRACTOR will be new and unused unless otherwise specified, and shall be fit and sufficient for the purpose intended by CalOptima, as disclosed to CONTRACTOR, CONTRACTOR shall promptly make whatever adjustments or corrections that may be necessary to cure any defects, including repairs of any damage to other parts of the system resulting from such defects. CalOptima shall give notice to CONTRACTOR of any observed defects. In the event that CONTRACTOR fails to make adjustments, repairs, corrections, or other work made necessary by such defects, CalOptima may do so and charge CONTRACTOR the costs incurred.

13.4 CONTRACTOR's warranties, together with its service guarantees, must run to CalOptima and its customers or users of the material and services, and must not be deemed exclusive. CalOptima's inspection, approval, acceptance, use of and payment for all or any part of the material and services must in no way affect its warranty rights whether or not a breach of warranty had become evident in time.

13.5 CONTRACTOR's obligations under this Section are in addition to CONTRACTOR's other express or implied warranties and other obligations under this Contract or state law, and in no way diminish any other rights that CalOptima may have against CONTRACTOR for faulty materials, equipment or work. CalOptima rejects any disclaimer by CONTRACTOR of any warranty, standard, implied or express, unless specifically agreed to in writing by both parties.

13.6 Any CalOptima property damaged by CONTRACTOR, its subcontractor(s), or by the personnel of either, will be subject to repair and replacement by CONTRACTOR at no cost to CalOptima.

14. Compensation.

14.1 Payment.

14.1.1 CalOptima agrees to pay, and CONTRACTOR agrees to accept as full consideration for the faithful performance of this Contract, the rates, charges and other payment terms identified in Exhibit B, which is attached hereto and incorporated herein by this reference.

14.1.2 CalOptima will not reimburse CONTRACTOR any expenses incurred in connection with its performance of the services, unless such reimbursement is specifically authorized in Exhibit B. Each expense reimbursement request, when authorized in Exhibit B must include receipts or other suitable documentation.

14.1.3 CONTRACTOR's requests for payments and reimbursements must comply with the requirements set forth in Exhibit B. CalOptima will not make payment for work that fails to meet the standards of performance as set forth in the Contract and Exhibit A, Scope of Work that may be reasonably expected by CalOptima. **CALOPTIMA SHALL NOT PAY ANY FEES, EXPENSES OR COSTS WHATSOEVER INCURRED BY CONTRACTOR IN RENDERING ADDITIONAL SERVICES NOT AUTHORIZED IN WRITING UNDER THIS CONTRACT.**

14.1.4 In no event shall the total compensation payable to CONTRACTOR for the services performed under this Contract exceed the maximum cumulative payment obligation, as set forth in the attached Exhibit B, without the express prior written authorization of CalOptima. CONTRACTOR shall at all times monitor its costs and expenditures for work performed under this Contract, and shall monitor its invoices, costs, and expenditures, to ensure it does not exceed the maximum cumulative payment obligation set forth herein. CONTRACTOR shall provide CalOptima with 60 days written notice if at any time during this Contract CONTRACTOR becomes aware that it may exceed the maximum cumulative payment obligation authorized under this Contract. **CONTRACTOR ACKNOWLEDGES AND AGREES THAT CALOPTIMA SHALL NOT BE LIABLE FOR ANY FEES, EXPENSES OR COMPENSATION IN EXCESS OF THE MAXIMUM CUMULATIVE PAYMENT OBLIGATION.**

14.1.5 The maximum cumulative payment obligation includes all applicable federal, state, and local taxes and duties, except sales tax, which is shown separately, if applicable. CONTRACTOR is responsible for submitting any withholding exemption forms (e.g., W-9) to CalOptima. Such forms and information should be furnished to CalOptima before payment is made. If taxes are required to be withheld on any amounts otherwise to be paid by CalOptima to CONTRACTOR due to CONTRACTOR'S failure to timely submit such forms, CalOptima will deduct such taxes from the amount otherwise owed and pay them to the appropriate taxing authority, and shall have no liability for or any obligation to refund any payments withheld.

14.2 Contractor Travel Policy. CONTRACTOR is not entitled to any reimbursement for travel, meals, accommodations, or other similar expenses under this Contract.

15. Term. This Contract shall commence on August 1st, 2021, and shall continue in full force and effect through 06/30/2022, unless earlier terminated as provided in this Contract.

16. Termination.

16.1 Termination without Cause. CalOptima may terminate this Contract at any time, in whole or in part, for its convenience and without cause, by giving CONTRACTOR thirty (30) days written notice hereof. Upon termination, CalOptima may pay CONTRACTOR its allowable cost incurred for

services satisfactorily performed and accepted by CalOptima as of the date of termination. Thereafter, CONTRACTOR shall have no further claims against CalOptima under this Contract.

16.2 Termination for Unavailability of Funds. In recognition that CalOptima is a governmental entity and its operations and budgets are determined on an annual basis, CalOptima shall have the right to terminate this Contract as follows:

16.2.1 CalOptima may terminate this Contract if it does not receive funding from the State of California or the federal government, as applicable, for any fiscal year.

16.2.2 In the event of Termination for Unavailability of Funds, as provided in this Section, CalOptima agrees to promptly pay CONTRACTOR all fees and other charges due and payable for services satisfactorily performed and accepted by CalOptima as of the termination date. CONTRACTOR shall not be entitled to payment for any other items, including, without limitation, lost or anticipated profit on work not performed, administrative costs, attorneys' fees, or consultants' fees.

16.2.3 In the event of Termination for Unavailability of Funds, as provided in this Section, and funds are received by CalOptima from the State of California within one-hundred twenty (120) days of the date of termination, then CalOptima shall promptly notify CONTRACTOR in writing and CalOptima shall have the right to reinstate this Contract for that period for which funds are received by CalOptima or the unexpired term of this Contract as of the date of termination, whichever period is shorter in duration. Notwithstanding the foregoing, CalOptima may only reinstate this Contract two (2) times during the Term of this Contract.

16.3 Termination for Default. Subject to a ten (10) day cure period, CalOptima may terminate this Contract for CONTRACTOR's default, or if a federal or state proceeding for the relief of debtors is undertaken by or against CONTRACTOR, or if CONTRACTOR makes an assignment for the benefit of creditors as defined in Section 6, or if CONTRACTOR breaches any term(s) or violates any provision(s) of this Contract and does not cure such breach or violation within ten (10) days after written notice thereof by CalOptima. In the event of Termination for Default, as provided by this Section, CONTRACTOR shall be liable for any and all reasonable costs incurred by CalOptima as a result of such default, including, but not limited to, reprocurement costs of the same or similar services defaulted by CONTRACTOR under this Contract.

16.4 Notwithstanding the foregoing, CalOptima may terminate this Contract immediately upon CONTRACTOR's breach of Section 3, (Insurance), Section 10, (Prohibited Interest), or Section 24, (Confidentiality).

16.5 Effect of Termination. Upon expiration or receipt of a termination notice under this Section:

16.5.1 CONTRACTOR shall promptly discontinue all services (unless the notice directs otherwise), and deliver or otherwise make available to CALOPTIMA all documents, reports, software programs and any other products, data and such other materials, equipment, and information, including but not limited to confidential information, or equipment provided by CalOptima, as may have been accumulated by CONTRACTOR in performing this Contract, whether completed or in process. If CONTRACTOR personnel were granted access to CalOptima's premises and issued a badge or access card, such badge or access card shall be returned prior to departure. Failure to return any information or equipment, badge or access card, is considered a material breach of this Contract and CalOptima's privacy and security rules.

16.5.2 CalOptima may take over the services, and may award another party a contract to complete the services under this Contract.

16.5.3 CalOptima may withhold from payment any sum that it determines to be owed to CalOptima by CONTRACTOR, or as necessary to protect CalOptima against loss due to outstanding liens or claims of former lien holders.

17. Modifications. CalOptima reserves the right to modify the Contract at any time should such modification be required by CMS or applicable law or regulation. Modifications shall be executed only by a written amendment to the Contract, signed by CalOptima and CONTRACTOR. Execution of amendments shall be contingent upon CONTRACTOR's notification to CalOptima, and CalOptima's approval, of any increase or decrease in the price of this Contract or in the time required for its performance.

18. Verification of CalOptima Costs by Government. Until the expiration of ten (10) years after the later of furnishing of any service pursuant to this Contract or completion of any audit, or longer as required by applicable regulations, CONTRACTOR will make available, upon written request of the Secretary of Health and Human Services or the Comptroller General of the United States or any of their duly authorized representatives, or the California Department of Health Care Services, or the California Department of Managed Health Care, or the Department of Justice, or the Bureau of Medical Fraud, copies of this Contract and any financial statements, books, documents, records, patient care documentation, and other records or data of CONTRACTOR that pertain to any aspect of services performed, reconciliation of benefit liabilities, and determination of amounts payable under this Contract, or as are otherwise necessary to certify the nature and extent of costs incurred by CalOptima for such services. This provision shall also apply to any agreement between a subcontractor and an organization related to the subcontractor by control or common ownership. CONTRACTOR further agrees that regulating entities have the right to inspect, evaluate and audit any pertinent information and to facilitate the review of the items referenced herein, to make available its premises, physical facilities and equipment, records related to Medicare enrollees, and any additional relevant information that regulating entities may require. CONTRACTOR further agrees and acknowledges that this provision will be included in any and all agreements with CONTRACTOR's subcontractors.

19. Confidential Material.

19.1 During the term of this Contract, either Party may have access to confidential material or information ("Confidential Information") belonging to the other Party or the other Party's customers, vendors, or partners. "Confidential Information" shall include without limitation the disclosing Party's computer programs and codes, business plans, customer/member lists and information, financial records, partnership arrangements and licensing plans or other information, materials, records, writings or data that is marked confidential or that due to its character and nature, a reasonable person under like circumstances would treat as confidential. Confidential Information will be used only for the purposes of this Contract and related internal administrative purposes. Each Party agrees to protect the other's Confidential Information at all times and in the same manner as each protects the confidentiality of its own confidential materials, but in no event with less than a reasonable standard of care.

19.2 For the purposes of this Section 19, "Confidential Information" does not include information which: (i) is already known to the other Party at the time of disclosure; (ii) is or becomes publicly known through no wrongful act or failure of the receiving Party; (iii) is independently developed without use or benefit of the other's Confidential Information or proprietary information; (iv) is received from a third party which is not under and does not thereby breach an obligation of confidentiality; or (v) is a public record, not exempt from disclosure pursuant to California Public Records Act, Government Code Section 6250 et seq., applicable provisions of California Welfare and Institutions Code or other state or federal laws, regardless of whether such information is marked as confidential or proprietary.

19.3 Disclosure of the Confidential Information will be restricted to the receiving Party's employees, consultants, suppliers or agents on a "need to know" basis in connection with the services performed under this Contract, who are bound by confidentiality obligations no less stringent than these prior

to any disclosure. The receiving Party may disclose Confidential Information pursuant to legal, judicial, or administrative proceeding or otherwise as required by law; providing that the receiving Party shall give reasonable prior notice, if not prohibited by applicable law, to the disclosing Party and shall assist the disclosing Party, at the disclosing Party's expense, to obtain protective or other appropriate confidentiality orders, and further provided that a required disclosure of Confidential Information or proprietary information to an agency or Court does not relieve the receiving Party of its confidentiality obligations with respect to any other party.

19.4 Except as to the confidentiality of trade secrets, these confidentiality restrictions and obligations will terminate five (5) years after the expiration or termination of the Contract, unless the law requires a longer period. Upon written request of the disclosing Party, the receiving Party shall promptly return to the disclosing Party all documents, notes and other tangible materials representing the disclosing Party's Confidential Information or Proprietary Information and all copies thereof. This obligation to return materials or copies thereof does not extend to automatically generated computer backup or archival copies generated in the ordinary course of the receiving Party's information systems procedures, provided that the receiving Party shall make no further use of such copies.

19.5 For the purposes of this Section only, "Confidential Information" does not include protected health information or individually identifiable information, as defined by the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and other privacy statutes or regulations. The access, use and disclosure of Protected Health Information is referenced below in Section 24, and shall be governed by a Business Associate Protected Health Information Disclosure Agreement, which shall be executed by the parties if CONTRACTOR will create, receive, maintain, use, or transmit Protected Health Information in performing services under this Contract.

20. Record Ownership and Retention.

20.1 The originals of all letters, documents, reports, software programs and any other products and data prepared or generated for the purposes of this Contract shall be delivered to, and become the property of CalOptima at no cost to CalOptima and in a form accessible for CalOptima's use. Copies may be made for CONTRACTOR's records, but shall not be furnished to others without written authorization from CalOptima. Such deliverables shall become the sole property of CalOptima and all rights in copyright therein shall be retained by CalOptima. CalOptima's ownership of these documents includes use of, reproduction or reuse of, and all incidental rights. CONTRACTOR shall provide all deliverables within a reasonable amount of time upon CalOptima's request, but in no event shall such time exceed thirty (30) calendar days unless otherwise specified by CalOptima.

20.2 CONTRACTOR hereby assigns to CalOptima all of its rights in all materials prepared by or on behalf of CalOptima under this Contract ("Works"), and this Contract shall be deemed a transfer to CalOptima of the sole and exclusive copyright of any copyrightable subject matter CONTRACTOR created in these Works. CONTRACTOR agrees to cause its agents and employees to execute any documents necessary to secure or perfect CalOptima's legal rights and worldwide ownership in such materials, including, but not limited to, documents relating to patent, trademark and copyright applications. Upon CalOptima's request, CONTRACTOR will return or transfer all property and materials, including the Works, in CONTRACTOR's possession or control belonging to CalOptima.

20.3 Notwithstanding the foregoing, CONTRACTOR's intellectual property ("CONTRACTOR IP") that preexists this Contract shall remain the sole and exclusive property of CONTRACTOR. CONTRACTOR shall not incorporate any CONTRACTOR IP into the Works that would limit CalOptima's use of the Works without CalOptima's written approval. To the extent that CONTRACTOR incorporates any CONTRACTOR IP into the Works, CONTRACTOR hereby grants to CalOptima a non-exclusive, irrevocable, perpetual, worldwide, royalty-free license to use and reproduce the CONTRACTOR IP to the extent required to fully utilize the Works.

20.4 CONTRACTOR acknowledges and agrees that, notwithstanding any provision herein to the contrary, CalOptima's Intellectual Property ("CalOptima IP") in the information, documents and other materials provided to CONTRACTOR shall remain the sole and exclusive property of CalOptima. Any information, documents or materials provided by CalOptima to CONTRACTOR pursuant to this Contract and all copies thereof (including without limitation CalOptima IP, Proprietary Information and Confidential Information, as these terms are defined in Section 19) shall upon the earlier of CalOptima's request or the expiration or termination of this Contract be returned to CalOptima.

20.5 For purposes of this Section, Intellectual Property shall mean patents, copyrights, trademarks, trade secrets, and other proprietary information.

21. Patent and Copyright Infringement. In lieu of any other warranty by CalOptima or CONTRACTOR against infringement, statutory or otherwise, it is agreed that CONTRACTOR shall indemnify, hold harmless and defend, at its expense, any suit against CalOptima based on a claim that any item furnished under this Contract, or the normal use or sale thereof, infringes on any United States letters patent, patent, trademark, copyright, or other intellectual property right, and shall pay costs and damages finally awarded in any such suit, provided that CONTRACTOR is notified in writing of the suit and given authority, information, and assistance at CONTRACTOR's expense for the defense of the suit. CONTRACTOR, at no expense to CalOptima, shall obtain for CalOptima the right to use and sell said item, or shall substitute an equivalent item acceptable to CalOptima and extend this patent indemnity thereto.

22. Names and Marks. Neither Party shall use the name, logo or other proprietary mark of the other in any press release, advertising, promotional, marketing or similar publicly disseminated material without first submitting such material to the other Party and obtaining the other Party's express written approval of the material and consent to such use.

23. Business Associate Protected Health Information Disclosure Agreement. This Contract does not require or permit CONTRACTOR to create, receive, maintain, use, or transmit Protected Health Information. As such, no Business Associate Agreement is required for this Contract.

24. Confidentiality of Member Information.

24.1 CONTRACTOR and its employees, agents, or subcontractors shall protect from unauthorized disclosure, the names and other identifying information concerning persons either receiving services pursuant to this Contract, or persons whose names or identifying information become available or are disclosed to CONTRACTOR, its employees, agents, or subcontractors as a result of services performed under this Contract, except for statistical information not identifying any such person. CONTRACTOR and its employees, agents, or subcontractors shall not use such identifying information for any purpose other than carrying out CONTRACTOR's obligations under this Contract. CONTRACTOR and its employees, agents, or subcontractors shall promptly transmit to CalOptima all requests for disclosure of such identifying information not emanating from the Member. CONTRACTOR shall not disclose, except as otherwise specifically permitted by this Contract or authorized by the Member, any such identifying information to anyone other than DHCS or CalOptima without prior written authorization from CalOptima. For purposes of this provision, identity shall include, but not be limited to, name, identifying number, symbol, or other identifying particular assigned to the individual, such as finger or voice print or a photograph.

24.2 Names of persons receiving public social services are confidential and are to be protected from unauthorized disclosure in accordance with Title 42 CFR Section 431.300 et seq., Section 14100.2, Welfare and Institutions Code, and regulations adopted thereunder. For the purpose of this Contract, all information, records, data, and data elements collected and maintained for the operation of the Contract and pertaining to Members shall be protected by CONTRACTOR from unauthorized disclosure. CONTRACTOR may release Medical Records in accordance with applicable law pertaining to the release of this type of information. CONTRACTOR is not required to report

requests for Medical Records made in accordance with applicable law. With respect to any identifiable information concerning a Member under this Contract that is obtained by CONTRACTOR or its Subcontractors, CONTRACTOR:

24.2.1 Will not use any such information for any purpose other than carrying out the express terms of this Contract;

24.2.2 Will promptly transmit to CalOptima all requests for disclosure of such information, except requests for Medical Records in accordance with applicable law;

24.2.3 Will not disclose, except as otherwise specifically permitted by this Contract, any such information to any party other than DHCS or CalOptima without CalOptima's prior written authorization specifying that the information is releasable under Title 42 CFR Section 431.300 et seq., Section 14100.2, Welfare and Institutions Code, and regulations adopted there under; and

24.2.4 Will, at the termination of this Contract, return all such information to CalOptima or maintain such information according to written procedures sent to the CONTRACTOR by CalOptima for this purpose.

24.3 CONTRACTOR agrees to complete a CalOptima Medi-Cal Data Access Agreement, which is attached hereto as Exhibit D and incorporated herein by this reference. All materials covered under this Medi-Cal Data Access Agreement shall be designated confidential, to the extent permitted by California law.

25. Medicare Advantage Program. Medicare Advantage Program requirements are not applicable under this Contract.

26. Time is of the Essence. Time is of the essence in performance of this Contract.

27. CalOptima Designee. The Chief Executive Officer of CalOptima, or his designee, shall have the authority to act for and exercise any of the rights of CalOptima, as set forth in this Contract, subsequent to and in accordance with the authority granted by the Board of Directors.

28. Omissions. In the event that either party hereto discovers any material omission in the provisions of this Contract which such party believes is essential to the successful performance of this Contract, the party may so inform the other party in writing, and the parties hereto shall thereafter promptly negotiate in good faith with respect to such matters for the purpose of making such reasonable adjustments, as may be necessary to perform the objectives of this Contract.

29. Choice of Law. This Contract shall be governed by and construed in accordance with all laws of the State of California. In the event any party institutes legal proceedings to enforce or interpret this Contract, venue and jurisdiction shall be in the County of Orange, California.

30. Force Majeure. When satisfactory evidence of a cause beyond a party's control is presented to the other party, and nonperformance is unforeseeable, beyond the control, and not due to the fault of the party not performing, a party shall be excused from performing its obligations under this Contract during the time and to the extent that it is prevented from performing by such cause, including, but not limited to, any incidence of fire, flood, acts of God, commandeering of material, products, plants or facilities by the federal, state or local government, or a material act or omission by the other party.

31. Notices. All notices required or permitted under this Contract and all communications regarding the interpretation of the terms of this Contract, or changes thereto, shall be in writing and shall be sent by registered or certified mail, postage prepaid, return receipt requested, or by any other overnight delivery service which delivers to the noticed destination and provides proof of delivery to the sender. All notices

shall be effective when first received at the following addresses set forth below. Any party whose address changes shall notify the other party in writing.

To CONTRACTOR:	To CalOptima:
Miller Geer and Associates	CalOptima
3532 Katella Ave, UNIT 110	505 City Parkway West
Los Alamitos, CA 90720	Orange, CA 92868
Attention: James Chisum	Attention: Ryan Prest

32. Notice of Labor Disputes. Whenever CONTRACTOR has knowledge that any actual or potential labor dispute may delay this Contract, CONTRACTOR shall immediately notify and submit all relevant information to CalOptima. CONTRACTOR shall insert the substance of this entire clause in any subcontract hereunder as to which a labor dispute may delay this Contract.

33. Unavoidable Delays.

33.1 If the delivery of services under this Contract should be unavoidably delayed, CalOptima's Purchasing Department shall extend the time for completion of the Contract for the determined number of days of excusable delay. A delay is unavoidable only if the delay was not reasonably expected to occur in connection with, or during CONTRACTOR's performance, and was not caused directly or substantially by acts, omissions, negligence, or mistakes of CONTRACTOR, CONTRACTOR's subcontractors, or their agents, and was substantial and in fact caused CONTRACTOR to miss delivery dates, and could not adequately have been guarded against by contractual or legal means. Delays caused by CalOptima will be sufficient justification for delay of services, and CONTRACTOR shall be allowed a day-for-day extension.

33.2 CONTRACTOR shall notify CalOptima's Purchasing Department as soon as CONTRACTOR has, or should have, knowledge that an event has occurred that will delay deliveries. Within five (5) working days, CONTRACTOR shall confirm such notice in writing, furnishing as much detail as is available.

33.3 CONTRACTOR agrees to supply, as soon as such data is available, any reasonable proof that is required by CalOptima's Purchasing Department to make a decision on any request for extension. CalOptima's Purchasing Department shall examine the request and any documents supplied by CONTRACTOR and shall determine if CONTRACTOR is entitled to an extension and the duration of such extension. CalOptima's Purchasing Department shall notify CONTRACTOR of this decision in writing. It is expressly understood and agreed that CONTRACTOR shall not be entitled to damages or compensation, and shall not be reimbursed for losses on account of delays resulting from any cause under this provision.

34. No Liability of County of Orange. As required under Ordinance No. 3896 of the County of Orange, State of California, as amended, the parties hereto acknowledge and agree that the obligations of CalOptima under this Contract are solely the obligations of CalOptima, and the County of Orange, State of California, shall have no obligation or liability therefor.

35. Attorneys' Fees. Should either party to this Contract institute any action or proceeding to enforce or interpret this Contract or any provision hereof, or for damages by reason of any alleged breach of this Contract, otherwise arising under this Contract, or for a declaration of rights hereunder, the prevailing party in any such

action or proceeding shall be entitled to receive from the other party all costs and expenses, including, without limitation, reasonable attorneys' fees incurred by the prevailing party in such action or proceeding.

36. Entire Agreement. This Contract, including all exhibits and documents incorporated by reference and all Contract Documents referenced in Section 1 herein, contains the entire agreement between CONTRACTOR and CalOptima with respect to the subject matter of this Contract, and it supersedes all prior written or oral and all or contemporaneous oral agreements, representations, understandings, discussions, negotiations and commitments between CONTRACTOR and CalOptima, whether express or implied, with respect to the subject matter of this Contract.

37. Headings. The section headings used herein are for reference and convenience only and shall not enter into the interpretation hereof.

