NOTICE OF A
REGULAR MEETING OF THE
CALOPTIMA BOARD OF DIRECTORS

JUNE 2, 2022
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.	Blair Contratto
José Mayorga, M.D.	J. Scott Schoeffel
Nancy Shivers, R.N.	Trieu Tran, M.D.

Supervisor Katrina Foley, Alternate

CHIEF EXECUTIVE OFFICER	OUTSIDE GENERAL COUNSEL	CLERK OF THE BOARD
Michael Hunn	Troy R. Szabo Kennaday Leavitt	Sharon Dwiers

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

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

The Board Meeting Agenda and supporting materials are available for review at CalOptima, 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:
Participate via Zoom Webinar at:
https://us06web.zoom.us/webinar/register/WN_v290CpsiRDK_AlrnAFq-Ng and Join the Meeting.
Webinar ID: 829 0057 3731
Passcode: 288808-- Webinar instructions are provided below.

CALL TO ORDER
Pledge of Allegiance
Establish Quorum

PRESENTATIONS/INTRODUCTIONS

MANAGEMENT REPORTS
1. Chief Executive Officer Report

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

CONSENT CALENDAR
2. Minutes
   a. Approve Minutes of the May 5, 2022 Regular Meeting of the CalOptima Board of Directors
   b. Receive and File Minutes of the February 17, 2022 Special Meeting of the CalOptima Board of Directors' Finance and Audit Committee

3. Authorize Expenditures in the CalOptima Fiscal Year 2021-22 Operating Budget for Claims Editing Solution

4. Adopt Board Resolution No. 22-0602-01, Authorizing Remote Teleconference Meetings for the CalOptima Board of Directors and its Advisory Committees in Accordance with California Government Code section 54953, subdivision (e)

5. Ratify Contract with Rostrum, LLC for State Advocacy Services and Authorize Related Expenditures for Fiscal Year 2022–23

6. Adopt Resolution Dissolving Existing Board Ad Hoc Committees and Creating New Board Ad Hoc Committees, and Establish a Policy for Administration of Ad Hoc Committees

7. Approve Modifications to CalOptima Grievance and Appeals Resolution Services Policy HH.1108

8. Approve Proposed Changes to the CalOptima Medical Affairs Policy Related to Long Term Care Authorization Processes

9. Approve Proposed Changes to the CalAIM Community Supports Policy

10. Approve Modifications to CalOptima Policy HH.2021: Exclusion and Preclusion Monitoring

11. Appointments to the CalOptima Board of Directors' Member Advisory Committee

12. Appointments to the CalOptima Board of Directors' Provider Advisory Committee

13. Appointments to the CalOptima Board of Directors' Whole-Child Model Family Advisory Committee

14. Adoption of the Proposed CalOptima Board of Directors Meeting Schedule for Fiscal Year 2022-23

15. Receive and File:
    a. April 2022 Financial Summary
    b. Compliance Report
    c. Federal and State Legislative Advocates Reports
    d. CalOptima Community Outreach and Program Summary

REPORTS/DISCUSSION ITEMS

16. Approve the CalOptima Fiscal Year 2022-23 Operating Budget

17. Approve the CalOptima Fiscal Year 2022-23 Capital and Digital Transformation Year One Capital Budgets

18. Adopt Strategic and Tactical Priorities for 2022-2025

19. Authorize the CalOptima Administrative Fellowship Program

20. Approve New OneCare Health Network Health Maintenance Organization, Shared-Risk Group, and Physician Hospital Consortia Contract Templates, and Authorize Utilization for New Contracts to be Executed with Currently Participating OneCare and OneCare Connect Health Networks, except ARTA Western California Inc., Talbert Medical Group P.C., Monarch Healthcare, A Medical Group, and Monarch Health Plan Inc.

21. Approve New OneCare Health Network Health Maintenance Organization, Shared-Risk Group, and Physician Hospital Consortia Contract Templates, and Authorize Template Use for New Contracts to be Executed with ARTA Western California Inc., Talbert Medical Group P.C., Monarch Healthcare, A Medical Group, and Monarch Health Plan Inc.

22. Approve Amendment to Ancillary Services Contract to Extend Coverage of Temporary Alternative Services for Community-Based Adult Services

23. Authorize Extension of a Temporary, Short-Term Supplemental Payment Increase for Certain Contracted CalOptima Fee-for-Service Providers for COVID-Related Expenses for Services Provided to CalOptima Community Network and CalOptima Direct Medi-Cal Members

24. Authorize Extension of a Temporary, Short-Term Supplemental Payment Increase for Contracted CalOptima Community Network and CalOptima Direct-Administrative Medi-Cal Fee-for-Service Community Health Centers, for COVID-Related Expenses for Services Provided to CalOptima Community Network and CalOptima Direct-Administrative Medi-Cal Members