38. Waiver. No delay or failure by either party hereto to exercise any right or power accruing upon noncompliance or default by the other party with respect to any of the terms of this Contract shall impair such right or power, or be construed to be a waiver thereof. A waiver by either of the parties hereto of a breach of any of the covenants, conditions or agreements to be performed by the other shall not be construed to be a waiver of any succeeding breach thereof, or of any other covenant, condition, or agreement herein contained. Any information delivered, exchanged, or otherwise provided hereunder shall be delivered, exchanged or otherwise provided in a manner that does not constitute a waiver of immunity or privilege under applicable law.

39. California Public Records Act. As a local public agency, CalOptima is subject to the California Public Records Act (California Government Code Sections 6250 et seq.) (the "Public Records Act"). CONTRACTOR hereby acknowledges that any materials, documents, data, or similar items are subject to disclosure upon public request, unless they are exempt from disclosure under the provisions of the Public Records Act. CalOptima may be required to reveal certain information believed to be proprietary or confidential by CONTRACTOR pursuant to the Public Records Act. In the event that CONTRACTOR discloses information that it believes to be proprietary or confidential to CalOptima, it shall mark such information as "Confidential," "Proprietary," or "Restricted" or other similar marking. Unless CONTRACTOR marks its materials as "Confidential," "Proprietary," or "Restricted," and also notifies CalOptima in writing that CONTRACTOR has so marked each piece of material, then CalOptima will not be responsible to take any actions to protect any CONTRACTOR's materials under the Public Records Act that are not so marked. In the event CalOptima receives a request under the Public Records Act that potentially encompasses CONTRACTOR materials that have been properly marked, CalOptima will provide CONTRACTOR with notice thereof to allow CONTRACTOR to take actions it deems appropriate to prevent disclosure of the marked material. CONTRACTOR agrees to defend, indemnify, and hold harmless CalOptima, its officers, agents, employees, members, subsidiaries, joint venture partners, and predecessors and successors in interest from and against any claim, action, proceeding, liability, loss, damage, cost, or expense, including, without limitation, attorneys' fees, and any costs awarded to the person or entity that sought the CONTRACTOR marked material, arising out of or related to CalOptima's failure to produce or provide the CONTRACTOR marked material (collectively referred to for purposes of this Section as "Public Records Act Claim(s)"). CONTRACTOR shall pay to CalOptima any expenses or charges relating to or arising from any such Public Record Act Claim(s) as they are incurred by CalOptima.

40. Audit Disclosure. Pursuant to California Government Code Section 8546.7, if this Contract is over ten thousand dollars ($10,000), it is subject to examination and audit of the State Auditor, at the request of CalOptima, or as part of any audit of CalOptima, for a period of three (3) years after final payment under this Contract. In addition to and notwithstanding any other right of access or inspection that may be otherwise set forth in this Contract or its attachments, CONTRACTOR agrees that, during the term of this Contract and for a period of three (3) years after its termination, CalOptima shall have access to and the right to examine any directly pertinent books, documents, invoices, and records of CONTRACTOR relating to services provided under this Contract. Where another right of access or inspection in this Contract provides for a period of greater than three (3) years, nothing herein shall be construed to shorten that time period.

41. Debarment and Suspension Certification.

41.1 By signing this Contract, the CONTRACTOR agrees to comply with any and all applicable Federal suspension and debarment regulations.

41.2 By signing this Contract, the CONTRACTOR certifies to the best of its knowledge and belief, that it and its principals:

41.2.1 Are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded by any Federal department or agency;

41.2.2 Have not within a three-year period preceding this Contract been convicted of or had a civil judgment rendered against them for commission of fraud or a criminal offense in connection with obtaining, attempting to obtain, or performing a public (Federal, State or local) transaction or contract under a public transaction; violation of Federal or State antitrust statutes or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, or receiving stolen property;

41.2.3 Are not presently indicted for or otherwise criminally or civilly charged by a governmental entity (Federal, State or local) with commission of any of the offenses enumerated in Paragraph 41.2.2 herein;

41.2.4 Have not within a three-year period preceding this Contract had one or more public transactions (Federal, State or local) terminated for cause or default;

41.2.5 Have not and shall not knowingly enter into any lower tier covered transaction with a person who is proposed for debarment under Federal regulations (i.e., 48 CFR 9, subpart 9.4), debarred, suspended, declared ineligible, or voluntarily excluded from participation in such transaction, unless authorized by the State; and

41.2.6 Will include a clause entitled, "Debarment and Suspension Certification'' that essentially sets forth the provisions herein, in all lower tier covered transactions and in all solicitations for lower tier covered transactions.

41.3 If the CONTRACTOR is unable to certify to any of the statements in this certification, the CONTRACTOR shall submit an explanation to CalOptima.

41.4 The terms and definitions herein have the meanings set out in the Definitions and Coverage sections of the rules implementing Federal Executive Order 12549.

41.5 If the CONTRACTOR knowingly violates this certification, in addition to other remedies available to the Federal Government, CalOptima may terminate this Contract for cause or default.

42. Lobbying Restrictions and Disclosure Certification.

42.1 Applicable to federally funded contracts in excess of $100,000 per Section 1352 of the 31, U.S.C.

42.2 Certification and Disclosure Requirements.

42.2.1 Each person (or recipient) who requests or receives a contract, subcontract, grant, or subgrant, which is subject to Section 1352 of the 31, U.S.C., and which exceeds $100,000 at any tier, shall file a certification (in the form set forth in Exhibit E, Part 1, consisting of one page, entitled "Certification Regarding Lobbying") that the recipient has not made, and will not make, any payment prohibited by Paragraph 42.3of this provision. Exhibit E is attached hereto and incorporated herein by this reference.

42.2.2 Each recipient shall file a disclosure (in the form set forth in Exhibit E, Part 2, entitled "Certification Regarding Lobbying") if such recipient has made or has agreed to make any payment using nonappropriated funds (to include profits from any covered federal action) in connection with a contract or grant or any extension or amendment of that contract or grant, which would be prohibited under Paragraph 42.3 of this provision if paid for with appropriated funds.

42.2.3 Each recipient shall file a disclosure form at the end of each calendar quarter in which there occurs any event that requires disclosure or that materially affect the accuracy of the information contained in any disclosure form previously filed by such person under Paragraph 42.2.2herein. An event that materially affects the accuracy of the information reported includes:

42.2.3.1 A cumulative increase of $25,000 or more in the amount paid or expected to be paid for influencing or attempting to influence a covered federal action;

42.2.3.2 A change in the person(s) or individuals(s) influencing or attempting to influence a covered federal action; or

42.2.3.3 A change in the officer(s), employee(s), or member(s) contacted for the purpose of influencing or attempting to influence a covered federal action.

42.2.3.4 Each person (or recipient) who requests or receives from a person referred to in Paragraph 42.2.1of this provision a contract, subcontract, grant or subgrant exceeding $100,000 at any tier under a contract or grant shall file a certification, and a disclosure form, if required, to the next tier above.

42.2.3.5 All disclosure forms (but not certifications) shall be forwarded from tier to tier until received by the person referred to in Paragraph 42.2.1of this provision. That person shall forward all disclosure forms to CalOptima Purchasing Manager.

42.3 Prohibition—Section 1352 of Title 31, U.S.C., provides in part that no appropriated funds may be expended by the recipient of a federal contract, grant, loan, or cooperative agreement to pay any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with any of the following covered federal actions, the awarding of any federal contract, the making of any federal grant, the making of any federal loan, entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any federal contract, grant, loan, or cooperative agreement.

43. Air and Water Pollution Requirements. Any federally funded agreement and/or subcontract in excess of $100,000 must comply with the following provisions unless said agreement is exempt under 40 CFR § 15.5. CONTRACTOR agrees to comply with all applicable standards, orders, or requirements issued under the Clean Air Act (42 USC § 7401 et seq.), as amended, and the Federal Water Pollution Control Act (33 USC § 1251 et seq.), as amended.

44. Survival. The following provisions of this Contract shall survive termination or expiration of this Contract: Prohibited Interest, Warranties, Compensation, Confidentiality, Indemnification, Duty to Defend, Ownership of Records and Documents, Record Retention, Audit Disclosure, California Public Records Act, Patent and Copyright Infringement, Governing Law, and this Section.

45. Severability. If any section, subsection or provision of this Contract, or any Contract Documents incorporated into this Contract, or the application of such section, subsection or provision, is held invalid or

unenforceable by any court of competent jurisdiction, the remainder of this Contract, other than that to which it is held invalid, shall not be affected thereby.

46. Third Party Beneficiaries. There are no intended third party beneficiaries of this Contract. Nothing in this Contract shall be construed as conferring any rights on any other persons.

47. Successors and Assigns. Except as otherwise expressly provided in this Contract, this Contract will be binding on, and will inure to the benefit of, the successors and permitted assigns of the Parties to this Contract. Nothing in this Contract is intended to confer upon any Party other than the Parties hereto or their respective successors and permitted assigns any rights or obligations under or by reason of this Contract, except as expressly provided in this Contract.

48. Authority to Execute. The persons executing this Contract on behalf of the Parties warrant that they are duly authorized to execute this Contract and that by executing this Contract the Parties are formally bound.

49. Counterparts. This Contract may be executed and delivered in one or more counterparts, each of which shall be deemed an original, but all of which together will constitute one and the same instrument.

[Remainder of page left intentionally blank. Signatures on following page]

IN WITNESS WHEREOF, these Parties have, by their duly authorized representatives, executed this Contract No. 22-10159.

Miller Geer and Associates	CalOptima
By:	By:
Print Name:	Print Name:
Title: Date:	Title: Date:

By:	By:
Print Name:	Print Name:
Title: Date:	Title: Date:

If CONTRACTOR is a corporation, two officer signatures
or a Corporation Resolution or Corporate Seal is required

Exhibit A
SCOPE OF WORK

I. OBJECTIVE

CalOptima has determined that the potential gravity of negative coverage warrants the engagement of external crisis communication services. CalOptima shall engage CONTRACTOR's expertise to strengthen CalOptima's response to urgent and emerging issues that may garner negative media attention, and to mitigate any adverse impact to the CalOptima brand or reputation.

II. SCOPE OF WORK

The CONTRACTOR shall bring specific background in the area of crisis response and provide the following services:

1. PRODUCTS/SERVICES

CONTRACTOR shall utilize their extensive contacts within both the general media as well as the specialized health care industry media, and deep experience in managing those relationship to the benefit of CalOptima. The CONTRACTOR shall provide services and deliverables outline below upon CalOptima request, based on the timing of the urgent issue to be addressed. The products/services shall be delivered electronically to the Director, Communications.

2. SUPPLIER'S RESPONSIBILITIES

The CONTRACTOR's responsibilities shall include but not be limited to"

- timely response to all parties, including CalOptima staff, Board members and consultants.
- be available for meetings and conference calls as needed.
- adhere to all mutually agreed upon deadlines for deliverables in 4. and provide revisions as requested.
- provide a monthly summary with each invoice that recounts key activities in the month and the impact of the work.

3. CALOPTIMA'S RESPONSIBILITIES

- CalOptima shall set deadlines for deliverables and approve all materials developed as outlined in 4.
- CalOptima shall conduct all work with the vendor in a virtual environment, and the vendor shall deliver work product electronically.
- CalOptima shall provide access to executives as needed by the vendor to gather information or arrange media response.

4. DELIVERABLES

a. Given the nature of crisis communications, CalOptima requires the products/services to be delivered within 24 hours or sooner after the assignment is made. CalOptima includes the following deliverables within this scope of work:
    a. Crisis Communications Plan (specific to each engagement/crisis): An outline of the issue, key messages, audiences to reach and tactics to use.
    b. Company Statements: Official statements that will serve as a comment for the media.
    c. Talking Points: Message points that can be used by leaders and key stakeholders, including affected providers.
    d. Ongoing Support: Communications counsel as CalOptima works through crisis cycle, from initial announcement to resolution/closure.

5. PERFORMANCE GUARANTIES/MEASURES

a. Performance shall be measured based on adherence to deadlines and responsiveness to changing needs during the crisis period. Some measure of flexibility shall be required based on the nature of the crisis; therefore, performance shall be measured in terms of ability to adapt to situations and supply appropriate, beneficial response. Monitoring of performance shall be conducted by Executive Director, Public Affairs and Director, Communications. The penalty for lack of performance may result in Contract termination as outlined in the Contract.

Exhibit B

PAYMENT

A. For CONTRACTOR's full and complete performance of its obligations under this Contract, CalOptima shall pay CONTRACTOR for fees and expenses in accordance with the provisions of this Exhibit and subject to the maximum cumulative payment obligations specified below.

B. CONTRACTOR shall invoice CalOptima on a fixed monthly retainer basis. The rates, as defined below, are acknowledged to include CONTRACTOR's base labor rates, overhead and profit. Work completed shall be documented in a detailed monthly progress report prepared by CONTRACTOR, which report shall accompany each invoice submitted by CONTRACTOR. CONTRACTOR shall also furnish such other information as may be requested by CalOptima to substantiate the validity of an invoice. At its sole discretion, CalOptima may decline to make full payment for any work and direct costs until such time as CONTRACTOR has documented, to CalOptima's satisfaction, that CONTRACTOR has fully completed all work required under this Contract and CONTRACTOR's performance is accepted by CalOptima. CalOptima's payment in full for any work shall not constitute CalOptima's final acceptance of CONTRACTOR's work under this Contract.

C. CONTRACTOR shall submit to CalOptima, to the attention of Accounts Payable, accountspayable@caloptima.org, an invoice at the conclusion of every month for the Services performed during the prior thirty (30) days. Each invoice shall cite Contract No. 22-10159; detailed description of work performed; the time period covered by the invoice and the amount of payment requested; and be accompanied by a progress report. CalOptima shall remit payment within thirty (30) days of receipt and approval of each invoice.

D. Notwithstanding any provisions of this Contract to the contrary, CalOptima and CONTRACTOR mutually agree that CalOptima's maximum cumulative payment obligation hereunder for work performed and/or products received on Exhibit A of this Contract shall not exceed Twelve Thousand Hundred Dollars ($12,000.00) per month equaling One Hundred Thirty-Two Thousand Dollars ($132,000.00), including all amounts payable to CONTRACTOR for its direct labor and expenses, overhead costs, fixed fee, subcontracts, leases, materials, and costs arising from or due to termination of this Contract. This rate is fixed for the duration of the Contract. CONTRACTOR agrees to extend this rate to CalOptima for a period of one year after Contract termination. CalOptima shall not pay CONTRACTOR for time spent traveling.

E. Should the Contract terminate early and that termination land mid-month, the final month shall be prorated at 1/30th of the monthly retainer per day equaling Four Hundred Dollars ($400) per day.

F. Should CalOptima or CONTRACTOR feel that the level of support for the Services listed in Exhibit A has grown or reduced significantly, both parties agree to negotiate in good faith any price adjustment needed. For such price adjustment to be valid, an Amendment signed by both parties shall be executed prior to incurring any additional fees.

Exhibit B-1

Not applicable for this Contract

Exhibit C

Not applicable for this Contract

Exhibit D

MEDI-CAL DATA ACCESS AGREEMENT

As a condition of obtaining access to information concerning procedures or other data records utilized/maintained by the Department of Health Care Services and CalOptima, Miller Geer and Associates, including any and all individual employees and agents, agrees not to divulge any information obtained in the course of completion of this Contract to any unauthorized persons.

CONTRACTOR further agrees not to publish or otherwise make public any information regarding persons receiving Medi-Cal services such that the persons who receive such services are identifiable.

CONTRACTOR further recognizes that unauthorized release of confidential information may be subject to civil and criminal sanctions pursuant to the provisions of the Welfare and Institutions Code Section 14100.2.

CONTRACTOR further agrees that this Medi-Cal Data Access Agreement shall remain in full force and effect after the termination of this Contract.

By: _____ Date: _____

Print Name: _____

Title: _____

Exhibit E
Part 1

STATE OF CALIFORNIA
DEPARTMENT OF HEALTH CARE SERVICES
CERTIFICATION REGARDING LOBBYING

The undersigned certifies, to the best of his or her knowledge and belief, that :

(1) No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned, to any person for influencing or attempting to influence an officer or employee of an agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the making, awarding or entering into of this Federal contract, Federal grant, or cooperative agreement, and the extension, continuation, renewal, amendment, or modification of this Federal contract, grant, or cooperative agreement.

(2) If any funds other than Federal appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency of the United States Government, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, or cooperative agreement, the undersigned shall complete and submit Standard Form LLL, “Disclosure of Lobbying Activities" in accordance with its instructions.

(3) The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontractors, subgrants, and contracts under grants and cooperative agreements) of $100,000 or more, and that all subrecipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by Section 1352, Title 31, U.S.C., any person who fails to file the required certification shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

_____	_____
Name of Contractor	Printed Name of Person Signing for Contractor
_____	_____
Contract/Grant Number	Signature of Person Signing for Contractor
_____	_____
Date	Title

After execution by or on behalf of Contractor, please return to:

Department of Health Care Services
Medi-Cal Managed Care Division
MS 4415, 1501 Capitol Avenue, Suite 71.4001
P.O. Box 997413
Sacramento, CA 95899-7413

Exhibit E

Part 2

CERTIFICATION REGARDING LOBBYING

Approved by OMB 0348-0046

Complete this form to disclose lobbying activities pursuant to 31 U.S.C. 1352
(See reverse for public burden disclosure)

1. Type of Federal Action: ☐a. contract ☐b. grant ☐c. cooperative agreement ☐d. loan ☐e. loan guarantee ☐f. loan insurance	2. Status of Federal Action: ☐a. bid/offer/application ☐b. initial award ☐c. post-award	3. Report Type: ☐a. initial filing ☐b. material change **For Material Change Only:** Year _____ quarter_____ date of last report _____

4. Name and Address of Reporting Entity: ☐ Prime ☐ Subawardee Tier ____, *if known*: Congressional District, *if known*:	5. If Reporting Entity in No. 4 is Subawardee, Enter Name and Address of Prime: Congressional District, *if known*:
6. Federal Department/Agency:	7. Federal Program Name/Description: CDFA Number, *if applicable*:
8. Federal Action Number, *if known*:	9. Award Amount, *if known*: $_____
10. a. Name and Address of Lobbying Entity (*If individual, last name, first name, MI*):	b. Name and Address of Lobbying Entity (If individual, last name, first name, MI):

(*attach Continuation Sheet(s) SF-LLLA, if necessary)*

11. Amount of Payment (check all that apply): $_____ ☐actual ☐planned	13. Type of Payment ☐ a. retainer ☐ b. one-time fee ☐ c. commission ☐ d. contingent fee ☐ e. deferred ☐ f. other, specify: _____
12. Form of Payment (check all that apply): ☐ a. cash ☐ b. in-kind, specify: Nature _____ Value_____	

14. Brief Description of Services Performed or to be Performed and Dates(s) of Service, including Officer(s), Employee(s), or Member(s) Contracted for Payment indicated in item 11:

(Attach Continuation Sheet(s) SF-LLL-A, If necessary)

15. Continuation Sheet(s) SF-LLL-A Attached: ☐Yes ☐No

16. Information requested through this form is authorized by Title 31, U.S.C., Section 1352. This disclosure of lobbying activities is a material representation of fact upon which reliance was placed by the tier above when this transaction was made or entered into. This disclosure is required pursuant to Title 31, U.S.C., Section 1352. This information will be reported to the Congress semiannually and will be available for public inspection. Any person who fails to file the required disclosure shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.	Signature: Print Name: Title: Telephone No.: Date:

Federal Use Only	Authorized for Local Reproduction Standard Form-LLL

Exhibit E

INSTRUCTIONS FOR COMPLETION OF SF-LLL, DISCLOSURE OF LOBBYING ACTIVITIES

This disclosure form shall be completed by the reporting entity, whether subawardee or prime federal recipients at the initiation or receipt of a covered federal action, or a material change to a previous filing, pursuant to Title 31, U.S.C., Section 1352. The filing of a form is required for each payment or agreement to make payment to any lobbying entity for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with a covered federal action. Use the SF - LLL- A Continuation Sheet for additional information if the space on the form is inadequate. Complete all items that apply for both the initial filing and material change report. Refer to the implementing guidance published by the Office of Management and Budget for additional information.

1. Identify the type of covered federal action for which lobbying activity is and/or has been secured to influence the outcome of a covered federal action.

2. Identify the status of the covered federal action.

3. Identify the appropriate classification of this report. If this is a follow-up report caused by a material change to the information previously reported, enter the year and quarter in which the change occurred. Enter the date of the last previously submitted report by this reporting entity for this covered federal action.

4. Enter the full name, address, city, state, and ZIP code of the reporting entity. Include Congressional District, if known. Check the appropriate classification of the reporting entity that designates if it is, or expects to be, a prime or subaward recipient. Identify the tier of the subawardee, e.g., the first subawardee of the prime is the 1st tier. Subawards include but are not limited to subcontracts, subgrants, and contract awards under grants.

5. If the organization filing the report in Item 4 checks "Subawardee," then enter the full name, address, city, state, and ZIP code of the prime federal recipient. Include Congressional District, if known.

6. Enter the name of the federal agency making the award or loan commitment. Include at least one organizational level below agency name, if known. For example, Department of Transportation United States Coast Guard.

7. Enter the federal program name or description for the covered federal action (Item 1). If known, enter the full Catalog of Federal Domestic Assistance (CDFA) number for grants, cooperative agreements, loans, and loan commitments.

8. Enter the most appropriate federal identifying number available for the federal action identified in Item 1 (e.g., Request for Proposal (RFP) number; Invitation for Bid (IFB) number; grant announcement number; the contract grant, or loan award number; the application/proposal control number assigned by the federal agency). Include prefixes, e.g., "RFP-DE-90401."

9. For a covered federal action where there has been an award or loan commitment by the federal agency, enter the federal amount of the award/loan commitment for the prime entity identified in Item 4 or 5.

10. (a) Enter the full name, address, city, state, and ZIP code of the lobbying entity engaged by the reporting entity identified in Item 4 to influence the covered federal action.

    (b) Enter the full names of the Individual(s) performing services and include full address if different from 10.(a). Enter last name, first name, and middle initial (MI).

11. Enter the amount of compensation paid or reasonably expected to be paid by the reporting entity (Item 4) to the lobbying entity (Item 10). Indicate whether the payment has been made (actual) or will be made (planned). Check all boxes that apply. If this is a material change report, enter the cumulative amount of payment made or planned to be made.

12. Check the appropriate box(es). Check all boxes that apply. If payment is made through an in-kind contribution, specify the nature and value of the in-kind payment.

13. Check the appropriate box(es). Check all boxes that apply. If other, specify nature.

14. Provide a specific and detailed description of the services that the lobbyist has performed, or will be expected to perform, and the date(s) of any services rendered. Include all preparatory and related activity, not just time spent in actual contact with federal officials. Identify the federal official(s) or employee(s) contacted or the officer(s), employee(s), or Member(s) of Congress that were contacted.

15. Check whether or not a SF-LLL-A Continuation Sheet(s) is attached.

16. The certifying official shall sign and date the form, print his/her name, title, and telephone number.

Exhibit F

Not applicable for this Contract

Exhibit G

Not applicable for this Contract

Exhibit H

Not applicable for this Contract

Exhibit I

Officer, Owner, Shareholder, and Creditor Information

Contractor's Business Name: _____

Business Entity Type: _____
(*Sole Proprietorship, Partnership, LLC, California Corporation, etc.*)

Business Address: _____

City:_____ State:_____ Zip:_____

Business Phone:_____ Email: :_____

President: _____ Contact Person:_____

Person(s) Signing Contract & Title: :_____

*Please provide names of owners, officers, stockholders, and creditors of Contractor's business if such interest is over 5%.

Name	Officer Title or Ownership/Creditorship %
_____	_____
_____	_____
_____	_____
_____	_____

BY SIGNING BELOW, THE UNDERSIGNED HEREBY CERTIFIES THAT THE ABOVE INFORMATION IS TRUE AND CORRECT TO THE BEST OF HIS OR HER KNOWLEDGE AND BELIEF.

_____ _____
Authorized Signature Date

_____
Name and Title

Exhibit J

Not applicable for this Contract

Exhibit K

Not applicable for this Contract

Exhibit L

Not applicable for this Contract

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken October 7, 2021
Regular Meeting of the CalOptima Board of Directors

Report Item

20. Consider Appropriation of Funds and Authorization of Unbudgeted Expenditures and Other Actions as Necessary to Implement the All-Plan Letter (APL) 21-010: Medi-Cal COVID-19 Vaccination Incentive Program

Contacts

Rachel Selleck, Executive Director, Public Affairs, (657) 900-1096
Marie Jeannis, Executive Director, Quality & Population Health Management, (714) 246-2891

Recommended Actions

1. Authorize appropriation of funds and authorize unbudgeted expenditures in an amount up to $659,000 from existing reserves to implement the All-Plan Letter (APL) 21-010: Medi-Cal COVID-19 Vaccination Incentive Program (DHCS VIP) for CalOptima members;
2. Authorize unbudgeted expenditures in an amount up to $23,311 from existing reserves to fund a Community Relations Specialist position through December 31, 2021; and
3. Authorize the Chief Executive Officer, with the assistance of Legal Counsel, to execute agreements and take other actions as necessary to implement the DHCS VIP for CalOptima members.

Background

CalOptima's Board of Directors approved the allocation of funds related to CalOptima's Coronavirus (COVID-19) Vaccination Incentive Program (CalOptima VIP), with Member Health Rewards for eligible CalOptima members to receive a $25 gift card per vaccine for a maximum of $50, as follows: on January 7, 2021, $35 million from Intergovernmental Transfer (IGT) 10 for Medi-Cal members and $400,000 from the Homeless Health Initiative for members experiencing homelessness for Member Health Rewards; and, on March 4, 2021, $695,974 from existing reserves for OneCare and OneCare Connect Member Health Rewards, $262,500 from existing reserves for member education materials and $221,145 from IGT 10 funds for staffing resources.

The Department of Health Care Services (DHCS) released All-Plan Letter (APL) 21-010: Medi-Cal COVID-19 Vaccination Incentive Program to the Medi-Cal and Cal MediConnect managed care plans on August 13, 2021 (revised September 1, 2021). DHCS is allocating up to $350 million statewide to incentivize COVID-19 vaccination efforts for the period September 1, 2021, through February 28, 2022. A combined total of $250 million may be earned by health plans, including CalOptima, for activities designed to close the vaccination gaps for enrolled Medi-Cal members. DHCS also identified populations of focus such as members who are homebound and unable to travel to vaccination sites, members between the ages of 50 and 64 with multiple chronic diseases, members who self-identify as persons of color, and younger members between the ages of 12 and 25. Subject to review and approval, DHCS will make payments for achievement of specified process and outcome measures accomplished for three intervals ending: October 31, 2021; January 2, 2022; and March 6, 2022. A separate $100 million funding pool is available for direct member incentives including, but not limited to, members in the identified populations of focus who are not fully vaccinated against COVID-19, as well as members who received the first dose of a multi-dose vaccine, but not subsequent recommended doses.

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On September 1, 2021, CalOptima submitted to DHCS a Vaccination Response Plan, including direct member incentives. CalOptima received DHCS approval on September 9, 2021. While the first 20% payment is based on DHCS approval, the timing is unknown; further, the remaining 80% is based on achieving program requirements, is subject to DHCS review and approval and, if earned, will be paid over time starting no sooner than October 31, 2021.

Discussion

The Board's approval of the CalOptima VIP enables the agency to leverage work in progress and begin activities to achieve DHCS VIP program goals for the period September 1, 2021, through February 28, 2022. CalOptima has used and expects to continue using funds previously allocated for its current COVID-19 vaccine incentives, as receipt of reimbursement from DHCS for program implementation and direct member incentives is not assured and timing is not known. Staff has also identified additional funding needs to achieve program goals.

The additional funds will be used for increased communications and marketing efforts to identified populations of focus, hard-to-reach communities, broader membership and community stakeholders serving these groups. This will include, for example, development and distribution of outreach materials and support for CalOptima's and community partners' vaccination activities for members and the broader community. CalOptima will:

- Employ a multifaceted advertising campaign to increase marketing efforts to populations of focus and communities with high concentrations of Medi-Cal members. The campaign will employ digital, outdoor, radio and television advertising to promote the vaccine for these audiences;

- Engage with members and community stakeholders to implement, lead and/or support activities for the COVID-19 vaccines, as well as COVID-19 vaccines with flu immunization. Activities include, but are not limited to, leading vaccination events targeting CalOptima members and welcoming the community at large, as well as hosting CalOptima forums and conferences for providers and community stakeholders;

- Develop a series of videos, featuring trusted messengers as spokespeople for specific populations of focus, including student leaders for the youth population, senior advocates for the homebound population, and medical and religious leaders to address a general audience and correct misinformation. Videos will be produced in English, Spanish and Vietnamese, and shared via the CalOptima website, social media platforms, advertising/marketing and other methods;

- Conduct targeted outreach to support community stakeholders' vaccine events by having staff attend their vaccine events and share CalOptima resources and/or financial support through sponsorships and registration fees and other outreach activities to serve the identified populations of focus and broader population;

- Mail educational materials on the importance of flu immunizations during the pandemic and also on COVID-19 vaccine boosters to eligible populations; and,

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- Conduct DHCS-approved texting campaigns to distribute information in a timely manner to targeted populations including, but not limited to, populations of focus.

Budget request for these activities will be as follows:

Activity	**Dollar Amount**
Advertising	$ 327,000
Community outreach	$ 32,000
Education to members	$ 300,000
Total	**$ 659,000**

Additionally, to support these additional outreach activities to members, community stakeholders and the community at large, staff requests $23,311 for one full-time equivalent Community Relations Specialist position to be funded through the remainder of the calendar year; existing allocation has previously been approved for this position beginning January 1, 2022.

CalOptima requests appropriation of funds and the authorization of unbudgeted expenditures for this initiative. CalOptima's DHCS VIP is well aligned with 2020–2022 Strategic Plan priorities as it is member-centric, designed to increase access to and uptake of COVID-19 vaccination, and support collaboration with community partners.

Fiscal Impact
The recommended actions are unbudgeted. An appropriation of up to $682,311 from existing reserves will fund these actions through June 30, 2022.

As of this writing, DHCS has not released detailed information on CalOptima's allocation amount for the VIP. Management anticipates that the use of reserves may be reduced depending on actual funding provided by DHCS for this purpose.

Rationale for Recommendation
Staff recommends approval of the recommended actions as an opportunity to increase CalOptima's vaccination efforts under the DHCS APL 21-010 for the identified populations of focus and CalOptima's membership at large, in response to the COVID-19 pandemic.

Concurrence
Gary Crockett, Chief Counsel

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Attachments

1. CalOptima Board Action dated January 7, 2021: Consider Authorizing Coronavirus (COVID-19) Vaccination Member Incentive Program for Calendar Year 2021
2. CalOptima Board Action dated January 7, 2021: Consider Authorizing Homeless Health Initiative Vaccination Intervention and Member Incentive Strategy in Response to the Coronavirus Pandemic
3. CalOptima Board Action dated March 4, 2021: Consider Ratification and Authorization of Additional Unbudgeted Expenditures Related to Coronavirus (COVID-19) Member Vaccination Incentive Program
4. Department of Health Care Services All Plan Letter 21-010 (Revised): Medi-Cal COVID-19 Vaccination Incentive Program
5. CalOptima's Vaccination Response Plan

/s/ Richard Sanchez *09/29/2021*
Authorized Signature **Date**

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken January 7, 2021
Special Meeting of the CalOptima Board of Directors

Report Item

4. Consider Authorizing Homeless Health Initiative Vaccination Intervention and Member Incentive Strategy in Response to the Coronavirus Pandemic

Contacts

Emily Fonda, M.D., MMM, CHCQM, Interim Chief Medical Officer, (714) 246-8887
Betsy Ha, Executive Director, Quality and Population Health Management, (714) 246-8574
Ladan Khamseh, Chief Operating Officer (714) 246-8866

Recommended Actions

1. Authorize development and implementation of a Homeless Health Initiative (HHI) – Vaccination Intervention and Member Incentive Strategy, as described, to increase member participation and ensure community safety amid the COVID-19 pandemic, subject to approval of the California Department of Health Care Services (DHCS);
2. Approve an allocation of HHI funds not to exceed $400,000 to provide two $25 nonmonetary gift cards for members experiencing homelessness who are ages 14 and older for receiving the required two doses of the COVID-19 vaccine; and
3. Authorize the Chief Executive Officer, with the assistance of Legal Counsel, to enter into contracts/contract amendments with the Orange County Health Care Agency (OCHCA) and/or other entity/entities as appropriate for administration and implementation of this initiative program.

Background

Although the COVID-19 pandemic threatens everyone, CalOptima members experiencing homelessness may be at greater risk of being exposed to this deadly virus. As the population experiencing homelessness has increased significantly over the past few years in Orange County, and in response to the critical needs of this population, CalOptima, in partnership with the OCHCA and other community stakeholders, has focused on developing a system of care that uses a multifaceted approach to respond to the unique needs of members experiencing homelessness.

The economic downturn stemming from the COVID-19 pandemic has exacerbated the problem, causing more people to experience housing insecurity or become homeless for the first time. To continue providing access to quality health care and ensure safety of unsheltered members amid COVID-19, staff proposes a 1-year Homeless Health Initiative (HHI) that provides nonmonetary member incentives to promote COVID-19 vaccination while addressing Social Determinants of Health (SDOH), such as food insecurity. Public health experts have indicated that at least 70% of the overall population needs to get vaccinated to build herd immunity that will help end the pandemic, and the same percentage applies to those experiencing homelessness.

CalOptima has launched various initiatives to provide clinical care for CalOptima Medi-Cal members who are experiencing homelessness through a series of actions approved by the CalOptima Board of Directors (Board). On April 4, 2019, the Board approved the establishment of a restricted Homeless Health Reserve in the amount of $100 million that included: $24 million in previously approved initiatives using IGT 1-7 funds, and $76 million in IGT 8 funds (approximately $43 million), with the

balance from Fiscal Year (FY) 2018-19 operating funds. These funds have been designated by the Board to address the healthcare needs of members experiencing homelessness.

Beginning with IGT 8, the IGT program covers the current fiscal year and funds are incorporated into the contract between DHCS and CalOptima. Unlike previous IGT funds (i.e., IGTs 1-7) that could be used to provide enhanced services to existing CalOptima Medi-Cal members, beginning with IGT 8, IGT funds are paid through capitation, and as such, may only be used in the same way that CalOptima uses its primary capitation funds; that is, for covered Medi-Cal medically necessary services for CalOptima members and for administration expense. These IGT capitation payments are also subject to all applicable requirements as set forth in CalOptima's contract with DHCS. In other words, the unallocated funds remaining in the Reserve are IGT 8 and FY 2018-19 operating funds. Based on state requirements, use of these funds is limited to covered, medically necessary Medi-Cal services for CalOptima members and administrative expense.

Subject to DHCS approval, staff proposes use of HHI funds allocated from IGT 8 to support vaccine acceptance by CalOptima members experiencing homelessness.

Discussion

CalOptima staff recommends implementing a one-year public health focused intervention to support vaccination and public health awareness to mitigate COVID-19 exposure and infection for individuals experiencing homelessness. CalOptima will work collaboratively with community partners, such as the OCHCA, shelter operators and clinics to support COVID-19 vaccination events at shelters, hotspots and other identified locations in the community; CalOptima staff will also encourage vaccination by providing nonmonetary incentives (such as food vouchers at nearly local fast food chains such as Subway, Burger King, etc.) in an amount not to exceed $50 (two $25 gift cards) to members experiencing homelessness and receiving the two required doses of the COVID-19 vaccines (i.e., one $25 gift card per shot, with a limit of two gift cards per member). Total incentive cost will not exceed $400,000.

Staff projects that approximately 8,000 members experiencing homelessness age 14 and older would participate in this initiative. CalOptima staff will work collaboratively with OCHCA (or other organizations, as appropriate) to develop a process to obtain confirmation that eligible individuals (i.e., CalOptima members experiencing homelessness who have received both of their COVID-19 vaccine shots) are provided with these incentives.

Fiscal Impact

The estimated fiscal impact of the HHI - Vaccination Intervention and Member Incentive Strategy is $400,000. A previous Board action on April 4, 2019, to Consider Actions Related to Delivery of Care for Homeless CalOptima Members, established a restricted Homeless Health Reserve in the amount of $100 million. Staff recommends the allocation of HHI funding from the remaining balance of $57 million of this reserve for the proposed initiative.

Rationale for Recommendation

The recommended action is to provide food vouchers for CalOptima members experiencing homelessness, who received COVID-19 vaccines identified under the HHI. This initiative will support CalOptima's efforts to address SDOH, prevent spread of COVID-19, ensure community immunity, and continue providing access to quality health care for members experiencing homelessness during the COVID-19 public health crisis.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. Entities Covered by this Recommended Action
2. CalOptima Board Action dated April 4, 2019, Consider Actions Related to Delivery of Care for Homeless CalOptima Members

/s/ Richard Sanchez *12/31/2020*

Authorized Signature **Date**

ENTITITES COVERED BY THIS RECOMMENDED ACTION

Legal Name	Address	City	State	Zip code
Central City Community Health Center	1000 San Gabriel Boulevard	Rosemead	CA	91770
Families Together of Orange County	661 W 1st St Suite G	Tustin	CA	92780
Hurtt Family Health Clinic, Inc.	One Hope Drive	Tustin	CA	92782
Korean Community Services, Inc. dba Korean Community Services Health Center	8633 Knott Ave.	Buena Park	CA	90620
Serve the People Community Health Center	1206 E. 17th St., Ste 101	Santa Ana	CA	92701
AltaMed Health Services Corporation	2040 Camfield Ave	Los Angeles	CA	90040
Share Our Selves Corporation	1550 Superior Avenue	Costa Mesa	CA	92627
St Jude Neighborhood Health Centers	731 S Highland Ave	Fullerton	CA	92832
County of Orange	405 W. 5th Street, Suite 756	Santa Ana	CA	92701

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Homeless Health Care Update

Board of Directors Meeting
April 4, 2019

Michael Schrader
Chief Executive Officer

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Impetus for Action in Orange County

- Address homeless crisis with urgency and commitment
- Address trend of homeless deaths
- Build a better system of care for members who are homeless that is long-lasting and becomes part of established delivery system
- Prioritize population health for this group

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Homeless Deaths

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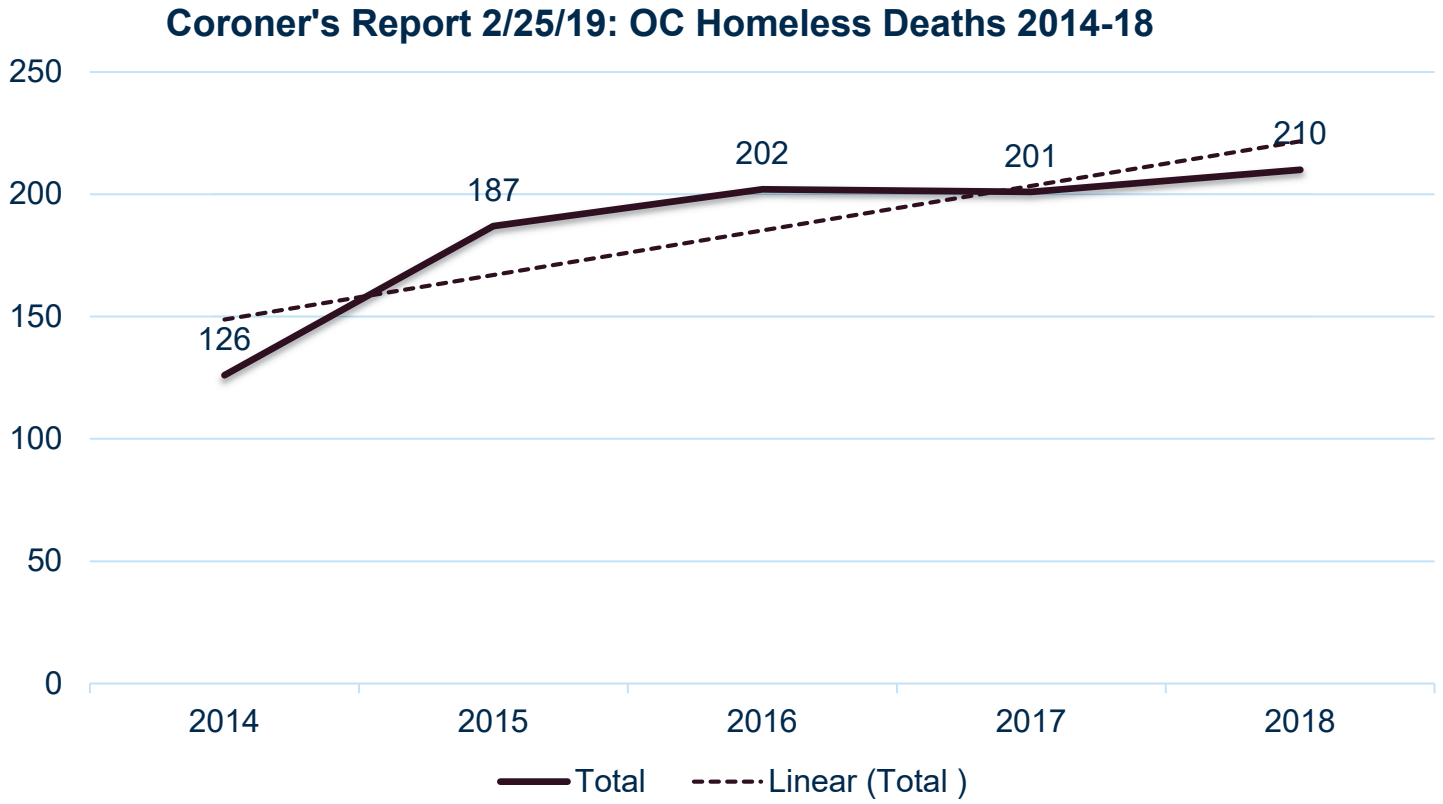
Coroner's Report on Homeless Deaths



- Includes all homeless deaths in Orange County, not limited to CalOptima members
- Methodology of reporting and identification of homeless may vary by county
- Increased homeless death rates over the past five years reported in the media statewide

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Coroner's Report on Homeless Deaths And Possible Interventions

- Natural causes (42% homeless v. 83% total OC population)
  - Clinical field teams (CalOptima)
  - CalOptima Homeless Response Team (CalOptima)
  - Recuperative care (County and CalOptima)
- Overdose (24% homeless v. 5% total OC population)
  - Opioid prescribing interventions (CalOptima)
  - Medication-assisted treatment (County and CalOptima)
  - Substance use disorder centers (County)
  - Medical detox (CalOptima)
  - Social model detox (County)
  - Naloxone (County and CalOptima)
  - Needle exchange (County)

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Coroner's Report on Homeless Deaths And Possible Interventions (cont.)

- Traffic accidents (12% homeless v. 3% total OC population)
- Suicide (7% homeless v. 4% total OC population)
  - Moderate-severe behavioral health (County)
    - Crisis intervention
    - Post-acute transitions
    - Intensive outpatient treatment programs
  - Mild-moderate behavioral health (CalOptima)
    - Screening
    - Early treatment
- Homicide (6% homeless v. 1% total OC population)
- Other accidents (5% homeless v. 5% total OC population)
- Undetermined (3% homeless v. 1% total OC population)

Quality Assurance Committee
Further Clinical Analysis

- Deeper analysis into causes of deaths and interventions
- Case studies for each cause of homeless death
- Benchmarks and comparison with interventions and resources in other counties
- Presentations from partnering organizations

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Better System of Care

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Ad Hoc Recommendations

- Take action to commit $100 million for homeless health
  - Create a restricted homeless health reserve
  - Stipulate that funds can only be used for homeless health

New Initiatives/Projects	BOD Approved	Pending BOD Approval	Funding Category
Be Well OC	$11.4 million		IGT 1–7 ($24 million total)
Recuperative Care	$11 million		
Clinical Field Team Startup	$1.6 million		
CalOptima Homeless Response Team ($1.2 million/year x 5 years)	$1.2 million	$4.8 million	IGT 8 and FY 2018–19 operating funds ($76 million total)
Homeless Coordination at Hospitals ($2 million/year x 5 years)		$10 million	
New Initiatives		$60 million	
Total Reserve: $100 million	**$25.2 million**	**$74.8 million**	

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Clinical Field Team Structure

- Team Components
  - Includes clinical and support staff
  - Vehicle for transportation of staff and equipment
  - Internet connectivity and use of Whole-Person Care (WPC) Connect
- Clinical Services
  - Urgent care, wound care, vaccinations, health screening and point-of-care labs
  - Prescriptions and immediate dispensing of commonly used medications
  - Video consults, referrals, appointment scheduling and care transitions

Clinical Field Team Structure (cont.)

- Referrals and Coordination
  - Coordination with CalOptima Homeless Response Team
  - Coordination with providers
  - Referrals for behavioral health, substance abuse, recuperative care and social services
- Availability and Coverage
  - Regular hours at shelters/hot spots
  - Rotation for on-call services from 8 a.m.–9 p.m. seven days a week, with response time of less than 90 minutes

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Clinical Field Team Partnerships

- Five FQHCs have received contract amendments
  - AltaMed
  - Central City Community Health Center*
  - Hurtt Family Health Clinic*
  - Korean Community Services*
  - Serve the People*
- Contract amendments to be authorized/ratified at April Board meeting, per Board direction
- Go-live
  - Deploy on a phased basis, based on FQHC readiness

** Signed contract amendment*

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CalOptima Homeless Response Team

- Phone line and daily hours (8 a.m.–9 p.m.) established
  - Available to Blue Shirts and CHAT-H nurses
  - Primary point of contact at CalOptima for rapid response
- Coordinate and dispatch clinical field teams
- Serve as liaisons with regular field visits to shelters/hot spots in the county and recuperative care facilities
  - Establish working in-person relationships with collaborating partners
  - Assess and coordinate physical health needs for CalOptima members

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Homeless Population in CalOptima Direct

- Pursue moving members who are homeless to CalOptima Direct, subject to regulatory approval
  - Maximum flexibility with access to any provider (no PCP assignment)
  - Fast-tracked authorization processing
  - Direct medical management in collaboration with clinical field teams, CalOptima Homeless Response Team, and County Blue Shirts and CHAT-H nurses
  - Connectivity with WPC Connect and CalOptima population health platform
- In the interim, move members identified in the field based on choice
- Obtain stakeholder input
  - County, PAC, MAC and health networks

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Homeless Coordination at Hospitals

- COBAR in April
- Help hospitals meet SB 1152 requirements for homeless-specific discharge planning and care coordination, effective July 1, 2019
- Utilization by hospitals of data sharing technology to help facilitate coordination of services for CalOptima members who are homeless
- Proposing 2 percent increase to the inpatient Classic rates for Medi-Cal contracted hospitals
  - $2 million financial impact per year
  - Distributes funding based on volume of services provided to members

Medical Respite Program

- Recuperative care beyond 90 days
  - Reallocate $250,000 of the $10 million in IGT6/7 already allocated to the County's WPC program for recuperative care
  - Leverage existing process
    - County to coordinate and pay recuperative care vendor
    - CalOptima to reimburse County for 100 percent of cost
  - COBAR in April
  - Return to CalOptima Board for ratification of associated policy

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WPC Connect

- Data-sharing tool for coordinating care used by the Whole-Person Care collaborative
  - Specifically used for homeless individuals
  - Includes social supports and referrals to services
  - Includes community partners (e.g., Illumination Foundation, 211, Lestonnac, Health Care Agency, Social Services Agency, hospitals, community clinics, health networks and CalOptima)
- WPC Connect workflow
  - Community partners can, with consent, add individuals into WPC Connect system once identified as homeless
  - WPC Connect sends an email notification and/or text message to identified care team for homeless individuals seen in ER, admitted to hospital or discharged

WPC Connect (cont.)

- CalOptima use of WPC Connect
  - Case management staff is trained and actively uses the system
    - Identify members enrolled in WPC
    - Coordinate with other partners caring for members
    - Access information from other partners

- Status of WPC Connect
  - Five hospitals are currently connected
  - COBAR to amend hospital contracts to support a discharge process for members experiencing homelessness, including the utilization by hospitals of data-sharing technology to help facilitate coordination of services with other providers and community partners

Better System of Care: Future Planning

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Evolving Strategy and Homeless Health Needs

- Propose and respond to changes
  - Regulatory and legislative
  - Available permanent supportive housing and shelters
  - State programs (e.g., expanded WPC funding and Housing for a Healthy California Program)
- Identify other potential uses for committed funds to optimize the delivery system, subject to Board consideration, for example:
  - Enrollment assistance
  - Enhanced data connectivity technology
  - Housing supportive services
  - Other physical health services
  - Rental assistance and shelter, if permissible

Recommended Actions

- Separate COBARs
  - Clinical field team implementation
  - Medical respite program
  - Homeless coordination at hospitals

- Additional action recommended by Board Ad Hoc
  - Create a restricted homeless health reserve in the amount of $100 million
    - $24 million – previously approved initiatives using IGT 1–7 funds
    - $76 million – all IGT 8 funds (approximately $43 million) with balance from FY 2018–19 operating funds
  - Stipulate that funds can only be used for homeless health

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CalOptima's Mission

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

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken January 7, 2021
Special Meeting of the CalOptima Board of Directors

Report Item

5. Consider Authorizing Coronavirus (COVID-19) Vaccination Member Incentive Program for Calendar Year 2021

Contacts

Emily Fonda, M.D., MMM, CHCQM, Interim Chief Medical Officer, 714-246-8887
Betsy Ha, Executive Director, Quality and Population Health Management, 714-246-8574
Ladan Khamseh, Chief Operating Officer, (714) 246-8866

Recommended Actions

1. Authorize the development and implementation of a COVID-19 Vaccination Incentive Program (VIP) for Calendar Year (CY) 2021, as described below, to increase member participation and ensure community safety amid the COVID-19 pandemic, subject to DHCS approval prior to implementation;
2. Approve the recommended allocation of Intergovernmental Transfer (IGT) 10 funds, not to exceed ~~$20 million~~ $35 million, to provide two $25 nonmonetary gift cards to individual Medi-Cal members ~~age 14 and older~~ for receiving the two required doses of the COVID-19 vaccine (one gift card per shot); and *Rev. 1/7/21*
3. Authorize implementation of the VIP prior to CalOptima's receipt of IGT 10 funds from the State of California.
4. Authorize the Chief Executive Officer, with the assistance of Legal Counsel, to enter into an Memorandum of Understanding (MOU), and/or contract or contract amendment with the Orange County Health Care Agency (OCHCA) as appropriate for administration and implementation of the VIP.

Background

In late December 2020, the first doses of the COVID-19 vaccines arrived in Orange County. Vaccines will be distributed according to a phased approach, with high-priority groups vaccinated first and eventually the general public as determined by the California Department of Public Health and local health department. The U.S. Food and Drug Administration issued an emergency use authorization (EUA) for the Pfizer-BioNTech and Moderna vaccines, both of which offer more than 94% protection against COVID-19 when two doses are taken. Public health experts recommend that at least 70% of the population needs to get vaccinated to develop herd community, which can bring an end to the pandemic.

As the only Medi-Cal plan serving Orange County's most vulnerable residents, CalOptima is responding in collaboration with the Orange County Health Care Agency (OCHCA) to support the community in achieving herd immunity. The first step is a strategy that promotes COVID-19 vaccination, including tailoring member education on the importance of vaccination, dispelling misconceptions, and providing nonmonetary member incentives to ensure health equity across race, ethnicity and socioeconomic status. To support this effort, CalOptima staff is seeking an allocation of IGT 10 funds.

Intergovernmental Transfers (IGT) are transfers of public funds between eligible government entities, which are used to draw down federal funds for the Medi-Cal program. To date, CalOptima has

participated in ten Voluntary Rate Range IGT transactions. Funds from IGTs 1 through 9 have been received, and IGT 10 funds will be distributed in two separate installments, which are expected from the state in 2021.

Discussion

Subject to state approval, staff will work with various internal and external partners on a member outreach program that provides COVID-19 vaccine information. The proposed program includes:

1. A mailing to all members with information about the vaccine.
2. A targeted text messaging campaign. When different priority groups are permitted to be vaccinated, CalOptima will send out targeted text messages to these members letting them know the following:
    a. They are now eligible to be vaccinated.
    b. Where they need to go to be vaccinated. (This information is not yet available, but staff continue to work with OCHCA to establish vaccine events in targeted geographic locations within the county. The vaccine events are likely to begin in Spring 2021, but may extend into the fall, depending on the vaccine distribution timeline as established by OCHCA.)
3. A targeted phone call campaign to population segments who are at high risk for not getting vaccinated. This will begin once the vaccine is widely available to at least essential workers, according to the phased approach.

Staff projects that as many as 400,000 members will participate in this program. To encourage members to participate in vaccination, staff proposes to provide two $25 nonmonetary gift cards for Medi-Cal members age 14 and older for receiving each of two doses of the COVID-19 vaccine, for a total of $50. Members will be encouraged to sign up with the OCHCA's app, Othena, at no cost, to receive the gift card incentives, one gift card for each shot received. The app is being developed to help healthcare providers track vaccine recipients to ensure they get a booster shot and to monitor for side effects. Staff is also seeking authority to enter into a Memorandum of Understanding (MOU) and/or contract or contract amendment with the County as necessary to implement the program. If it is subsequently determined that agreements with other entities, organizations or vendors are necessary, staff will return to the Board with further recommendations for consideration at a later date.

The targeted timeframe for the COVID-19 nonmonetary incentive is CY 2021. IGT 10 funds have not yet been received. For the approved and funded IGT transactions to date, the net proceeds have been evenly divided between CalOptima and the respective funding partners, and funds retained by CalOptima have been invested in addressing member's unmet health care needs. It is anticipated that CalOptima's share of IGT 10 funds will be approximately $66 million ($43.3 million in Spring 2021 and $22.7 million in Fall 2021).

Due to timing issues, staff requests that the Board authorize the CEO to implement the COVID-19 Vaccination Incentive Program for CY 2021 prior to CalOptima's receipt of IGT 10 funds from DHCS. Providing the nonmonetary incentive to coincide with the availability of the COVID-19 vaccination to members will support CalOptima's health promotion efforts in our community.

It should be noted that since IGT 10 funds are accounted for in the same fashion as the Medi-Cal capitation revenue CalOptima receives from DHCS, to the extent that these funds are not expended on covered, medically necessary Medi-Cal services or qualifying quality initiatives, the expenditures would be charged to CalOptima's administrative loss ratio (ALR), rather than the medical loss ratio (MLR).

Fiscal Impact

The recommended action to allocate up to ~~$20 million~~ $35 million in IGT 10 funds to support the COVID-19 Vaccination Member Incentive Program has no net fiscal impact to CalOptima's Fiscal Year 2020-21 Operating Budget approved by the Board on June 4, 2020. Staff anticipates any cash expended to implement the program will be replenished when IGT 10 funds are received from DHCS. Expenditure of IGT funds is for restricted one-time purposes for covered Medi-Cal services to CalOptima members and does not commit CalOptima to future budget allocations.

Rationale for Recommendation

Staff recommends adding a COVID-19 vaccination member incentive component to CalOptima's preventive initiatives to educate and encourage member participation. The recommended actions will support CalOptima's efforts to help the community reach herd immunity, address health disparities, and continue providing access to quality health care for members during the COVID-19 public health crisis.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. Entities Covered by this Recommended Action
2. CalOptima Board Action dated February 6, 2020, Consider Pursuit of Proposals with Qualifying Funding Partners to Secure Medi-Cal Funds Through the Voluntary Rate Range Intergovernmental Transfer Program for Rating Period 2019-20 (IGT 10)

/s/ Richard Sanchez — *12/31/2020*

Authorized Signature — **Date**

ENTITITES COVERED BY THIS RECOMMENDED ACTION

Legal Name	Address	City	State	Zip code
County of Orange	405 W. 5th Street, Suite 756	Santa Ana	CA	92701

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken February 6, 2020
Regular Meeting of the CalOptima Board of Directors

Report Item

15. Consider Pursuit of Proposals with Qualifying Funding Partners to Secure Medi-Cal Funds Through the Voluntary Rate Range Intergovernmental Transfer Program for Rating Period 2019-20 (IGT 10)

Contact

Candice Gomez, Executive Director, Program Implementation, (714) 246-8400

Recommended Actions

Authorize the following activities to secure Medi-Cal funds through the Voluntary Intergovernmental Transfer (IGT) Rate Range Program:

1. Submission of a proposal to the California Department of Health Care Services (DHCS) to participate in the Voluntary Rate Range IGT Program for Rating Period 2019-20 (IGT 10);
2. Pursuit of IGT funding partnerships with the University of California-Irvine, the Children and Families Commission, the County of Orange, the City of Orange, and the City of Newport Beach to participate in the upcoming Voluntary Rate Range IGT Program for Rating Period 2019-20 (IGT 10); and,
3. Authorize the Chief Executive Officer to execute agreements with these entities and their designated providers as necessary to seek IGT 10 funds.

Background

Intergovernmental Transfers (IGT) are transfers of public funds between eligible government entities which are used to draw down federal funds for the Medi-Cal program. To date, CalOptima has participated in eight Rate Range IGT transactions. Funds from IGTs 1 through 8 have been received and IGT 9 funds are expected from the state in the first quarter of 2020. IGTs 1 through 9 covered the applicable twelve-month state fiscal year (FY) periods (i.e., FY 2010-11 through FY 2018-19). IGT 1 through 7 funds were retrospective payments for prior rate range years and were designated to be used to provide enhanced/additional benefits to existing Medi-Cal beneficiaries, as represented to CMS. These funds have been best suited for one-time investments or as seed capital for enhanced health care services for the benefit of Medi-Cal beneficiaries.

The IGT funds received under IGTs 1 through 7 have supported special projects that address unmet healthcare needs of CalOptima members, such as vision and dental services for children, obesity prevention and intervention services, provider incentives for adolescent depression screenings, recuperative care for homeless members, and support for members through the Personal Care Coordinator (PCC) program.

Beginning with IGT 8, the IGT program covers the current fiscal year and funds will be incorporated into the contract between DHCS and CalOptima for the current fiscal year. Unlike previous IGTs (1-7), beginning with IGT 8 funds must be used in the current rate year for CalOptima covered Medi-Cal services per DHCS direction. IGT 8 funds have been allocated to the Homeless Health Initiative. IGT 9 funds have not yet been received, nor allocated; CalOptima staff anticipates returning with recommendations on an allocation plan in a separate Board action; however, as indicated,

per DHCS, the use of these funds is limited to covered Medi-Cal benefits for existing CalOptima members.

For the approved and funded IGT transactions to date, the net proceeds have been evenly divided between CalOptima and the respective funding partners, and funds retained by CalOptima have been invested in addressing Member's unmet healthcare needs.

Discussion

On December 20, 2019, CalOptima received notification from DHCS regarding the Rating Period 2019 - 20 Voluntary Rate Range IGT Program (IGT 10). Unlike the prior IGTs, which covered the applicable twelve-month state fiscal year, IGT 10 covers eighteen months including the periods of July 1, 2019 through June 30, 2020 and July 1, 2020. through December 31, 2020. CalOptima's proposal, along with the funding entities' supporting documents are due to DHCS no later than February 19, 2020.

The five eligible funding entities from the previous IGT transactions have been contacted regarding their interest in participation in IGT 10. All five funding entities have informally indicated that they are interested in participation in the IGT program this year. The formal DHCS required Letter of Interest is due to CalOptima by February 14, 2020 for delivery to DHCS by February 19, 2020. These entities are:

1. University of California, Irvine,
2. Children and Families Commission of Orange County,
3. County of Orange,
4. City of Orange, and
5. City of Newport Beach.

Board approval is requested to authorize staff to submit the proposal letter to DHCS for participation in the 2019-20 Voluntary IGT Rate Range Program and to authorize the Chief Executive Officer to enter into agreements with each of the five proposed funding entities submitting a letter of interest (or their designated providers) for the purpose of securing available IGT funds. Consistent with the nine prior IGT transactions, it is anticipated that the net proceeds will be split evenly between the respective funding entities and CalOptima.

Staff will return to the Board with additional information regarding the IGT 10 transaction and a proposed expenditure plan for CalOptima's share of the net proceeds at a later date.

Fiscal Impact

The recommended actions to submit a proposal to DHCS and pursue IGT funding partnerships with five governmental funding entities for IGT 10 is expected to generate one-time IGT revenue that will be invested in covered Medi-Cal services for CalOptima members. As such, there is no net fiscal impact on CalOptima's current and future operating budgets.

Rationale for Recommendation

Consistent with the previous nine IGT transactions, submission of the proposal and authorization of funding agreements will allow the ability to maximize Orange County's available IGT funds for Rate Year 2019-20 (IGT 10). Also, consistent with the 2020-22 Strategic Plan, it would increase funding to support delivery of covered Medi-Cal services for CalOptima members.

Concurrence

Gary Crockett, Chief Counsel

Attachment

1. Entities Covered by this Recommended Board Action
2. Department of Health Care Services Voluntary IGT Rate Range Program Notification Letter

/s/ Michael Schrader — *01/28/2020*

Authorized Signature — **Date**

Attachment 1 to February 6, 2020 Board of Directors Meeting – Agenda Item 15

ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Legal Name	Address	City	State	Zip code
Children and Families Commission of Orange County	1505 E. 17th Street, 230	Santa Ana	CA	92705
City of Newport Beach	100 Civic Center Drive	Newport Beach	CA	92660
City of Orange	300 E. Chapman Avenue	Orange	CA	92866
Orange County Health Care Agency	405 W. 5th Street, 7th Floor	Santa Ana	CA	92701
University of California, Irvine UCI Health	333 City Blvd. West, Suite 200	Orange	CA	92868

State of California—Health and Human Services Agency
Department of Health Care Services

RICHARD FIGUEROA
ACTING DIRECTOR

GAVIN NEWSOME
GOVERNOR

DEC 2 0 2019

Nancy Huang
Interim Chief Financial Officer
CalOptima
505 City Parkway West
Orange, CA 92868

SUBJECT: Rating Period 2019–20 (July 1, 2019 through December 31, 2020) Voluntary Rate Range Program – Request for Medi-Cal Managed Care Plan's (MCP) Proposal

Dear Ms. Nancy Huang:

The Rating Period 2019-20 Voluntary Rate Range Program, authorized by Welfare and Institutions (W&I) Code sections 14164, 14301.4, and 14301.5, provides a mechanism for funding the non-federal share of the difference between the lower and upper bounds of a MCP's actuarially sound rate range, as determined by the Department of Health Care Services (DHCS). Governmental funding entities eligible to transfer the non-federal share are defined as counties, cities, special purpose districts, state university teaching hospitals, and other political subdivisions of the state, pursuant to W&I Code section 14164(a). These governmental funding entities may voluntarily transfer funds to DHCS via intergovernmental transfer (IGT). These voluntary IGTs, together with the applicable Federal Financial Participation (FFP), will be used to fund payments by DHCS to MCPs as part of the capitation rates paid for the service periods of July 1, 2019 through June 30, 2020, and July 1, 2020 through December 31, 2020.

DHCS shall not direct the MCP's expenditure of payments received under the Rating Period 2019-20 Voluntary Rate Range Program. These payments are subject to all applicable requirements set forth in the MCP's contract with DHCS. These payments must also be tied to covered Medi-Cal services provided on behalf of Medi-Cal beneficiaries enrolled within the MCP's rating region.

The funds transferred by an eligible governmental funding entity must qualify for FFP pursuant to Title 42 Code of Federal Regulations (CFR) Part 433, Subpart B, including the requirements that the funding source(s) shall not be derived: from impermissible sources such as recycled Medicaid payments, Federal money excluded from use as state match, impermissible taxes, and non-bona fide provider-related donations. Impermissible sources do not include patient care or other revenue received from

programs such as Medicare or Medicaid to the extent that the program revenue is not obligated to the state as the source of funding.

DHCS shall continue to administer all aspects of the IGT related to the Rating Period 2019-20 Voluntary Rate Range Program, including determinations related to fees.

PROCESS FOR RATING PERIOD 2019-20:

MCPs should refer to the estimated Rating Period 2019-20 (service periods July 1, 2019 through June 30, 2020, and July 1, 2020 through December 31, 2020) county/region-specific non-federal share required to fund available rate range amounts for the MCP (see Attachment C). As a reminder, participation in the Rating Period 2019-20 Voluntary Rate Range Program is voluntary on the part of the transferring entity and the MCP. Note that for service periods July 1, 2019 through June 30, 2020 and July 1, 2020 through December 31, 2020, the Contribution (Non-Federal Share) amounts are based on Estimated Member Months, and the actual amounts may change based on actual enrollment. Note that for service period July 1, 2020 through December 31, 2020, the Contribution (Non-Federal Share) amounts are based on Projected Contribution PMPMs, and the actual amounts may change based on the risk adjustment process that DHCS uses as part of its rate development methodology.

If an MCP elect to participate in the Rating Period 2019-20 Voluntary Rate Range Program, the MCP must adhere to the process for participation outlined below:

Soliciting Interest

The MCP shall contact potential governmental funding entities to determine their interest, ability, and desired level of participation in the Rating Period 2019-20 Voluntary Rate Range Program. All providers and governmental funding entities who express their interest directly to DHCS will be redirected to the applicable MCP to facilitate negotiations related to participation. If, following the submission of the MCP's proposal, one or more governmental funding entities included in the MCP's proposal are unable or unwilling to participate in the Voluntary Rate Range Program, the MCP shall attempt to find other governmental funding entities able and willing to participate in their place.

The MCP must inform all participating governmental entities that, unless DHCS determines a statutory exemption applies, IGTs submitted in accordance with W&I Code section 14301.4 are subject to an additional 20 percent assessment fee (calculated on the value of their IGT contribution amount) to reimburse DHCS for the administrative costs of operating the Voluntary Rate Range Program and to support the Medi-Cal program. DHCS will determine if a fee waiver is appropriate.

Submission Requirements

Once the MCP has coordinated with the relevant governmental funding entities, the following documents must be submitted to DHCS in accordance with the requirements and procedures set forth below:

- The MCP must submit a **proposal** to DHCS. This proposal must include:

  1. A cover letter signed by the MCP's Chief Executive Officer or Chief Financial Officer on MCP letterhead.
  2. The MCP's primary contact information (name, e-mail address, mailing address, and phone number).
  3. County/region-specific summaries of the selected governmental funding entities, related providers, and participation levels specified for Rating Period 2019-20. The combined amounts or percentages must not exceed 100 percent of the estimated non-federal share of the available rate range amounts provided by DHCS. If the MCP is unable to use the entire available rate range, the MCP must indicate the unfunded amount and percentage.
  4. All letters of interest (described below) and supporting documents must be attached to the proposal. If the Rating Period 2019-20 Voluntary Rate Range Program Supplemental Attachment described below is not collected by the MCP and attached to the proposal at the time of submission, please indicate if the information will be submitted to DHCS directly by each governmental funding entity.

- The MCP must obtain a **letter of interest** from each governmental funding entity included in the MCP's proposal to DHCS. The highlighted sections in the letter of interest form provided in Attachment A must be filled out completely and printed on the participating governmental funding entity's letterhead. A separate letter of interest must be provided for each county or rating region. An individual who is authorized to sign the certification on behalf of the governmental funding entity must sign the letter of interest.

- The MCP must distribute to governmental funding entities and ensure submission to DHCS, either by the MCP or the governmental funding entity, of the **Rating Period 2019-20 Voluntary Rate Range Program Supplemental Attachment** (see Attachment B) by Wednesday, February 19, 2020.

- The proposals and letters of interest are due to DHCS ***by 5pm on* Wednesday, February 19, 2020**. Please send a PDF copy of the required documents by e-

mail to Sandra.Dixon@dhcs.ca.gov. ***Failure to submit all required documents by the due date may result in exclusion from the Rating Period 2019-20 Voluntary Rate Range Program.***

Each proposal is subject to review and approval by DHCS. The review will include an evaluation of the proposed provider participation levels in comparison to their uncompensated contracted Medi-Cal costs and/or charges. DHCS reserves the right to approve, amend, or deny the proposal at its discretion.

Upon DHCS' approval of the governmental funding entities and non-federal share amounts for the Rating Period 2019-20 Voluntary Rate Range Program, DHCS will provide the necessary funding agreement templates, forms, and related due dates to the specified governmental funding entities and MCP contacts. The governmental funding entities will be responsible for completing all necessary funding agreement documents, responding to any inquiries necessary for obtaining approval, and obtaining all required signatures.

If you have any questions regarding this letter, please contact Sandra Dixon at (916) 345-8269 or by email at Sandra.Dixon@dhcs.ca.gov.

Sincerely,

Jennifer Lopez
Division Chief
Capitated Rates Development Division

Attachments

cc: Michael Schrader
CalOptima
505 City Parkway West
Orange, CA 92868

Sandra Dixon
Capitated Rates Development Division
Department of Health Care Services
1501 Capitol Avenue, MS 4413
P.O. Box 997413
Sacramento, CA 95899-7413

ATTACHMENT A – LETTER OF INTEREST

Jennifer Lopez
Division Chief
Capitated Rates Development Division
Department of Health Care Services
1501 Capitol Avenue, MS 4413
P.O. Box 997413
Sacramento, CA 95899-7413

Dear Ms. Lopez:

This letter confirms the interest of _Insert Participating Funding Entity Name, a governmental entity, federal I.D. Number _Insert Federal Tax I.D. Number, in working with Managed Care Plan's Name (hereafter, "the MCP") and the California Department of Health Care Services (DHCS) to participate in the Voluntary Rate Range Program, including providing an Intergovernmental Transfer (IGT) to DHCS to be used as a portion of the non-federal share of actuarially sound Medi-Cal managed care capitation rate payments incorporated into the contract between the MCP and DHCS for the service periods of July 1, 2019 through June 30, 2020, and July 1, 2020 through December 31, 2020. This is a non-binding letter, stating our interest in helping to finance health improvements for Medi-Cal beneficiaries receiving services in our jurisdiction. The governmental entity's funds are being provided voluntarily, and the State of California is in no way requiring the governmental entity to provide any funding.

_Insert Participating Funding Entity Name is willing to contribute approximately $_____ for the Rating Period 2019-20 (July 1, 2019 through December 31, 2020) as negotiated with the MCP. We recognize that, unless a waiver is approved by DHCS, there will be an additional 20-percent assessment fee payable to DHCS on the funding amount, for the administrative costs of operating the voluntary rate range program.

The following individual from our organization will serve as the point of communication between our organization, the MCP and DHCS on this issue:

Entity Contact Information:

(Please provide complete information including name, street address, e-mail address and phone number.)

I certify that I am authorized to sign this certification on behalf of the governmental entity and that the statements in this letter are true and correct.

Sincerely,

Signature

Attachment B

Voluntary Rate Range Program Supplemental Attachment
Rating Period 2019-20 (July 1, 2019 through December 31, 2020)

Provider Name:	
County:	
Health Plan:	

Instructions

Complete all yellow-highlighted fields. **Submit this completed form via e-mail to Sandra Dixon (sandra.dixon@dhcs.ca.gov) at the Department of Health Care Services (DHCS) by no later than February 19, 2020.**

1. In the table below, report charges/costs and payments received or expected to be received from the Health Plan indicated above for Medi-Cal services (Inpatient, Outpatient, and All Other) provided to Medi-Cal beneficiaries enrolled in the Health Plan and residing in the County indicated above, for dates of service from July 1, 2018 - June 30, 2019.

	Charges	Costs	Payments from Health Plan*	Uncompensated Chares (charges less payments)	Uncompensated Costs (Costs less payments)
Inpatient				$	$
Outpatient				$	$
All Other				$	$
Total	$	$	$	$	$

* Include payments received and anticipated to be received for service dates of July 1, 2018 through June 30, 2019.

2. Are you able to fund 100% of the higher of the uncompensated charges or uncompensated costs (as stated above)? *(Yes / No)*

If No, please specify the amount of funding available:

3. Describe the scope of services provided to the specified Health Plan's Medi-Cal members, and if these services were provided under a contract arrangement.

4. Please provide the following information:

(i) The name of the entity transferring funds:

(ii) The operational nature of the entity (county, city, special purpose district, state university teaching hospitals or other political subdivisions of the state) transferring funding:

(iii) The source of the funds:
(Funds must not be derived from impermissible sources such as recycled Medicaid payments, federal funds excluded from use as State match, impermissible taxes, and non-bona fide provider-related donations. Impermissible sources do not include patient care or other revenue received from programs such as Medicare or Medicaid to the extent that the program revenue is not obligated to the State as the source of

(iv) Does the transferring entity have general taxing authority? *(Yes / No)*

If No, does the transferring entity receive State appropriations (identify level of appropriation)? This may include, but not limited to, annual State appropriations for various programs, or realignment funds to support programs transferred by State Law to local control. *(Yes / No)*

5. Comments / Notes

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ATTACHMENT C

TOTAL AVAILABLE RATE RANGE

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CalOptima - Orange (HCP 506)
IGT - 2019/20 (July 2019 - June 2020)

	Total	50% FFP (Non-MCHIP,SPD and LTC)	88% FFP (MCHIP - 7/2019 to 9/2019)	76.5% FFP (MCHIP - 10/2019 to 6/2020)	BCCTP[3]	WCM[4]	93% FFP Optional Expansion (7/2019 - 12/2019)	90% FFP Optional Expansion (1/2020 - 6/2020)
Total Funds Available	$ 143,831,947	$ 60,609,553	$ 2,248,273	$ 6,744,806	$ 567,560	$ 20,884,320	$ 26,388,727	$ 26,388,708
Federal Match	$ 98,389,329	$ 30,304,777	$ 1,978,480	$ 5,159,777	$ 189,344	$ 12,465,598	$ 24,541,516	$ 23,749,837
Governmental Funding Entity's Portion	$ 45,442,618	$ 30,304,776	$ 269,793	$ 1,585,029	$ 378,216	$ 8,418,722	$ 1,847,211	$ 2,638,871
	31.6%	50.0%	12.0%	23.5%	66.6%	40.3%	7.0%	10.0%

Rate Categories[1]	Member Months (per Mercer est.)	Lower Bound (per Mercer Rate Worksheets)	Upper Bound (per Mercer Rate Worksheets)	Difference between Upper and Lower Bound	Other Departmental Usage[2]	Available PMPM (less Other Dept. Usage)	Estimated Available Total Fund
Child - non MCHIP	2,271,664	$ 87.64	$ 94.40	$ 6.76	$ -	$ 6.76	$ 15,356,449
Child - MCHIP 7/2019 - 9/2019	303,510	$ 87.64	$ 94.40	$ 6.76	$ -	$ 6.76	$ 2,051,728
Child - MCHIP 10/2019 - 6/2020	910,531	$ 87.64	$ 94.40	$ 6.76	$ -	$ 6.76	$ 6,155,190
Adult - non MCHIP	1,007,518	$ 324.35	$ 344.15	$ 19.80	$ -	$ 19.80	$ 19,948,856
Adult - MCHIP 7/2019 - 9/2019	9,788	$ 324.35	$ 344.15	$ 19.80	$ -	$ 19.80	$ 193,802
Adult - MCHIP 10/2019 - 6/2020	29,363	$ 324.35	$ 344.15	$ 19.80	$ -	$ 19.80	$ 581,387
SPD	448,861	$ 814.48	$ 859.81	$ 45.33	$ -	$ 45.33	$ 20,346,869
SPD/Full-Dual	24,336	$ 205.34	$ 215.02	$ 9.68	$ -	$ 9.68	$ 235,572
BCCTP	7,026	$ 1,430.69	$ 1,511.47	$ 80.78	$ -	$ 80.78	$ 567,560
LTC	15,492	$ 11,026.93	$ 11,331.72	$ 304.79	$ -	$ 304.79	$ 4,721,807
LTC - MCHIP 7/2019 - 9/2019	9	$ 11,026.93	$ 11,331.72	$ 304.79	$ -	$ 304.79	$ 2,743
LTC - MCHIP 10/2019 - 6/2020	27	$ 11,026.93	$ 11,331.72	$ 304.79	$ -	$ 304.79	$ 8,229
LTC/Full-Dual	0	$ 6,630.57	$ 6,780.31	$ 149.74	$ -	$ 149.74	$ -
WCM	146,382	$ 1,876.85	$ 2,019.52	$ 142.67	$ -	$ 142.67	$ 20,884,320
Optional Expansion 7/2019 - 12/2019	1,394,753	$ 424.87	$ 450.10	$ 25.23	$ 6.31	$ 18.92	$ 26,388,727
Optional Expansion 1/2020 - 6/2020	1,394,752	$ 424.87	$ 450.10	$ 25.23	$ 6.31	$ 18.92	$ 26,388,708
	7,964,012	$ 333.59	$ 353.87	$ 20.27	$ 2.21	$ 18.06	$ 143,831,947

[1] The supplemental payments (Maternity, BHT and HEP C) and CCI population are not included in the rate range calculation.

[2] Other Departmental Usages decreases available rate range funding.

[3] BCCTP Federal Match is based on the portion of the population enrolleed in a BCCTP aid code associated with a FFP percentage of 65%.

[4] WCM Federal Match is based on the FFP percentage associated with the aid codes within each rating categories.

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CalOptima - Orange (HCP 506)
IGT - 2019/20 (July 2020 - December 2020)

	Total	50% FFP (Non-MCHIP and SPD)	76.5% FFP (MCHIP - 7/2020 to 9/2020)	65% FFP (MCHIP - 10/2020 to 12/2020)	BCCTP [3]	WCM [4]	90% FFP Optional Expansion
Total Funds Available	$ 71,458,138	$ 30,053,529	$ 2,227,321	$ 2,227,321	$ 282,165	$ 10,402,926	$ 26,264,876
Federal Match	$ 47,878,762	$ 15,026,765	$ 1,703,901	$ 1,447,759	$ 94,133	$ 5,967,816	$ 23,638,388
Governmental Funding Entity's Portion	$ 23,579,376	$ 15,026,764	$ 523,420	$ 779,562	$ 188,032	$ 4,435,110	$ 2,626,488
	33.0%	50.0%	23.5%	35.0%	66.6%	42.6%	10.0%

Rate Categories [1]	Member Months (per Mercer est.)	Lower Bound (per Mercer Rate Worksheets)	Upper Bound (per Mercer Rate Worksheets)	Difference between Upper and Lower Bound	Other Departmental Usage [2]	Available PMPM (less Other Dept. Usage)	Estimated Available Total Fund
Child - non MCHIP	1,126,338	$ 87.64	$ 94.40	$ 6.76	$ -	$ 6.76	$ 7,614,045
Child - MCHIP 7/2020 - 9/2020	300,973	$ 87.64	$ 94.40	$ 6.76	$ -	$ 6.76	$ 2,034,577
Child - MCHIP 10/2020 - 12/2020	300,973	$ 87.64	$ 94.40	$ 6.76	$ -	$ 6.76	$ 2,034,577
Adult - non MCHIP	493,892	$ 324.35	$ 344.15	$ 19.80	$ -	$ 19.80	$ 9,779,062
Adult - MCHIP 7/2020 - 9/2020	9,596	$ 324.35	$ 344.15	$ 19.80	$ -	$ 19.80	$ 190,001
Adult - MCHIP 10/2020 - 12/2020	9,596	$ 324.35	$ 344.15	$ 19.80	$ -	$ 19.80	$ 190,001
SPD	224,524	$ 814.48	$ 859.81	$ 45.33	$ -	$ 45.33	$ 10,177,673
SPD/Full-Dual	12,241	$ 205.34	$ 215.02	$ 9.68	$ -	$ 9.68	$ 118,493
BCCTP	3,493	$ 1,430.69	$ 1,511.47	$ 80.78	$ -	$ 80.78	$ 282,165
LTC	7,757	$ 11,026.93	$ 11,331.72	$ 304.79	$ -	$ 304.79	$ 2,364,256
LTC - MCHIP 7/2020 - 9/2020	9	$ 11,026.93	$ 11,331.72	$ 304.79	$ -	$ 304.79	$ 2,743
LTC - MCHIP 10/2020 - 12/2020	9	$ 11,026.93	$ 11,331.72	$ 304.79	$ -	$ 304.79	$ 2,743
LTC/Full-Dual	0	$ 6,630.57	$ 6,780.31	$ 149.74	$ -	$ 149.74	$ -
WCM	72,916	$ 1,876.85	$ 2,019.52	$ 142.67	$ -	$ 142.67	$ 10,402,926
Optional Expansion	1,388,207	$ 424.87	$ 450.10	$ 25.23	$ 6.31	$ 18.92	$ 26,264,876
	3,950,524	$ 334.30	$ 354.61	$ 20.31	$ 2.22	$ 18.09	$ 71,458,138

[1] The supplemental payments (Maternity, BHT and HEP C) and CCI population are not included in the rate range calculation.

[2] Other Departmental Usages decreases available rate range funding.

[3] BCCTP Federal Match is based on the portion of the population enrolleed in a BCCTP aid code associated with a FFP percentage of 65%.

[4] WCM Federal Match is based on the FFP percentage associated with the aid codes within each rating categories.

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken March 4, 2021
Regular Meeting of the CalOptima Board of Directors

Consent Calendar

16 Consider Ratification and Authorization of Additional Unbudgeted Expenditures Related to Coronavirus (COVID-19) Member Vaccination Incentive Program

Contacts

Emily Fonda, M.D., MMM, CHCQM, Interim Chief Medical Officer, (714) 246-8887
Marie Jeannis, Interim Executive Director, Quality and Population Health Management, (714) 246-8591

Recommended Actions

1. Ratify and authorize the unbudgeted expenditures in an amount up to $262,500 from existing reserves for mailing member education materials related to the Coronavirus (COVID-19) vaccination;
2. Authorize unbudgeted expenditures in an amount up to $695,974 from existing reserves for the COVID-19 Member Vaccination Incentive Program (VIP) to include the OneCare and OneCare Connect populations, subject to regulator(s) approval, as necessary;
3. Authorize the allocation of Intergovernmental Transfer (IGT) 10 funds in an amount not to exceed $221,145 for staffing resources for the COVID-19 Member VIP; and
4. Authorize funding for staffing resources for the COVID-19 Member VIP prior to CalOptima's receipt of IGT 10 funds from the State of California.

Background

On January 7, 2021, the CalOptima Board of Directors (Board) approved a COVID-19 Member VIP for calendar year 2021 (see Attachment 1). The goal of this program is to motivate members to get the required doses of COVID-19 vaccination by providing nonmonetary gift cards.

In addition to offering nonmonetary incentives, another essential strategy to promote vaccination is tailoring member education on the importance of vaccination and correcting misconceptions. As discussed at the Board's January 7, 2021 meeting, one element of the member communication plan is to mail information about the vaccine to all members. To provide this information in a timely manner, in February 2021, CalOptima has mailed member educational pieces (e.g., a cover letter addressing the importance of receiving vaccines, information on incentive administration, frequently asked questions, etc.) to all members. In addition, the texting campaign, which is another element of the strategy for member outreach, is currently pending approval by the Department of Health Care Services (DHCS), and staff will seek any additional required approvals as appropriate.

Staff also note that the OneCare (OC) and OneCare Connect (OCC) populations, among CalOptima's most vulnerable populations, were initially excluded from the COVID-19 Member VIP as this initiative is funded by IGT 10 dollars. In order to ensure the safety of these vulnerable populations and promote vaccination, staff recommend that the Board allocate additional funding for outreach and education of the OC and OCC members to align CalOptima's efforts with the County of Orange's COVID-19 Vaccine Equity Pilot Program (VEPP) deployment.

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Discussion

Member Education Mailing

Staff have been working with various internal and external partners on a member outreach program that provides COVID-19 vaccine information. The program includes a mailing to all members with information about the vaccine. Mailing outreach allows members who do not have a mobile phone or access to internet services to receive CalOptima's COVID-19 Member VIP information and other important vaccine-related information.

Staff estimates that the total cost for mailing educational materials, including postage, envelop, and printing and fulfillment, is $250,000. In addition, staff estimates mailing approximately 5,000 to 5,500 gift cards each month from March through June 2021. The total estimated cost for gift card mailing is $12,500.

Expanding the COVID-19 Member VIP to OC and OCC

OC and OCC members are among the highest risk populations that CalOptima serves due to their age and underlying chronic conditions. The OC/OCC populations are not eligible for IGT dollars as Medicare is their primary health insurance coverage; therefore, they were excluded from the COVID-19 Member VIP request that was approved at the Board's January 7, 2021 meeting. In order to promote vaccination among these populations, staff recommends that the Board authorize unbudgeted expenditures to expand the COVID-19 Member VIP to include OC and OCC members, subject to regulator(s) approvals as necessary.

Staff estimates a 70% vaccine take-up rate by OC and OCC members. The total estimated cost for Medicare member incentive gift cards and related gift card activation fees is $64,000 for OC and $631,974 for OCC. Staff note that OC and OCC members residing in long-term care settings and PACE members are excluded from this COVID-19 Member VIP.

Staffing Resources for COVID-19 Member VIP

In order to deploy the COVID-19 Member VIP in a timely and effective manner, staff recommends hiring a dedicated Program Specialist, Int. and two temporary staff under the Population Health Management department. The Program Specialist, Int. will work with various internal and external stakeholders to execute the planned activities, track vaccination status and member incentive distribution status. Staff proposes making this position permanent beyond the pandemic as member incentive programs continue to grow, and permanent staff resources would be beneficial to support coordination and tracking of various member incentives. Temporary staff will support any administrative and data entry related responsibilities.

The estimated salary and benefit expenses for the Program Specialist, Int. is $147,225 for an 18 month period. The estimated cost for 2 temporary staff for a 9 month period or approximately 1,000 work hours is $73,920.

CalOptima staff proposes staffing resources for COVID-19 Member VIP for up to $221,145 through allocation of IGT 10 funds. It is anticipated that CalOptima's share of IGT 10 funds will be

approximately $66 million ($43.3 million in Spring 2021 and $22.7 million in Fall 2021). Due to timing issues, staff requests the Board to authorize the CEO to approve this staff resources request prior to CalOptima's receipt of the IGT 10 funds from DHCS. As of February 1, 2021, the CalOptima Board of Directors has allocated $36.2 million of the anticipated IGT 10 funds, leaving $29.8 million unallocated. IGT 10 funds allocation recommendation requests totaling $221,145, including this one, are being made today. More information on IGT 10 is attached.

Fiscal Impact

The recommended actions to ratify and authorize mailing member education materials related to the COVID-19 vaccination and to include the OC and OCC populations in the COVID-19 Member VIP are unbudgeted items. An allocation of up to $958,474 from existing reserves will fund these actions.

The recommended action to allocate up to $221,145 for staffing resources for the COVID-19 Member VIP has no net fiscal impact to CalOptima's Fiscal Year 2020-21 Operating Budget approved by the Board on June 4, 2020. Staff anticipates any cash expended for this purpose will be replenished when IGT 10 funds are received from DHCS. Expenditure of IGT funds is for restricted, one-time purposes for covered Medi-Cal services to CalOptima members and does not commit CalOptima to future budget allocations.

Rationale for Recommendation

Ratification and authorization of the expenditures will allow CalOptima to promote vaccination for all members regardless of their eligibility program. The recommended actions will support CalOptima's efforts to help the community reach herd immunity and continue providing access to quality health care for members during the COVID-19 public health crisis.

Concurrence

Board of Directors' Finance and Audit Committee
Gary Crockett, Chief Counsel

Attachments

1. Board Action Dated January 7, 2021, Consider Authorizing Coronavirus (COVID-19) Vaccination Member Incentive Program for Calendar Year 2021
2. Intergovernmental Transfers (IGT) 10 Summary

/s/ Richard Sanchez *02/24/2021*
Authorized Signature **Date**

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken January 7, 2021
Special Meeting of the CalOptima Board of Directors

Report Item

5. Consider Authorizing Coronavirus (COVID-19) Vaccination Member Incentive Program for Calendar Year 2021

Contacts

Emily Fonda, M.D., MMM, CHCQM, Interim Chief Medical Officer, 714-246-8887
Betsy Ha, Executive Director, Quality and Population Health Management, 714-246-8574
Ladan Khamseh, Chief Operating Officer, (714) 246-8866

Recommended Actions

1. Authorize the development and implementation of a COVID-19 Vaccination Incentive Program (VIP) for Calendar Year (CY) 2021, as described below, to increase member participation and ensure community safety amid the COVID-19 pandemic, subject to DHCS approval prior to implementation;
2. Approve the recommended allocation of Intergovernmental Transfer (IGT) 10 funds, not to exceed $20 million, to provide two $25 nonmonetary gift cards to individual Medi-Cal members age 14 and older for receiving the two required doses of the COVID-19 vaccine (one gift card per shot); and
3. Authorize implementation of the VIP prior to CalOptima's receipt of IGT 10 funds from the State of California.
4. Authorize the Chief Executive Officer, with the assistance of Legal Counsel, to enter into an Memorandum of Understanding (MOU), and/or contract or contract amendment with the Orange County Health Care Agency (OCHCA) as appropriate for administration and implementation of the VIP.

Background

In late December 2020, the first doses of the COVID-19 vaccines arrived in Orange County. Vaccines will be distributed according to a phased approach, with high-priority groups vaccinated first and eventually the general public as determined by the California Department of Public Health and local health department. The U.S. Food and Drug Administration issued an emergency use authorization (EUA) for the Pfizer-BioNTech and Moderna vaccines, both of which offer more than 94% protection against COVID-19 when two doses are taken. Public health experts recommend that at least 70% of the population needs to get vaccinated to develop herd community, which can bring an end to the pandemic.

As the only Medi-Cal plan serving Orange County's most vulnerable residents, CalOptima is responding in collaboration with the Orange County Health Care Agency (OCHCA) to support the community in achieving herd immunity. The first step is a strategy that promotes COVID-19 vaccination, including tailoring member education on the importance of vaccination, dispelling misconceptions, and providing nonmonetary member incentives to ensure health equity across race, ethnicity and socioeconomic status. To support this effort, CalOptima staff is seeking an allocation of IGT 10 funds.

Intergovernmental Transfers (IGT) are transfers of public funds between eligible government entities, which are used to draw down federal funds for the Medi-Cal program. To date, CalOptima has participated in ten Voluntary Rate Range IGT transactions. Funds from IGTs 1 through 9 have been

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received, and IGT 10 funds will be distributed in two separate installments, which are expected from the state in 2021.

Discussion

Subject to state approval, staff will work with various internal and external partners on a member outreach program that provides COVID-19 vaccine information. The proposed program includes:

1. A mailing to all members with information about the vaccine.
2. A targeted text messaging campaign. When different priority groups are permitted to be vaccinated, CalOptima will send out targeted text messages to these members letting them know the following:
    a. They are now eligible to be vaccinated.
    b. Where they need to go to be vaccinated. (This information is not yet available, but staff continue to work with OCHCA to establish vaccine events in targeted geographic locations within the county. The vaccine events are likely to begin in Spring 2021, but may extend into the fall, depending on the vaccine distribution timeline as established by OCHCA.)
3. A targeted phone call campaign to population segments who are at high risk for not getting vaccinated. This will begin once the vaccine is widely available to at least essential workers, according to the phased approach.

Staff projects that as many as 400,000 members will participate in this program. To encourage members to participate in vaccination, staff proposes to provide two $25 nonmonetary gift cards for Medi-Cal members age 14 and older for receiving each of two doses of the COVID-19 vaccine, for a total of $50. Members will be encouraged to sign up with the OCHCA's app, Othena, at no cost, to receive the gift card incentives, one gift card for each shot received. The app is being developed to help healthcare providers track vaccine recipients to ensure they get a booster shot and to monitor for side effects. Staff is also seeking authority to enter into a Memorandum of Understanding (MOU) and/or contract or contract amendment with the County as necessary to implement the program. If it is subsequently determined that agreements with other entities, organizations or vendors are necessary, staff will return to the Board with further recommendations for consideration at a later date.

The targeted timeframe for the COVID-19 nonmonetary incentive is CY 2021. IGT 10 funds have not yet been received. For the approved and funded IGT transactions to date, the net proceeds have been evenly divided between CalOptima and the respective funding partners, and funds retained by CalOptima have been invested in addressing member's unmet health care needs. It is anticipated that CalOptima's share of IGT 10 funds will be approximately $66 million ($43.3 million in Spring 2021 and $22.7 million in Fall 2021).

Due to timing issues, staff requests that the Board authorize the CEO to implement the COVID-19 Vaccination Incentive Program for CY 2021 prior to CalOptima's receipt of IGT 10 funds from DHCS. Providing the nonmonetary incentive to coincide with the availability of the COVID-19 vaccination to members will support CalOptima's health promotion efforts in our community.

It should be noted that since IGT 10 funds are accounted for in the same fashion as the Medi-Cal capitation revenue CalOptima receives from DHCS, to the extent that these funds are not expended on covered, medically necessary Medi-Cal services or qualifying quality initiatives, the expenditures would be charged to CalOptima's administrative loss ratio (ALR), rather than the medical loss ratio (MLR).

Fiscal Impact

The recommended action to allocate up to $20 million in IGT 10 funds to support the COVID-19 Vaccination Member Incentive Program has no net fiscal impact to CalOptima's Fiscal Year 2020-21 Operating Budget approved by the Board on June 4, 2020. Staff anticipates any cash expended to implement the program will be replenished when IGT 10 funds are received from DHCS. Expenditure of IGT funds is for restricted one-time purposes for covered Medi-Cal services to CalOptima members and does not commit CalOptima to future budget allocations.

Rationale for Recommendation

Staff recommends adding a COVID-19 vaccination member incentive component to CalOptima's preventive initiatives to educate and encourage member participation. The recommended actions will support CalOptima's efforts to help the community reach herd immunity, address health disparities, and continue providing access to quality health care for members during the COVID-19 public health crisis.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. Entities Covered by this Recommended Action
2. CalOptima Board Action dated February 6, 2020, Consider Pursuit of Proposals with Qualifying Funding Partners to Secure Medi-Cal Funds Through the Voluntary Rate Range Intergovernmental Transfer Program for Rating Period 2019-20 (IGT 10)

/s/ Richard Sanchez *12/31/2020*
Authorized Signature **Date**

ENTITITES COVERED BY THIS RECOMMENDED ACTION

Legal Name	Address	City	State	Zip code
County of Orange	405 W. 5th Street, Suite 756	Santa Ana	CA	92701

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken February 6, 2020
Regular Meeting of the CalOptima Board of Directors

Report Item

15. Consider Pursuit of Proposals with Qualifying Funding Partners to Secure Medi-Cal Funds Through the Voluntary Rate Range Intergovernmental Transfer Program for Rating Period 2019-20 (IGT 10)

Contact

Candice Gomez, Executive Director, Program Implementation, (714) 246-8400

Recommended Actions

Authorize the following activities to secure Medi-Cal funds through the Voluntary Intergovernmental Transfer (IGT) Rate Range Program:

1. Submission of a proposal to the California Department of Health Care Services (DHCS) to participate in the Voluntary Rate Range IGT Program for Rating Period 2019-20 (IGT 10);
2. Pursuit of IGT funding partnerships with the University of California-Irvine, the Children and Families Commission, the County of Orange, the City of Orange, and the City of Newport Beach to participate in the upcoming Voluntary Rate Range IGT Program for Rating Period 2019-20 (IGT 10); and,
3. Authorize the Chief Executive Officer to execute agreements with these entities and their designated providers as necessary to seek IGT 10 funds.

Background

Intergovernmental Transfers (IGT) are transfers of public funds between eligible government entities which are used to draw down federal funds for the Medi-Cal program. To date, CalOptima has participated in eight Rate Range IGT transactions. Funds from IGTs 1 through 8 have been received and IGT 9 funds are expected from the state in the first quarter of 2020. IGTs 1 through 9 covered the applicable twelve-month state fiscal year (FY) periods (i.e., FY 2010-11 through FY 2018-19). IGT 1 through 7 funds were retrospective payments for prior rate range years and were designated to be used to provide enhanced/additional benefits to existing Medi-Cal beneficiaries, as represented to CMS. These funds have been best suited for one-time investments or as seed capital for enhanced health care services for the benefit of Medi-Cal beneficiaries.

The IGT funds received under IGTs 1 through 7 have supported special projects that address unmet healthcare needs of CalOptima members, such as vision and dental services for children, obesity prevention and intervention services, provider incentives for adolescent depression screenings, recuperative care for homeless members, and support for members through the Personal Care Coordinator (PCC) program.

Beginning with IGT 8, the IGT program covers the current fiscal year and funds will be incorporated into the contract between DHCS and CalOptima for the current fiscal year. Unlike previous IGTs (1-7), beginning with IGT 8 funds must be used in the current rate year for CalOptima covered Medi-Cal services per DHCS direction. IGT 8 funds have been allocated to the Homeless Health Initiative. IGT 9 funds have not yet been received, nor allocated; CalOptima staff anticipates returning with recommendations on an allocation plan in a separate Board action; however, as indicated,

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per DHCS, the use of these funds is limited to covered Medi-Cal benefits for existing CalOptima members.

For the approved and funded IGT transactions to date, the net proceeds have been evenly divided between CalOptima and the respective funding partners, and funds retained by CalOptima have been invested in addressing Member's unmet healthcare needs.

Discussion

On December 20, 2019, CalOptima received notification from DHCS regarding the Rating Period 2019 - 20 Voluntary Rate Range IGT Program (IGT 10). Unlike the prior IGTs, which covered the applicable twelve-month state fiscal year, IGT 10 covers eighteen months including the periods of July 1, 2019 through June 30, 2020 and July 1, 2020. through December 31, 2020. CalOptima's proposal, along with the funding entities' supporting documents are due to DHCS no later than February 19, 2020.

The five eligible funding entities from the previous IGT transactions have been contacted regarding their interest in participation in IGT 10. All five funding entities have informally indicated that they are interested in participation in the IGT program this year. The formal DHCS required Letter of Interest is due to CalOptima by February 14, 2020 for delivery to DHCS by February 19, 2020. These entities are:

1. University of California, Irvine,
2. Children and Families Commission of Orange County,
3. County of Orange,
4. City of Orange, and
5. City of Newport Beach.

Board approval is requested to authorize staff to submit the proposal letter to DHCS for participation in the 2019-20 Voluntary IGT Rate Range Program and to authorize the Chief Executive Officer to enter into agreements with each of the five proposed funding entities submitting a letter of interest (or their designated providers) for the purpose of securing available IGT funds. Consistent with the nine prior IGT transactions, it is anticipated that the net proceeds will be split evenly between the respective funding entities and CalOptima.

Staff will return to the Board with additional information regarding the IGT 10 transaction and a proposed expenditure plan for CalOptima's share of the net proceeds at a later date.

Fiscal Impact

The recommended actions to submit a proposal to DHCS and pursue IGT funding partnerships with five governmental funding entities for IGT 10 is expected to generate one-time IGT revenue that will be invested in covered Medi-Cal services for CalOptima members. As such, there is no net fiscal impact on CalOptima's current and future operating budgets.

Rationale for Recommendation

Consistent with the previous nine IGT transactions, submission of the proposal and authorization of funding agreements will allow the ability to maximize Orange County's available IGT funds for Rate Year 2019-20 (IGT 10). Also, consistent with the 2020-22 Strategic Plan, it would increase funding to support delivery of covered Medi-Cal services for CalOptima members.

Concurrence

Gary Crockett, Chief Counsel

Attachment

1. Entities Covered by this Recommended Board Action
2. Department of Health Care Services Voluntary IGT Rate Range Program Notification Letter

/s/ Michael Schrader — *01/28/2020*

Authorized Signature — **Date**

Attachment 1 to February 6, 2020 Board of Directors Meeting – Agenda Item 15

ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Legal Name	Address	City	State	Zip code
Children and Families Commission of Orange County	1505 E. 17th Street, 230	Santa Ana	CA	92705
City of Newport Beach	100 Civic Center Drive	Newport Beach	CA	92660
City of Orange	300 E. Chapman Avenue	Orange	CA	92866
Orange County Health Care Agency	405 W. 5th Street, 7th Floor	Santa Ana	CA	92701
University of California, Irvine UCI Health	333 City Blvd. West, Suite 200	Orange	CA	92868

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State of California—Health and Human Services Agency
Department of Health Care Services

RICHARD FIGUEROA
ACTING DIRECTOR

GAVIN NEWSOME
GOVERNOR

DEC 2 0 2019

Nancy Huang
Interim Chief Financial Officer
CalOptima
505 City Parkway West
Orange, CA 92868

SUBJECT: Rating Period 2019–20 (July 1, 2019 through December 31, 2020) Voluntary Rate Range Program – Request for Medi-Cal Managed Care Plan's (MCP) Proposal

Dear Ms. Nancy Huang:

The Rating Period 2019-20 Voluntary Rate Range Program, authorized by Welfare and Institutions (W&I) Code sections 14164, 14301.4, and 14301.5, provides a mechanism for funding the non-federal share of the difference between the lower and upper bounds of a MCP's actuarially sound rate range, as determined by the Department of Health Care Services (DHCS). Governmental funding entities eligible to transfer the non-federal share are defined as counties, cities, special purpose districts, state university teaching hospitals, and other political subdivisions of the state, pursuant to W&I Code section 14164(a). These governmental funding entities may voluntarily transfer funds to DHCS via intergovernmental transfer (IGT). These voluntary IGTs, together with the applicable Federal Financial Participation (FFP), will be used to fund payments by DHCS to MCPs as part of the capitation rates paid for the service periods of July 1, 2019 through June 30, 2020, and July 1, 2020 through December 31, 2020.

DHCS shall not direct the MCP's expenditure of payments received under the Rating Period 2019-20 Voluntary Rate Range Program. These payments are subject to all applicable requirements set forth in the MCP's contract with DHCS. These payments must also be tied to covered Medi-Cal services provided on behalf of Medi-Cal beneficiaries enrolled within the MCP's rating region.

The funds transferred by an eligible governmental funding entity must qualify for FFP pursuant to Title 42 Code of Federal Regulations (CFR) Part 433, Subpart B, including the requirements that the funding source(s) shall not be derived: from impermissible sources such as recycled Medicaid payments, Federal money excluded from use as state match, impermissible taxes, and non-bona fide provider-related donations. Impermissible sources do not include patient care or other revenue received from

programs such as Medicare or Medicaid to the extent that the program revenue is not obligated to the state as the source of funding.

DHCS shall continue to administer all aspects of the IGT related to the Rating Period 2019-20 Voluntary Rate Range Program, including determinations related to fees.

PROCESS FOR RATING PERIOD 2019-20:

MCPs should refer to the estimated Rating Period 2019-20 (service periods July 1, 2019 through June 30, 2020, and July 1, 2020 through December 31, 2020) county/region-specific non-federal share required to fund available rate range amounts for the MCP (see Attachment C). As a reminder, participation in the Rating Period 2019-20 Voluntary Rate Range Program is voluntary on the part of the transferring entity and the MCP. Note that for service periods July 1, 2019 through June 30, 2020 and July 1, 2020 through December 31, 2020, the Contribution (Non-Federal Share) amounts are based on Estimated Member Months, and the actual amounts may change based on actual enrollment. Note that for service period July 1, 2020 through December 31, 2020, the Contribution (Non-Federal Share) amounts are based on Projected Contribution PMPMs, and the actual amounts may change based on the risk adjustment process that DHCS uses as part of its rate development methodology.

If an MCP elect to participate in the Rating Period 2019-20 Voluntary Rate Range Program, the MCP must adhere to the process for participation outlined below:

Soliciting Interest

The MCP shall contact potential governmental funding entities to determine their interest, ability, and desired level of participation in the Rating Period 2019-20 Voluntary Rate Range Program. All providers and governmental funding entities who express their interest directly to DHCS will be redirected to the applicable MCP to facilitate negotiations related to participation. If, following the submission of the MCP's proposal, one or more governmental funding entities included in the MCP's proposal are unable or unwilling to participate in the Voluntary Rate Range Program, the MCP shall attempt to find other governmental funding entities able and willing to participate in their place.

The MCP must inform all participating governmental entities that, unless DHCS determines a statutory exemption applies, IGTs submitted in accordance with W&I Code section 14301.4 are subject to an additional 20 percent assessment fee (calculated on the value of their IGT contribution amount) to reimburse DHCS for the administrative costs of operating the Voluntary Rate Range Program and to support the Medi-Cal program. DHCS will determine if a fee waiver is appropriate.

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Submission Requirements

Once the MCP has coordinated with the relevant governmental funding entities, the following documents must be submitted to DHCS in accordance with the requirements and procedures set forth below:

- The MCP must submit a **proposal** to DHCS. This proposal must include:

  1. A cover letter signed by the MCP's Chief Executive Officer or Chief Financial Officer on MCP letterhead.
  2. The MCP's primary contact information (name, e-mail address, mailing address, and phone number).
  3. County/region-specific summaries of the selected governmental funding entities, related providers, and participation levels specified for Rating Period 2019-20. The combined amounts or percentages must not exceed 100 percent of the estimated non-federal share of the available rate range amounts provided by DHCS. If the MCP is unable to use the entire available rate range, the MCP must indicate the unfunded amount and percentage.
  4. All letters of interest (described below) and supporting documents must be attached to the proposal. If the Rating Period 2019-20 Voluntary Rate Range Program Supplemental Attachment described below is not collected by the MCP and attached to the proposal at the time of submission, please indicate if the information will be submitted to DHCS directly by each governmental funding entity.

- The MCP must obtain a **letter of interest** from each governmental funding entity included in the MCP's proposal to DHCS. The highlighted sections in the letter of interest form provided in Attachment A must be filled out completely and printed on the participating governmental funding entity's letterhead. A separate letter of interest must be provided for each county or rating region. An individual who is authorized to sign the certification on behalf of the governmental funding entity must sign the letter of interest.

- The MCP must distribute to governmental funding entities and ensure submission to DHCS, either by the MCP or the governmental funding entity, of the **Rating Period 2019-20 Voluntary Rate Range Program Supplemental Attachment** (see Attachment B) by Wednesday, February 19, 2020.

- The proposals and letters of interest are due to DHCS ***by 5pm on* Wednesday, February 19, 2020**. Please send a PDF copy of the required documents by e-

mail to Sandra.Dixon@dhcs.ca.gov. ***Failure to submit all required documents by the due date may result in exclusion from the Rating Period 2019-20 Voluntary Rate Range Program.***

Each proposal is subject to review and approval by DHCS. The review will include an evaluation of the proposed provider participation levels in comparison to their uncompensated contracted Medi-Cal costs and/or charges. DHCS reserves the right to approve, amend, or deny the proposal at its discretion.

Upon DHCS' approval of the governmental funding entities and non-federal share amounts for the Rating Period 2019-20 Voluntary Rate Range Program, DHCS will provide the necessary funding agreement templates, forms, and related due dates to the specified governmental funding entities and MCP contacts. The governmental funding entities will be responsible for completing all necessary funding agreement documents, responding to any inquiries necessary for obtaining approval, and obtaining all required signatures.

If you have any questions regarding this letter, please contact Sandra Dixon at (916) 345-8269 or by email at Sandra.Dixon@dhcs.ca.gov.

Sincerely,

Jennifer Lopez
Division Chief
Capitated Rates Development Division

Attachments

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cc: Michael Schrader
CalOptima
505 City Parkway West
Orange, CA 92868

Sandra Dixon
Capitated Rates Development Division
Department of Health Care Services
1501 Capitol Avenue, MS 4413
P.O. Box 997413
Sacramento, CA 95899-7413

ATTACHMENT A – LETTER OF INTEREST

Jennifer Lopez
Division Chief
Capitated Rates Development Division
Department of Health Care Services
1501 Capitol Avenue, MS 4413
P.O. Box 997413
Sacramento, CA 95899-7413

Dear Ms. Lopez:

This letter confirms the interest of _Insert Participating Funding Entity Name, a governmental entity, federal I.D. Number _Insert Federal Tax I.D. Number, in working with Managed Care Plan's Name (hereafter, "the MCP") and the California Department of Health Care Services (DHCS) to participate in the Voluntary Rate Range Program, including providing an Intergovernmental Transfer (IGT) to DHCS to be used as a portion of the non-federal share of actuarially sound Medi-Cal managed care capitation rate payments incorporated into the contract between the MCP and DHCS for the service periods of July 1, 2019 through June 30, 2020, and July 1, 2020 through December 31, 2020. This is a non-binding letter, stating our interest in helping to finance health improvements for Medi-Cal beneficiaries receiving services in our jurisdiction. The governmental entity's funds are being provided voluntarily, and the State of California is in no way requiring the governmental entity to provide any funding.

_Insert Participating Funding Entity Name is willing to contribute approximately $_____ for the Rating Period 2019-20 (July 1, 2019 through December 31, 2020) as negotiated with the MCP. We recognize that, unless a waiver is approved by DHCS, there will be an additional 20-percent assessment fee payable to DHCS on the funding amount, for the administrative costs of operating the voluntary rate range program.

The following individual from our organization will serve as the point of communication between our organization, the MCP and DHCS on this issue:

Entity Contact Information:

(Please provide complete information including name, street address, e-mail address and phone number.)

I certify that I am authorized to sign this certification on behalf of the governmental entity and that the statements in this letter are true and correct.

Sincerely,

Signature

Attachment B

Voluntary Rate Range Program Supplemental Attachment
Rating Period 2019-20 (July 1, 2019 through December 31, 2020)

Provider Name:
County:
Health Plan:

Instructions

Complete all yellow-highlighted fields. **Submit this completed form via e-mail to Sandra Dixon (sandra.dixon@dhcs.ca.gov) at the Department of Health Care Services (DHCS) by no later than February 19, 2020.**

1. In the table below, report charges/costs and payments received or expected to be received from the Health Plan indicated above for Medi-Cal services (Inpatient, Outpatient, and All Other) provided to Medi-Cal beneficiaries enrolled in the Health Plan and residing in the County indicated above, for dates of service from July 1, 2018 - June 30, 2019.

	Charges	Costs	Payments from Health Plan*	Uncompensated Chares (charges less payments)	Uncompensated Costs (Costs less payments)
Inpatient				$	$
Outpatient				$	$
All Other				$	$
Total	$	$	$	$	$

* Include payments received and anticipated to be received for service dates of July 1, 2018 through June 30, 2019.

2. Are you able to fund 100% of the higher of the uncompensated charges or uncompensated costs (as stated above)? *(Yes / No)*

If No, please specify the amount of funding available:

3. Describe the scope of services provided to the specified Health Plan's Medi-Cal members, and if these services were provided under a contract arrangement.

4. Please provide the following information:

(i) The name of the entity transferring funds:

(ii) The operational nature of the entity (county, city, special purpose district, state university teaching hospitals or other political subdivisions of the state) transferring funding:

(iii) The source of the funds:
(Funds must not be derived from impermissible sources such as recycled Medicaid payments, federal funds excluded from use as State match, impermissible taxes, and non-bona fide provider-related donations. Impermissible sources do not include patient care or other revenue received from programs such as Medicare or Medicaid to the extent that the program revenue is not obligated to the State as the source of

(iv) Does the transferring entity have general taxing authority? *(Yes / No)*

If No, does the transferring entity receive State appropriations (identify level of appropriation)? This may include, but not limited to, annual State appropriations for various programs, or realignment funds to support programs transferred by State Law to local control. *(Yes / No)*

5. Comments / Notes

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ATTACHMENT C

TOTAL AVAILABLE RATE RANGE

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CalOptima - Orange (HCP 506)
IGT - 2019/20 (July 2019 - June 2020)

	Total	50% FFP (Non-MCHIP,SPD and LTC)	88% FFP (MCHIP - 7/2019 to 9/2019)	76.5% FFP (MCHIP - 10/2019 to 6/2020)	BCCTP[3]	WCM[4]	93% FFP Optional Expansion (7/2019 - 12/2019)	90% FFP Optional Expansion (1/2020 - 6/2020)
Total Funds Available	$ 143,831,947	$ 60,609,553	$ 2,248,273	$ 6,744,806	$ 567,560	$ 20,884,320	$ 26,388,727	$ 26,388,708
Federal Match	$ 98,389,329	$ 30,304,777	$ 1,978,480	$ 5,159,777	$ 189,344	$ 12,465,598	$ 24,541,516	$ 23,749,837
Governmental Funding Entity's Portion	$ 45,442,618	$ 30,304,776	$ 269,793	$ 1,585,029	$ 378,216	$ 8,418,722	$ 1,847,211	$ 2,638,871
	31.6%	50.0%	12.0%	23.5%	66.6%	40.3%	7.0%	10.0%

Rate Categories[1]	Member Months (per Mercer est.)	Lower Bound (per Mercer Rate Worksheets)	Upper Bound (per Mercer Rate Worksheets)	Difference between Upper and Lower Bound	Other Departmental Usage[2]	Available PMPM (less Other Dept. Usage)	Estimated Available Total Fund
Child - non MCHIP	2,271,664	$ 87.64	$ 94.40	$ 6.76	$ -	$ 6.76	$ 15,356,449
Child - MCHIP 7/2019 - 9/2019	303,510	$ 87.64	$ 94.40	$ 6.76	$ -	$ 6.76	$ 2,051,728
Child - MCHIP 10/2019 - 6/2020	910,531	$ 87.64	$ 94.40	$ 6.76	$ -	$ 6.76	$ 6,155,190
Adult - non MCHIP	1,007,518	$ 324.35	$ 344.15	$ 19.80	$ -	$ 19.80	$ 19,948,856
Adult - MCHIP 7/2019 - 9/2019	9,788	$ 324.35	$ 344.15	$ 19.80	$ -	$ 19.80	$ 193,802
Adult - MCHIP 10/2019 - 6/2020	29,363	$ 324.35	$ 344.15	$ 19.80	$ -	$ 19.80	$ 581,387
SPD	448,861	$ 814.48	$ 859.81	$ 45.33	$ -	$ 45.33	$ 20,346,869
SPD/Full-Dual	24,336	$ 205.34	$ 215.02	$ 9.68	$ -	$ 9.68	$ 235,572
BCCTP	7,026	$ 1,430.69	$ 1,511.47	$ 80.78	$ -	$ 80.78	$ 567,560
LTC	15,492	$ 11,026.93	$ 11,331.72	$ 304.79	$ -	$ 304.79	$ 4,721,807
LTC - MCHIP 7/2019 - 9/2019	9	$ 11,026.93	$ 11,331.72	$ 304.79	$ -	$ 304.79	$ 2,743
LTC - MCHIP 10/2019 - 6/2020	27	$ 11,026.93	$ 11,331.72	$ 304.79	$ -	$ 304.79	$ 8,229
LTC/Full-Dual	0	$ 6,630.57	$ 6,780.31	$ 149.74	$ -	$ 149.74	$ -
WCM	146,382	$ 1,876.85	$ 2,019.52	$ 142.67	$ -	$ 142.67	$ 20,884,320
Optional Expansion 7/2019 - 12/2019	1,394,753	$ 424.87	$ 450.10	$ 25.23	$ 6.31	$ 18.92	$ 26,388,727
Optional Expansion 1/2020 - 6/2020	1,394,752	$ 424.87	$ 450.10	$ 25.23	$ 6.31	$ 18.92	$ 26,388,708
	7,964,012	$ 333.59	$ 353.87	$ 20.27	$ 2.21	$ 18.06	$ 143,831,947

[1] The supplemental payments (Maternity, BHT and HEP C) and CCI population are not included in the rate range calculation.

[2] Other Departmental Usages decreases available rate range funding.

[3] BCCTP Federal Match is based on the portion of the population enrolleed in a BCCTP aid code associated with a FFP percentage of 65%.

[4] WCM Federal Match is based on the FFP percentage associated with the aid codes within each rating categories.

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CalOptima - Orange (HCP 506)
IGT - 2019/20 (July 2020 - December 2020)

	Total	50% FFP (Non-MCHIP and SPD)	76.5% FFP (MCHIP - 7/2020 to 9/2020)	65% FFP (MCHIP - 10/2020 to 12/2020)	BCCTP [3]	WCM [4]	90% FFP Optional Expansion
Total Funds Available	$ 71,458,138	$ 30,053,529	$ 2,227,321	$ 2,227,321	$ 282,165	$ 10,402,926	$ 26,264,876
Federal Match	$ 47,878,762	$ 15,026,765	$ 1,703,901	$ 1,447,759	$ 94,133	$ 5,967,816	$ 23,638,388
Governmental Funding Entity's Portion	$ 23,579,376	$ 15,026,764	$ 523,420	$ 779,562	$ 188,032	$ 4,435,110	$ 2,626,488
	33.0%	50.0%	23.5%	35.0%	66.6%	42.6%	10.0%

Rate Categories [1]	Member Months (per Mercer est.)	Lower Bound (per Mercer Rate Worksheets)	Upper Bound (per Mercer Rate Worksheets)	Difference between Upper and Lower Bound	Other Departmental Usage [2]	Available PMPM (less Other Dept. Usage)	Estimated Available Total Fund
Child - non MCHIP	1,126,338	$ 87.64	$ 94.40	$ 6.76	$ -	$ 6.76	$ 7,614,045
Child - MCHIP 7/2020 - 9/2020	300,973	$ 87.64	$ 94.40	$ 6.76	$ -	$ 6.76	$ 2,034,577
Child - MCHIP 10/2020 - 12/2020	300,973	$ 87.64	$ 94.40	$ 6.76	$ -	$ 6.76	$ 2,034,577
Adult - non MCHIP	493,892	$ 324.35	$ 344.15	$ 19.80	$ -	$ 19.80	$ 9,779,062
Adult - MCHIP 7/2020 - 9/2020	9,596	$ 324.35	$ 344.15	$ 19.80	$ -	$ 19.80	$ 190,001
Adult - MCHIP 10/2020 - 12/2020	9,596	$ 324.35	$ 344.15	$ 19.80	$ -	$ 19.80	$ 190,001
SPD	224,524	$ 814.48	$ 859.81	$ 45.33	$ -	$ 45.33	$ 10,177,673
SPD/Full-Dual	12,241	$ 205.34	$ 215.02	$ 9.68	$ -	$ 9.68	$ 118,493
BCCTP	3,493	$ 1,430.69	$ 1,511.47	$ 80.78	$ -	$ 80.78	$ 282,165
LTC	7,757	$ 11,026.93	$ 11,331.72	$ 304.79	$ -	$ 304.79	$ 2,364,256
LTC - MCHIP 7/2020 - 9/2020	9	$ 11,026.93	$ 11,331.72	$ 304.79	$ -	$ 304.79	$ 2,743
LTC - MCHIP 10/2020 - 12/2020	9	$ 11,026.93	$ 11,331.72	$ 304.79	$ -	$ 304.79	$ 2,743
LTC/Full-Dual	0	$ 6,630.57	$ 6,780.31	$ 149.74	$ -	$ 149.74	$ -
WCM	72,916	$ 1,876.85	$ 2,019.52	$ 142.67	$ -	$ 142.67	$ 10,402,926
Optional Expansion	1,388,207	$ 424.87	$ 450.10	$ 25.23	$ 6.31	$ 18.92	$ 26,264,876
	3,950,524	$ 334.30	$ 354.61	$ 20.31	$ 2.22	$ 18.09	$ 71,458,138

[1] The supplemental payments (Maternity, BHT and HEP C) and CCI population are not included in the rate range calculation.

[2] Other Departmental Usages decreases available rate range funding.

[3] BCCTP Federal Match is based on the portion of the population enrolleed in a BCCTP aid code associated with a FFP percentage of 65%.

[4] WCM Federal Match is based on the FFP percentage associated with the aid codes within each rating categories.

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Intergovernmental Transfers (IGT) 10 Summary

Intergovernmental Transfers (IGT) are transfers of public funds between eligible government entities, which are used to draw down federal funds for the Medi-Cal program. To date, CalOptima has participated in ten Voluntary Rate Range IGT transactions. Funds from IGTs 1 through 9 have been received. IGT 10 funds are expected to be received from DHCS in two installments in 2021.

For the DHCS approved and funded IGT transactions to date, the net proceeds have been evenly divided between CalOptima and the respective funding partners, and funds retained by CalOptima have been invested in addressing member's unmet health care needs. It is anticipated that CalOptima's share of IGT 10 funds will be approximately $66 million ($43.3 million in Spring 2021 and $22.7 million in Fall 2021). As of February 1, 2021, the CalOptima Board of Directors has allocated $36.2 million of IGT 10 funds, leaving $29.8 unallocated as follows:

Date	Initiative	Amount
	Total Anticipated	**$66.0 million**
1/7/2021	Orange County COVID-19 Nursing Home Prevention Program Grant Extension and Expansion	$1.2 million
1/7/2021	COVID-19 Vaccination Member Incentive Program for Calendar Year 2021	$35.0 million
	Total Allocated	**$36.2 million**
	Unallocated	**$29.8 million**
	Total Allocation Recommendation Requested at the February 2021 Finance and Audit Committee Meeting	**$221,145**

It should be noted that since IGT 10 funds are accounted for in the same fashion as the Medi-Cal capitation revenue CalOptima receives from DHCS, to the extent that these funds are not expended on covered, medically necessary Medi-Cal services or qualifying quality initiatives, the expenditures would be charged to CalOptima's administrative loss ratio (ALR), rather than the medical loss ratio (MLR).

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State of California—Health and Human Services Agency
Department of Health Care Services

WILL LIGHTBOURNE
DIRECTOR

GAVIN NEWSOM
GOVERNOR

DATE: September 1, 2021

ALL PLAN LETTER 21-010 *(Revised)*

TO: ALL MEDI-CAL MANAGED CARE HEALTH PLANS

SUBJECT: MEDI-CAL COVID-19 VACCINATION INCENTIVE PROGRAM

PURPOSE:
The purpose of this All Plan Letter (APL) is to provide guidance to Medi-Cal managed care health plans (MCPs) regarding the Medi-Cal COVID-19 Vaccination Incentive Program. For the purposes of this APL, MCPs include Cal MediConnect Medicare-Medicaid Plans (MMPs). Revised text is found in *italics*.

BACKGROUND:
As of *August 8*, 2021, *48.7* percent of Medi-Cal beneficiaries ages 12 years and older compared with *73.7* percent of all Californians ages 12 years and older have received at least one dose of a COVID-19 vaccine. Approximately 14 million Californians are enrolled in Medi-Cal, including individuals from diverse racial and ethnic groups, those with complex care needs, seniors and persons with disabilities, those who live in rural/frontier communities, individuals experiencing homelessness, refugee and immigrant communities, those dually eligible for Medicare and Medi-Cal, and other individuals who may be hard to reach or face health disparities.

MCPs are responsible for managing care for the vast majority of Medi-Cal beneficiaries. As part of their contractual obligations, MCPs are required to provide case management and care coordination for members, making them well positioned to provide enhanced coordination services, partner with primary care providers, pharmacies and other trusted community partners, and conduct outreach for vaccine distribution for their members, including harder-to-reach populations.

The Department of Health Care Services (DHCS) is allocating up to $350 million to incentivize COVID-19 vaccination efforts in the Medi-Cal managed care delivery system for the service period of September 1, 2021 through February 28, 2022 (“performance period”). MCPs are eligible to earn incentive payments for activities that are designed to close vaccination gaps with their enrolled members. Participating MCPs will develop Vaccination Response Plans to improve vaccine access and to develop the infrastructure to support this work in the long term. DHCS is seeking Centers for Medicare and Medicaid Services (CMS) approval for this program in accordance with 42 Code of Federal Regulations (CFR) section 438.6(b)(2), but will go live at the state’s risk

even if CMS approval is still pending. Terms of the program may be modified to obtain CMS approval.

POLICY:
Effective September 1, 2021, participating MCPs may be eligible to participate in the Medi-Cal COVID-19 Vaccination Incentive Program.

MCP Eligibility and Participation
MCP participation in this incentive program is voluntary, but strongly encouraged. MCPs that elect to participate must adhere to program and applicable federal and state requirements in order to earn incentive payments.

All MCPs, including Cal MediConnect MMPs, are eligible to participate, except the following:

- Family Mosaic Project;
- Programs of All-Inclusive Care for the Elderly;
- Rady Children's Hospital San Diego (California Children's Services pilot program); and
- MCPs that are not primarily responsible for physical health care, such as county Mental Health Plans and Dental Managed Care Plans.

Impacted and Focus Populations
This incentive program covers all MCP members who are not fully vaccinated against COVID-19. This includes members who received the first dose of a multi-dose vaccine prior to September 1, 2021, but not *subsequent recommended doses*.

To assist Primary Care Providers and, if applicable, other local partners as needed with outreaching to their assigned members, MCPs must share the data provided by DHCS on their unvaccinated members.

DHCS has identified some populations of focus served by MCPs who have been disproportionately challenged in the initial phases of vaccine distribution and take-up. These include members who:

- Are homebound and unable to travel to vaccination sites;
- Are 50-64 years of age with *one or more* chronic diseases;
- Self-identify as persons of color; and
- Are youth 12-25 years of age.

MCPs are encouraged to consider strategies particularly for, but not limited to, these populations of focus. As information and strategies evolve, DHCS may identify additional populations of focus.

Incentive Program Structure
The incentive program is designed to encourage MCPs to attain specific performance measures that include both process and outcome measures. The maximum amount of MCP incentive payments that may be earned by all MCPs for these measures is $250 million. The maximum incentive amount that each individual MCP is eligible to earn will be established in proportion to the MCP's enrolled membership relative to total Medi-Cal managed care enrollment, as determined by DHCS and subject to the requirement of 42 CFR 438.6(b)(2) that incentive payments not exceed five percent of the value of capitation payments attributable to the enrollees or services covered by the incentive arrangement. Additionally, there will be a $100 million pool of funds available for MCPs to utilize for direct member incentives (e.g., $50 gift card to grocery store) as part of the MCP's Vaccination Response Plan.

To fully meet the vaccine needs of members, the measures will allow MCPs to earn incentives for increasing outreach efforts to underserved communities, building and monitoring data systems, and coordinating with regional partners to ensure all members have equitable access to vaccines, regardless of demographic factors such disability, race, and/or ethnicity. See the Process and Outcome Measures section below for details regarding MCP incentive structures.

Vaccination Response Plan
Participating MCPs are required to develop a Vaccination Response Plan, and submit this plan to DHCS for review and approval. MCP Vaccination Response Plan submissions are due no later than September 1, 2021. DHCS will review MCP Vaccination Response Plan submissions on a rolling and expedited basis. This Vaccination Response Plan must be broad reaching, but must consider the outcome measures and prioritize impacted and focus populations as described above. MCPs must specifically identify strategies for collaborating and supporting organizations, which include but are not limited to community-based organizations, trusted local partners, tribal partners, community health workers, promotoras, pharmacies, local health departments, and faith-based partnerships, in their Vaccination Response Plans to increase vaccine uptake success. MCPs must also identify strategies to ensure homebound members are contacted, that opportunities to receive the vaccine are identified, and coordination activities to receive the vaccine are implemented. MCPs must report to DHCS on their activities under the Vaccine Response Plan at the program's conclusion.

DHCS has developed a Vaccination Response Plan Template that contains the required components of the Vaccination Response Plan, which MCPs are required to use. DHCS will provide this template via email upon initial issuance of this APL; however, MCPs can request a copy of this template by emailing mcqmd@dhcs.ca.gov. *MCPs must*

submit their Vaccination Response Plans on the template to mcqmd@dhcs.ca.gov by September 1, 2021.

Process and Outcome Measures

MCPs collectively may earn up to $250 million, statewide, for achieving specified process and outcome measures. Please refer to Attachment A for outcome measures.

- Process Measure (20%)
  - MCPs may earn 20% of their maximum incentive allocation, as determined by DHCS, for development and submission of a Vaccination Response Plan that addresses all of the components listed in the Vaccination Response Plan Template and is approved by DHCS.
  - MCPs must submit their Vaccination Response Plan to DHCS by September 1, 2021, and all Vaccination Response Plans must have a start or implementation date no later than September 21, 2021.
  - Payment to each MCP will be made following DHCS' approval of its Vaccination Response Plan.

- Outcome Measures (80%)
  - MCPs may earn 80% of their maximum incentive amount for achievement of outcomes measures specified by DHCS. Please refer to Attachment A for the structure of the payment as tied to specific outcomes measures and further details regarding each outcome measures.
  - Partial payments will be made available for MCPs that make some progress in improving vaccination rates but do not meet pre-specified endpoints for full payment.
  - DHCS will make incentive payments on a schedule to be determined DHCS. Payments will be based on achievement of specified outcome measures.

Direct Member Vaccine Incentives

There will be a $100 million pool of funds available for MCPs to utilize for direct member incentives (e.g., $50 gift card to grocery store). In order to draw funds from the direct member incentive pool, MCPs must attest to meeting specified requirements and include their direct member incentive strategy in their Vaccination Response Plan. See the Vaccination Response Plan Template for specified requirements that MCPs must meet to draw funds from the direct member incentive pool. MCPs that elect to offer direct member incentives must comply with applicable state and federal requirements, including but not limited to the U.S. Department of Health and Human Services Office of

the Inspector General guidance related to offering or providing a reward or incentive in connection with a beneficiary receiving a COVID-19 vaccine.[1]

Payment and Other Considerations
DHCS will issue payment for process and outcome measures upon approving the MCP's Vaccination Response Plan and assessing achievement of outcomes at three intervals: as of October 31, 2021, January 2, 2022, and March 6, 2022.

As a condition of participation, MCPs will be expected to report to DHCS all available data and information that DHCS deems to be necessary to evaluate the MCP's performance on specified incentive program measures and for the disbursement of funds from the direct member incentive pool. Additional guidance related to the reporting schedule and requirements for progress being made on achieving the outcome measures, as well as for the direct member incentive pool, are forthcoming.

Incentive payments earned by MCPs under this program, as well as expenses directly associated with a MCP's participation in this program including but not limited to administrative costs and costs of direct member incentives, must be excluded from all applicable risk mitigation calculations. In addition, these incentive payments must be independent of, and must not interact with, the application of savings percentages and quality withholds to capitation rates for Cal MediConnect MMPs.

Member Outreach
DHCS requests MCPs to outreach to members using all communication mechanisms. Calls and text messages are exempt from the Telephone Consumer Protection Act (TCPA) under a COVID-19 exemption if they meet the following requirements: [2,3]

- The caller must be from a hospital, or be a health care provider, state or local health official, or other government official, as well as a person under the express direction of such an organization and acting on its behalf.
- The content of the call must be:
    - Solely informational;
    - Made necessary because of the COVID-19 outbreak; and

[1] See Frequently Asked Questions – Application of the Office of Inspector General's Administrative Enforcement Authorities to Arrangements Directly Connected to the Coronavirus Disease 2019 (COVID-19) Public Health Emergency at: https://oig.hhs.gov/coronavirus/authorities-faq.asp
[2] See Telephone Consumer Protection Act of 1991, Pub. L. No. 102-243, 105 Stat. 2394 (1991), codified at 47 U.S.C. Section 227, available at: https://www.govinfo.gov/content/pkg/USCODE-2011-title47/pdf/USCODE-2011-title47-chap5-subchapII-partI-sec227.pdf.
[3] See FCC Public Notice, Consumer and Governmental Affairs Bureau Clarification on Emergency COVID-19 Related Calls, DA 20-793.

- Directly related to the imminent health or safety risk arising out of the COVID-19 outbreak.

Based on guidance in the Federal Communications Commission (FCC) notice, the rise in COVID-19 cases across California poses a significant and imminent health and safety risk for all state citizens, including Medi-Cal beneficiaries. To address the surge in COVID-19 cases, DHCS is requesting that MCPs conduct outreach to their members regarding the availability of COVID-19 vaccines; the goal of these outreach campaigns is to increase vaccine rates to stop the spread of COVID-19.

MCPs may use calls and text messages that meet the requirements of the TCPA COVID-19 exemption as part of this outreach campaign. As a reminder, texting campaigns related to COVID-19 can be submitted as File and Use only if the MCP has previously received approval on a texting campaign (as of June 18, 2019, forward). If prior approval has not been given, the MCP must submit the texting campaign template for review and approval prior to implementing the campaign. Please refer to the March 30, 2020, email from DHCS related to texting flexibilities. DHCS will prioritize and expedite the review of MCP File and Use texting campaign request submissions.

MCPs may submit their vaccine outreach campaign member materials to DHCS under the File and Use flexibility set forth in APL 20-004. DHCS will make every effort to review and approve submissions expeditiously. *MCPs may use vaccine materials developed by the California Department of Public Health (CDPH) without undergoing DHCS review.*[4]

[4] *CDPH-developed materials are available on DHCS' COVID-19 Response webpage, located at: https://www.dhcs.ca.gov/Pages/DHCS-COVID%E2%80%9119-Response.aspx*.

MCPs are responsible for ensuring that their 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.[5] These requirements must be communicated by each MCP to all Subcontractors and Network Providers. If you have any questions regarding this APL, please contact your MCOD Contract Manager.

Sincerely,

Original signed by Bambi Cisneros

Bambi Cisneros, Acting Chief
Managed Care Quality and Monitoring Division

[5] For more information on Subcontractors and Network Providers, including the definition and applicable requirements, see APL 19-001, and any subsequent APLs on this topic.

Attachment A
Department of Health Care Services
Vaccination Incentive Program
Outcome Metrics

<table>
<tr><th>Program component</th><th>Determination of incentive amount</th><th>Terms of incentive payment</th><th>Timing of baseline data and outcome ascertainment</th></tr>
<tr><td rowspan="2">Vaccine Outcome Achievement ($200M)</td><td>Initial determination of maximum Medi-Cal managed care health plan (MCP) incentive amount based on MCP proportion of total Medi-Cal managed care enrollment</td><td>Specified payment earned upon MCP achievement of specified outcome</td><td>Baseline: Vaccination rate as of August 29, 2021.
Outcome ascertainment: Vaccination rate as of:
• October 31, 2021
• January 2, 2022
• March 6, 2022</td></tr>
<tr><td colspan="3"><u>Proposed outcome measures (and weight)</u>

<u>Intermediate outcome measures</u>
MCPs must choose two of the following three intermediate outcome measures to report:
1. Percent of homebound Medi-Cal beneficiaries who received at least one dose of a COVID-19 vaccine (5% weight).
2. Percent of Medi-Cal beneficiaries ages 50-64 years of age with one or more chronic diseases (as defined by the federal Centers for Disease Control and Prevention (CDC) https://www.cdc.gov/coronavirus/2019-ncov/need-extra-precautions/people-with-medical-conditions.html) who received at least one dose of a COVID-19 vaccine (5% weight).
3. Percent of primary care providers in the MCP's network providing COVID-19 vaccine in their office (5% weight).

<u>Vaccine uptake outcome measures</u>
Payment will be based on performance on all of the below vaccine uptake outcome measures, calculated by the Department of Health Care Services (DHCS) and weighted as indicated.
Overall vaccine uptake
4. Percent of Medi-Cal beneficiaries ages 12 years and older who received at least one dose of a COVID-19 vaccine (35% weight).
Age group
5. Percent of Medi-Cal beneficiaries ages 12-25 years who received at least one dose of a COVID-19 vaccine (10% weight).
6. Percent of Medi-Cal beneficiaries ages 26-49 years who received at least one dose of a COVID-19 vaccine (5% weight).
7. Percent of Medi-Cal beneficiaries ages 50-64 years who received at least one dose of a COVID-19 vaccine (5% weight).</td></tr>
</table>

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	8. Percent of Medi-Cal beneficiaries ages 65+ years who received at least one dose of a COVID-19 vaccine (5% weight). **Race/ethnicity** 9. Percent of Medi-Cal beneficiaries ages 12 years and older from the race/ethnicity group with the lowest baseline vaccination rate who received at least one dose of a COVID-19 vaccine (15% weight). 10. Percent of Medi-Cal beneficiaries ages 12 years and older from the race/ethnicity group with the second-lowest baseline vaccination rate who received at least one dose of a COVID-19 vaccine (15% weight). The "race/ethnicity group with the lowest baseline vaccination rate" is defined based on the MCP-specific baseline vaccination rate of persons of Hispanic, American Indian/Alaska Native, Asian/Pacific Islander, Black/African American, and White race/ethnicity as identified using the below data sources.
	Data sources **Intermediate outcome measures**: MCP-reported data. Measure specifications and due dates for MCP-reported data for these intermediate outcome measures will be *forthcoming*. **Vaccine uptake outcome measures**: Eligibility data from the Medi-Cal Data Warehouse, matched with COVID-19 vaccination data from the California Immunization Registry. Data currently does not include doses administered by federal agencies who received vaccines allocated directly from CDC.
	Target setting Intermediate outcome measures **For measures 1-3**, the MCP-specific targets will be as follows: • By October 31, 2021, a 10% increase over the MCP's baseline rate. • By January 2, 2022, a 20% increase over the MCP's baseline rate. • By March 6, 2022, a 30% increase over the MCP's baseline rate. Vaccine uptake outcome measures **For measure 4**, gap closure from baseline to a target defined as the percent of persons 12 years of age and older who received at least one dose of a COVID-19 vaccine on or before the outcome ascertainment date in the county or counties served by the MCP. For MCPs that serve one county, this would be the county rate. For MCPs that serve more than one county, this would be the weighted-average rate across all counties served. **For measures 5-8**, gap closure from baseline to a target defined as the percent of persons in the same age group who received at least one

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	dose of a COVID-19 vaccine on or before the outcome ascertainment date in the county or counties served by the MCP. For MCPs that serve one county, this would be the county rate. For MCPs that serve more than one county, this would be the weighted-average rate across all counties served. **For measures 9-10**, gap closure from baseline to a target defined as the percent of the MCP's members 12 years of age and older who received at least one dose of a COVID-19 vaccine on or before the outcome ascertainment date. For MCPs that serve one county, this would be the county rate. For MCPs that serve more than one county, this would be the weighted-average rate across all counties served. <u>Gap closure for vaccine uptake outcome measures</u> To earn full payment for measures 4-10, MCPs would need to close 33.3% of the gap between their baseline rate and the above-defined target rate by October 31, 2021; 66.6% of the gap between their baseline rate and the target rate by January 2, 2022; and 100% of the gap between their baseline rate and the target rate by March 6, 2022.
Partial payment	For vaccine uptake outcome measures 4-10, MCPs may earn partial payment in proportion to the gap closure they achieve between their baseline rate and the targeted 33.3%, 66.6%, and 100% gap closure at each respective time point. *MCPs must achieve* gap closure of *at least* 5%, 10%, and 15% at each respective time point *to qualify for partial payment. The actual amount of any partial payment will be calculated as the actual gap closure divided by the targeted gap closure at each respective time point, multiplied by the full payment amount*.
High Performance Pool	Any leftover funds not claimed by MCPs will be pooled and placed into a High Performance Pool (HPP). **HPP Measures** HPP funds will be redistributed to MCPs with at least 85% of Medi-Cal members ages 12 years and older who received at least one dose of a COVID-19 vaccine by March 6, 2022. DHCS will also consider adding a HPP outcome measure for children ages 5-11 years, assuming the vaccine has Emergency Use Authorization (EUA) approval for these ages within this timeframe, and may also consider adding an outcome measure related to the percent of Medi-Cal members who are fully vaccinated, if data indicates a significant portion of Medi-Cal members who receive at least one dose are not becoming fully vaccinated. The payment from the HPP will be proportionate to MCP's Medi-Cal membership achieving the HHP Measure. DHCS will amend the Vaccine Incentive Program APL to incorporate any updates to measures (e.g., for younger ages upon EUA approval)

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	and the payment methodology related to the valuation and distribution of this HHP.

Contents

Cover Sheet

Fill in Medi-Cal Managed Care Health Plan (MCP) Contact Information:

MCP Name	CalOptima
Contact Person First and Last Name	Michael Wood
Contact Person Title/Position	Manager, Regulatory Affairs & Compliance
Phone Number	714-246-8415
Email Address	mwood@caloptima.org
Mailing Address	505 City Parkway West Orange, CA 92868

I. Vaccination Response Plan

Participating Medi-Cal managed care plans are required to develop a Vaccination Response Plan, and submit this plan to DHCS for review and approval. MCP Vaccination Response Plan submissions are due no later than September 1, 2021. DHCS will review MCP Vaccination Response Plan submissions on a rolling and expedited basis. This Vaccination Response Plan must be broad reaching, but must consider the outcome measures and prioritize impacted and focus populations as described in the APL 21-010.

MCPs must report to DHCS on their activities under the Vaccine Response Plan at the program's conclusion.

Strategies for Building Vaccine Confidence and Combating Misinformation

1. Describe how the MCP will provide evidence-based information to members, providers, community-based organizations (CBO), tribal partners, and other local partners about the COVID-19 vaccine to encourage vaccine uptake from all members. Character limit: 2,500 characters.

CalOptima will develop a new series of trusted messenger videos and evidenced-based messages appropriate for promoting vaccination uptake in the current environment. These videos and messages will be shared via the CalOptima website, social media platforms, SMS text and advertising/marketing. In addition, CalOptima will engage providers in sharing evidence-based messaging through a COVID-19 vaccine tool kit available via the provider area of the CalOptima website and provider portal.

Further, CalOptima will engage our extensive network of community-based organizations and partners to amplify the messages. CalOptima has developed a very robust process to inform nearly 2,700 community-based organizations using an electronic newsletter, Community Announcements, which includes COVID-19 guidance provided by regulators and other subject matter experts. Sent bi-weekly at minimum, the newsletter not only supports educating our local partners but empowers them to share information with their clients, including CalOptima members. As part of our ongoing community relations efforts, CalOptima will also distribute evidence-based information and available resources at the more than 30 collaboratives meetings we regularly attend and/or host.

2. Describe how the MCP will provide information on where to get the vaccine within the member's community. Character limit: 2,500 characters.

CalOptima will share available vaccine locations using social media, SMS texts and the CalOptima website. We will also inform our networks of community-based organizations and providers to raise awareness.

In particular, vaccine location information will be available in the electronic Community Announcements newsletter (bi-weekly at minimum). Further, CalOptima will continue collaborating with community partners to host vaccination events that increase awareness of CalOptima member incentives and serve target populations, including children and young adults. For example, CalOptima will continue working with community partners to host back-to-school vaccine events to make getting a COVID-19 vaccine more convenient.

In addition, using the same communication vehicles mentioned in 1, CalOptima will share information (available in 10 languages) from the Orange County Health Care Agency COVID-19 Education Tool Kit that includes a call-in number and website to find out where local vaccination clinics are being held and make appointments.

3. Describe the MCP's plans for a local media campaign to disseminate information to members about vaccines, resources, and availability. MCPs can consider amplifying existing media campaign efforts using a variety of media channels. Character limit: 2,500 characters.

CalOptima will restart our robust advertising campaign, which ran most recently in March–June 2021, emphasizing vaccine safety and effectiveness. The tactics will include print, radio, outdoor, digital (website), social media and TV (cable), and will include English, Spanish and Vietnamese. In response to the need to target certain geographies based on lower vaccination rates, CalOptima will add a new tactic of hyperlocal advertising, which features ads placed in local businesses, such as grocery stores, barber shops, laundromats, etc.

Further, CalOptima will update the messages to make them relevant to current issues and respond to vaccine hesitancy. A campaign of this size and breadth requires considerable investment and coordination, but CalOptima has an internal team of ad designers and marketing specialists who can implement this program efficiently.

a. Describe how the local media campaign will counter misinformation. Character limit: 2,500 characters.

CalOptima will update the media messages to make them relevant to current issues and respond to vaccine hesitancy. The potential theme will use a myth/reality approach to ensure misinformation is addressed.

b. Describe how the MCP with engage trusted partners and tribal partners where applicable in the local media campaign. Character limit: 2,500 characters.

In April 2021, CalOptima released a series of effective and engaging videos using trusted messengers as spokespeople (in three languages). As part of the new incentive program, CalOptima will re-engage the same or other trusted messengers within the identified target populations to create a new series that uses a myth/reality approach.

4. Describe how the MCP will collaborate with schools and colleges to target youth who are 12-25 years of age. Character limit: 2,500 characters.

CalOptima will leverage our well-established relationships with school districts to share information as well as conduct targeted outreach to community organizations serving this age group. In addition, CalOptima will work with schools and organizations to host back-to-school fairs, vaccine clinics and other COVID-19 informational events.

CalOptima will also provide information about the availability of the vaccine incentive with the schools and organizations to post on their social media and share through other communication platforms.

5. Describe the MCP's strategy for countering misinformation and reaching vaccine hesitant individuals who may have a fear of vaccine side effects, have a mistrust of the government and/or vaccine makers, believe that vaccines are not needed for persons in good health or persons who have already had COVID-19, and/or have an insistence regarding a person's right to not be vaccinated. Character limit: 2,500 characters.

CalOptima will leverage trusted messenger videos, SMS texting and social media campaigns to counter misinformation and vaccine hesitancy. CalOptima will partner with recognizable key figures in the community to continue encouraging vaccinations in our ethnic populations.

6. Describe how the MCP will partner with trusted community organizations (e.g., Indian health facilities, faith- based partnerships, advocacy groups, food banks, race/ethnic based organizations) that can assist with outreach, communication content and messaging, and identify strategies as defined above, which can be used to also target Medi-Cal Fee-For-Service beneficiaries Character limit: 2,500 characters.

As described above, CalOptima will continue our Community Announcements newsletter (bi-weekly at minimum), which includes information relevant to the entire Orange County population about COVID-19 vaccine clinics as well as evidence-based information and strategies to address vaccine hesitancy. Information about the CalOptima vaccine incentive will also be shared as noted above. These materials include links to relevant source materials as well as outreach materials that can be used by professionals to amplify the message. CalOptima also routinely participates in 30+ community, coalition, collaborative meetings throughout Orange County. These community meetings cover a wide range of communities, age groups, health conditions and more; these meetings can be utilized as a platform to address vaccine hesitancy, share information for vaccine events, and increase awareness about CalOptima's Vaccine Incentive Program. CalOptima has also established strong relationships with the various populations listed above including organizations serving the majority of CalOptima's members, various ethnic communities, target age groups, advocacy groups and organizations providing basic and emergent needs for Medi-Cal members. CalOptima will leverage these relationships to identify opportunities to collaborate and address vaccine hesitancy, increase awareness of CalOptima's Vaccine Incentive Program, and support our community partners' vaccine efforts.

7. Describe how the MCP will collaborate with local public health agencies to coordinate with vaccine response plans and learn best practices, including what has and has not worked. Character limit: 2,500 characters.

CalOptima has a regular meeting with our public health agency, Orange County Health Care Agency, to support coordinated efforts to develop vaccine plans and strategies. Within this forum, best practices are discussed, including lessons learned and future opportunities.

8. Describe the MCP's efforts to build additional capacity to address member vaccination needs in future years (identification, education, and follow-up). Character limit: 2,500 characters.

With support from internal analysts, CalOptima has developed a process to leverage HEDIS, claims/encounter and CAIR data to support identification, education and follow-up to address member vaccination needs. CalOptima has also expanded member outreach to include SMS text, in addition to leveraging a fulfillment vendor to distribute vaccine-related member incentives.

9. Describe how the MCP will provide information and support for members with access barriers, especially transportation, navigating appointment systems, and language needs. Character limit: 2,500 characters.

CalOptima's Customer Service department will continue to support CalOptima members as it has throughout the pandemic. The department has established processes in place to ensure members are assisted with any access barriers. Customer Service Representatives respond to and resolve such issues, which can include transportation, appointment scheduling or other assistance a member may need.

Strategies for Addressing Barriers to Vaccine Access

10. Describe the MCP's current primary care vaccine access and how the MCP will collaborate with primary care providers (PCPs) to conduct direct outreach to unvaccinated members assigned to that clinic's/doctor's office.

a. Describe the MCP's current primary care vaccine access, including an analysis of any pockets and/or regions that lack access. Character limit: 2,500 characters.

CalOptima has primary care facilities providing vaccinations throughout Orange County, representing full coverage across the community. In September, CalOptima will survey primary care providers to determine the status of such coverage and identify if any regions can benefit from additional access. Further, using data analysis of specific pockets/regions with the lowest vaccine rates, CalOptima's Provider Relations department can conduct telephone outreach to identify any issues that may hinder further vaccination progress.

b. How will the MCP collaborate with PCPs to conduct outreach to members? Character limit: 2,500 characters.

CalOptima will refresh the current COVID-19 Provider Toolkit available on the website. The toolkit has material that is designed to aid communications to members about COVID-19 vaccines, assist in building member confidence and awareness about the benefits of COVID-19 vaccines, and help providers respond to common questions and concerns. All toolkit elements encourage vaccination and are available in threshold languages. CalOptima will also include a COVID-19 section within the monthly provider newsletter that offers vaccination analysis and "hotspots" so providers are more aware of vaccination gaps.

c. How will the MCP encourage more PCPs to enroll as vaccine providers? Character limit: 2,500 characters.

CalOptima will encourage PCPs to enroll as vaccine providers through provider alerts and newsletters. Further, we plan to make the CALVAX enrollment link accessible on the provider page of the CalOptima website.

11. Describe the MCP's strategy for supporting vaccination pop-up clinics and other vaccination sites, especially in communities of color and/or other communities with lower vaccination rates. Character limit: 2,500 characters.

CalOptima has frequent interactions/meetings with the Orange County Health Care Agency and the Coalition of Orange County Community Health Centers to support coordinated efforts to develop vaccine plans and strategies. Opportunities to address communities with lower vaccination rates will rely on a coordinated effort and include vaccine pop-up clinics.

CalOptima's Community Relations department will continue to share information about our community partners' vaccine clinics in our Community Announcements newsletter (bi-weekly at minimum). We will also continue to collaborate with community partners by supporting their vaccine clinics with resource booths where CalOptima shares information about programs and services, and/or CalOptima-branded items. At times, CalOptima may also provide financial support for these vaccine clinics by way of sponsorship and/or registration fees, if they meet eligibility criteria as defined in CalOptima's community events policy. This financial support provides a platform for CalOptima to promote vaccination and raise visibility in targeted communities of color.

12. Describe the MCP's strategy that can be used to make getting a vaccination as convenient and easily accessible as possible. Character limit: 2,500 characters.

CalOptima has implemented various public events and programs, including but not limited to, incentivizing members with gift cards, hosting vaccination clinics and coordinating with the Orange County Health Care Agency. These efforts will be amplified as part of this incentive program as we engage community partners to make vaccination more convenient for the audiences they serve. For example, CalOptima can conduct outreach campaigns to micro-target specific areas of Orange County where vaccinations rates are low.

a. Describe how the MCP will collaborate with CBOs, trusted local partners, tribal partners, community health workers, promotoras, local health departments, and faith-based partnerships to serve the homebound population. Character limit: 2,500 characters.

CalOptima has regular interactions/meetings with Orange County Health Care Agency, Coalition of Orange County Community Health Centers, community-based organizations and other trusted partners to support efforts to develop vaccine plans and strategies. Opportunities to serve homebound members, including with in-home vaccinations, will be a coordinated effort with these partners. For example, CalOptima will continue our SMS texting campaign for identified homebound members that offers support with arranging an in-home vaccination.

13. Describe how the MCP will collaborate with pharmacies to share data on members' vaccine status or other efforts to use members' visits to the pharmacy as an opportunity to increase vaccination rates. Character limit: 2,500 characters.

CalOptima will communicate with contracted pharmacies to raise awareness of vaccination rates in their areas. CalOptima will recommend that pharmacy providers use member visits as an opportunity to engage in a conversation about getting the COVID-19 vaccine. Further, CalOptima will highlight the section of the website with information about how members can easily receive the COVID-19 vaccine at participating pharmacies.

14. Describe the MCP's efforts that will bring vaccinations to members, such as mobile units or home vaccinations. Character limit: 2,500 characters.

CalOptima has regular interactions/meetings with Orange County Health Care Agency, Coalition of Orange County Community Health Centers, community-based organizations and other trusted partners to support efforts to develop vaccine plans and strategies. Opportunities to serve homebound members, including with in-home vaccinations, will be a coordinated effort with these partners. For example, CalOptima will continue our SMS texting campaign for identified homebound members that offers support with arranging an in-home vaccination.

Strategies for Addressing Data and Operational Challenges

15. Describe how the MCP will use data obtained from DHCS to track vaccination data in real time and at granular geographic and demographic levels and identify members to outreach. Character limit: 2,500 characters.

CalOptima has data available that reveals which ZIP codes are least vaccinated. Using this information, CalOptima can direct specialized advertising and outreach efforts to these areas, which includes hyperlocal advertising, geotargeted digital and social media ads, as well as traditional phone calling through our CareNet vendor. Further, CalOptima's social media postings can help promote vaccine clinics that may be nearby these areas, to ensure awareness of local resources.

a. Describe how the MCP will share data with providers, trusted partners, or tribal partners, where applicable to drive outreach. Character limit: 2,500 characters.

CalOptima currently shares data and COVID-19 member vaccination information with all Board of Directors committees, such as the Member Advisory Committee and the Provider Advisory Committee.
CalOptima will also include a COVID-19 section within the monthly provider newsletter that offers vaccination analysis and "hotspots" so providers are more aware of vaccination gaps.

16. Describe how the MCP will use data obtained from other sources to track vaccination data and identify members to outreach. Character limit: 2,500 characters.

With support from internal analysts, CalOptima has developed a process to leverage HEDIS, claims/encounter and CAIR data to support identification, education and follow-up to address member vaccination needs. CalOptima has also expanded member outreach to include SMS text, in addition to leveraging a fulfillment vendor to distribute vaccine-related member incentives.

17. Describe how the MCP will determine local misinformation trends and root causes for low vaccination rates/vaccine hesitancy. Character limit: 2,500 characters.

CalOptima's Population Health Management department is planning a text-based survey of members who have not received their vaccination. Using the outcomes of this survey, CalOptima will be able to understand and address the root issues at the heart of vaccine hesitancy. The response may include community education efforts, marketing/advertising programs, provider engagement and other strategies.

Plan Administration

18. Describe the MCP's plan for administrative oversight of the coordination activities (including controls to ensure no duplicative member incentives). Character limit: 2,500 characters.

CalOptima has a DHCS-approved COVID-19 member incentive program currently in place. The agency reconciles regularly with internal departments (accounting, buyers, etc.) and our external fulfillment vendor to ensure members already incentivized do not receive additional incentives.

19. Describe the MCP's intentional efforts to avoid negative unintended consequences, including but not limited to vaccine coercion. Character limit: 2,500 characters.

CalOptima avoids negative unintended consequences by using messaging built on widely accepted ideas about vaccine safety and effectiveness. Further, as a public agency, CalOptima's approach to information sharing is based on transparency and equity.

20. Describe the MCP's plan to partner with Subcontractors (i.e., delegated health plans) to increase vaccination rates, coordinate strategies, and implement this Vaccination Response Plan. Character limit: 2,500 characters.

Pending Board approval, CalOptima will implement a temporary rate increase to support delegated health networks in improving vaccination rates among delegated members and creating a vaccine strategy consistent with DHCS' COVID-19 Vaccine Incentive Program and CalOptima's Vaccine Response Plan. The health networks will be required to implement strategies that focus on the target populations, such as pop-up clinics, mobile units and/or vaccinations for homebound members.

21. Are direct member vaccine incentives a planned strategy? If so, please explain the strategy. Character limit: 2,500 characters.

CalOptima currently uses IGT funding to pay for direct member incentives and a fulfillment vendor to distribute the incentives. CalOptima created a Member Health Rewards program to increase motivation for COVID-19 vaccinations. Eligible members receive a $25 gift card for each vaccination. The COVID-19 Member Health Rewards program has been promoted on local news programs, social media, the website and in a letter mailed to every CalOptima household. Contracted providers and community-based organizations are aware and have been supporting this outreach campaign.

a. If direct member vaccine incentives are used as a vaccination strategy, demonstrate how the MCP will meet DHCS guidelines for member incentives below and verify member incentives do not exceed $50 per member (single or multi-dose). Character limit: 2,500 characters.

CalOptima has already been approved by DHCS for direct member vaccine incentives for single and multi-dose. CalOptima would like to leverage DHCS funding moving forward to continue the direct member incentive process that includes use of a fulfillment vendor and subcontractor to administer the incentive directly to members. Further, CalOptima requests DHCS' consideration of whether incentives can be provided for booster doses if appropriate and based on medical criteria.

II. Direct Member Vaccine Incentives

There will be a $100M pool of funds available for MCPs to utilize for direct member vaccine incentives (e.g., $50 gift card to grocery store). In order to draw funds from the direct member incentive pool, MCPs must attest to meeting the following requirements and include their direct member vaccine incentive strategy in their Vaccination Response Plan:

- Institute controls to ensure member incentives are only available for medically necessary vaccinations (i.e., MCPs have controls in place to track vaccinated members to ensure no duplicative member incentives).
- Ensure that the value of member incentives is reasonable for "in-kind" incentives (i.e., non-cash or cash-equivalent).
- Verify member incentives do not exceed $50 per member (single or multi-dose).
- The value of member incentives must be uniform and standardized.
- Member incentives must be provider agnostic, and on equal terms for all vaccinations administered by all participating Medi-Cal-enrolled providers, regardless of their Network Provider status or relationship with the MCP.
- Ensure member incentives are issued by the MCP directly, and not through Subcontractors, Network Providers, or non-contracted providers, unless DHCS grants prior approval for an exception from this requirement. MCPs can use a vendor for member incentives with prior approval from DHCS.
- Demonstrate that 100% of applicable MCP incentive payments for direct member vaccine incentives are expended on direct incentives to members.
- The incentive meets the six safeguards set forth in the U.S. Department of Health and Human Services Office of the Inspector General guidance to ensure sufficiently low risk under the Federal anti-kickback statute and Beneficiary Inducements Civil Monetary Penalty.[1]

☐ **I hereby attest that all information provided in this plan is true and accurate to the best of my knowledge, and that this plan has been completed based on a good faith understanding of the Medi-Cal COVID-19 Vaccination Incentive Program participation requirements.**

Signature of MCP Representative & Date

[1] See Frequently Asked Questions – Application of the Office of Inspector General's Administrative Enforcement Authorities to Arrangements Directly Connected to the Coronavirus Disease 2019 (COVID-19) Public Health Emergency at: https://oig.hhs.gov/coronavirus/authorities-faq.asp.

Board of Directors Meeting
October 7, 2021

OneCare Connect Cal MediConnect Plan (Medicare-Medicaid Plan)
Member Advisory Committee Update

On August 26, 2021, the OneCare Connect Member Advisory Committee (OCC MAC) held its bi-monthly meeting via teleconference using GoTo Meeting Webinar technology.

Ladan Khamseh, Chief Operating Officer, shared that, in an effort improve provider communications, CalOptima transitioned over 8,600 (90% of CalOptima Community Network (CCN) providers) from fax-based provider alerts, updates and newsletters to electronic mail. This functionality gives providers instant access to links, websites and other documents that could not be achieved with blast-faxes. Ms. Khamseh also provided an update on the Centers for Medicare & Medicaid (CMS) audit of CalOptima's OneCare and OneCare Connect programs that concluded the first week of August. Ms. Khamseh also notified the committee that Mike Herman had accepted the position of Interim Executive Director, Program Implementation.

Emily Fonda, M.D., Chief Medical Officer, provided a comprehensive COVID-19 update and updated the PAC on the vaccine status in Orange County and distribution of the vaccine gift cards for CalOptima members. Dr. Fonda also updated the PAC on the Delta Variant of COVID that has been spreading, primarily among unvaccinated individuals.

Debra Kegel, Director, Strategic Development, presented an update on Intergovernmental Transfers Funds (IGT) 10 funding. Ms. Kegel noted that CalOptima expects to receive approximately $45.1M in IGT 10 funds for 2021 and reviewed with the committee possible funding options available.

The committee also received a Federal and State Legislative update from Jackie Mark, Manager, Government Affairs, and a Community Relations update from Tiffany Kaaiakamanu, Manager, Community Relations.

The OCC MAC appreciates the opportunity to provide the CalOptima Board with input and updates on OCC MAC activities.

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Board of Directors Meeting
October 7, 2021

Whole-Child Model Family Advisory Committee Update

On August 24, 2021, the Whole-Child Model Member Family Advisory Committee (WCM FAC) held its bi-monthly meeting via teleconference using GoTo Meeting Webinar technology.

The WCM FAC approved its FY 2020-2021 accomplishments. WCM FAC members contributed over 179 hours which equates to 22 business days for the year. These hours do not account for the innumerable hours that the members dedicate to the Whole-Child Model on a day-to-day basis. The WCM FAC also approved a recommendation to appoint Kathleen Lear, Authorized Family Member as the Vice Chair of the committee to fulfill a remaining term through June 30, 2022.

Ladan Khamseh, Chief Operating Officer, Ms. Khamseh shared that, in an effort improve provider communications, CalOptima transitioned over 8,600 (90% of CalOptima Community Network (CCN) providers) from fax-based provider alerts, updates and newsletters to electronic mail. This functionality gives providers instant access to links, websites and other documents which could not be achieved with blast-faxes. She also noted that the next steps will include gathering email addresses from health networks' exclusive providers who do not currently participate with CCN. Ms. Khamseh also provided an update on the Centers for Medicare & Medicaid Services (CMS) audit of CalOptima's OneCare and OneCare Connect programs that has just been completed.

Emily Fonda, M.D., Chief Medical Officer, provided a comprehensive COVID-19 update and updated the WCM FAC on the current vaccine status in Orange County and distribution of the vaccine gift cards for CalOptima members. Dr. Fonda also updated the committee on the Delta Variant of COVID that has been spreading, primarily among unvaccinated individuals and answered questions on how CalOptima has been successful with vaccinations to children and young adults with special needs.

Mike Herman, Interim Executive Director, Program Implementation provided an update on the CalAIM program noting that the program was scheduled to start on January 1, 2022 with rollout to a certain population of Medi-Cal members and reviewed the timeline for the program's full implementation.

Kristin Gericke, Director, Pharmacy Management, provided an update on the Medi-Cal Rx transition, Jackie Mark, Manager, Government Affairs presented a Federal and State Legislative update and Tiffany Kaaiakamanu provided a Community Relations update to the members.

The WCM FAC appreciates and thanks the CalOptima Board for the opportunity to present input and updates on the WCM FAC's current activities.

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Provider Advisory Committee Update
Board of Directors Meeting
October 7, 2021

On September 9, 2021, the Provider Advisory Committee (PAC) held its monthly meeting via teleconference using GoTo Meeting Webinar technology.

Richard Sanchez, Chief Executive Officer, updated the committee on the CalAIM and vaccine initiatives and thanked the CalOptima staff for their hard work in these endeavors.

Ladan Khamseh, Chief Operating Officer, updated the committee on the Qualified Medical Beneficiary outreach that will begin soon and noted that over 1500 members had been identified who could possibly qualify for receiving Medicare Part A and B. She also noted that a notification mailing would be sent to approximately 4000 members in November with text messages to those members who opted in to receive text messages. She also noted that CalOptima is wrapping up submission of further documentation about certain cases in response to Centers for Medicare and Medicaid Services (CMS) requests as part of the audit. It is expected that CMS will provide a draft final report in October and CalOptima will have 10 days to respond to any concerns raised. Subsequent to that, CMS will issue a final report.

Emily Fonda, M.D., Chief Medical Officer, provided a comprehensive COVID-19 update and updated the PAC on the vaccine status in Orange County and distribution of the vaccine gift cards for CalOptima members

Mike Herman, Interim Executive Director, Program Implementation, presented on the upcoming CalAIM program and the various deadlines for each segment of implementation through 2023.

Anjan Batra, MD, MBA, Director of Electrophysiology, CHOC, Professor of Pediatrics, UC Irvine, and Physician Representative on the PAC, presented on how telehealth during the COVID Pandemic has increased efficiency and patient satisfaction.

PAC also received a OneCare Connect Transition update from Ravina Hui, Manager, Program Implementation, and a Community Relations presentation from Tiffany Kaaiakamanu, Manager, Community Relations.

Once again, the PAC appreciates and thanks the CalOptima Board for the opportunity to provide input and updates on the PAC's activities.

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Member Advisory Committee Update
Board of Directors Meeting
October 7, 2021

On September 9, 2021, the Member Advisory Committee (MAC) held its monthly meeting via teleconference using GoTo Meeting Webinar technology.

Richard Sanchez, Chief Executive Officer, thanked the CalOptima staff for their work on ensuring that all submissions to the Department of Health Care Services (DHCS) on the CalAIM program were submitted timely. Mr. Sanchez also answered a question on an item of interest from his August report regarding Governor Newsom's Children and Youth Behavioral Health Initiative, that was included in the Fiscal Year 2021–22 Enacted Budget. This initiative allows Medi-Cal plans to receive incentive payments to expand access to school-based behavioral health services. He noted that CalOptima has reached out to Orange County school districts regarding this new initiative.

Ladan Khamseh, Chief Operating Officer, updated the committee on the Qualified Medical Beneficiary outreach and noted that over 1,500 members had been identified who could possibly qualify to receive Medicare Part A and B. She also noted that a notification mailing would be sent to approximately 1,000 members in November with follow up phone outreaches afterwards.

Emily Fonda, M.D., Chief Medical Officer, provided a COVID-19 presentation and updated the MAC on the vaccine status in Orange County and distribution of the vaccine gift cards for CalOptima members.

Mike Herman, Interim Executive Director, Program Implementation, presented on the upcoming CalAIM program and the various deadlines for each segment of implementation through 2023.

Omar Moreno, Chief Operating Officer of Families Together of Orange County, provided a video and a verbal update of how Families Together of Orange County has been able to assist CalOptima members during the COVID-19 pandemic. Jillian Youngerman, O.D. Assistant Professor, Ketchum University, presented on Back to School Learning Related Vision Disorders. This presentation, along with the Families Together presentation, was part of a collaboration between MAC and PAC in sharing items of mutual interest.

Once again, the MAC appreciates and thanks the CalOptima Board for the opportunity to provide input and updates on the MAC's activities.

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