25. Authorize Extension of a Supplemental Capitation Rate Increase for all Contracted Medi-Cal Health Networks, except ARTA Western California Inc., Monarch Health Plan Inc., Talbert Medical Group P.C., and Kaiser Foundation Health Plan Inc., for COVID-Related Expenses for Services Provided to CalOptima Medi-Cal Members and Authorize CEO to Execute Necessary Amendments

26. Authorize Extension of a Supplemental Capitation Rate Increase for ARTA Western California Inc., Monarch Health Plan Inc., and Talbert Medical Group P.C., Medi-Cal Health Networks Only, for COVID-Related Expenses for Services Provided to CalOptima Medi-Cal Members and Authorize CEO to Execute Necessary Amendments

27. Authorize Extension of a Temporary, Short-Term Supplemental Payment Increase for Certain Contracted CalOptima Community Network and CalOptima Direct Medi-Cal Fee-for-Service Hospitals, for COVID-Related Expenses for Services Provided to CalOptima Community Network and CalOptima Direct-Administrative Medi-Cal Members

28. Adopt Resolution No. 22-0602-02 Approving and Adopting Updated CalOptima Human Resources Policies and Appropriation of Funds and Authorization of Unbudgeted Expenditures

29. Election of Officers of the Board of Directors for Fiscal Year 2022-23

ADVISORY COMMITTEE UPDATES

30. OneCare Connect Member Advisory Committee Update

31. Provider Advisory Committee Update

32. Member Advisory Committee Update

CLOSED SESSION

CS-1 Pursuant to Government Code section 54956.8 CONFERENCE WITH REAL PROPERTY NEGOTIATIORS
Property: 14851 Yorba Street & 165 N. Myrtle Avenue, Tustin, CA 92780
Agency Negotiator: David Kluth, John Scruggs, and Mai Hu, Newmark Knight Frank
Negotiating Parties: Yorba Myrtle LLC
Under Negotiation: Price and terms of payments

BOARD MEMBER COMMENTS AND BOARD COMMITTEE REPORTS

ADJOURNMENT

TO JOIN THE MEETING

Please register for the Regular Meeting of the CalOptima Board of Directors on June 2, 2022 at 2:00 p.m. (PST)

Join from a PC, Mac, iPad, iPhone or Android device:
Please click this URL to join.
https://us06web.zoom.us/webinar/register/WN_v290CpsiRDK_AlrnAFq-Ng

Or One tap mobile:
+12532158782,,82900573731#,,,,*288808# US (Tacoma)
+13462487799,,82900573731#,,,,*288808# US (Houston)

Or join by phone:
Dial (for higher quality, dial a number based on your current location): US: +1 253 215 8782 or +1 346 248 7799 or +1 720 707 2699 or +1 301 715 8592 or +1 312 626 6799 or +1 646 558 8656

Webinar ID: 829 0057 3731
Passcode: 288808

International numbers available: https://us06web.zoom.us/u/kbzC9Z8btY

MEMORANDUM

DATE:	May 26, 2022
TO:	CalOptima Board of Directors
FROM:	Michael Hunn, Chief Executive Officer
SUBJECT:	CEO Report — June 2, 2022, 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. CalOptima Requests Change in Ordinance to Join Covered California

On May 24, the Orange County Board of Supervisors voted 3-2 to support a modification to the CalOptima Ordinance that will allow CalOptima to participate in the California Health Benefit Exchange. One more vote is needed in order to formally adopt the amended Ordinance on Tuesday, June 7. To date, the agency has received more than 20 letters of support from CEOs of our health networks, medical groups, hospitals and community-based organizations supporting the effort. Once the modified Ordinance is approved, CalOptima will offer a Covered California product line by January 2024 based on the following drivers:

- To improve care: A CalOptima Covered California plan will provide continuity of care for former Medi-Cal members and allow them to keep their "medical home" if they choose.
- To improve access: A CalOptima Covered California plan will expand the choice of options for members who lose eligibility through redetermination.

CalOptima will continue to provide additional information requested by the Board of Supervisors ahead of the next meeting. We will also continue to educate Hospital Association of Southern California (HASC) on the benefits of CalOptima's participation in the Exchange.

NOTE: L.A. Care has been in the Exchange since 2014 and Inland Empire Health Plan will be offering its Exchange product in January 2024.

b. Governor Releases Revised Budget Proposal

On May 13, Gov. Gavin Newsom released his revised Fiscal Year (FY) 2022–23 budget proposal, also known as the May Revise, with total spending at $300.7 billion ($227.4 billion General Fund). This represents an increase of $14.3 billion compared with his original budget proposal released in January and $38.1 billion compared with the current FY 2021–22 enacted budget. Specifically, the May Revise proposes $135.5 billion ($36.6 billion General Fund) in Medi-Cal spending, an 11.2% increase from the current FY, with an assumption that Medi-Cal caseload will increase by 0.6% to 14.5 million beneficiaries as redeterminations resume later this year. Based on a record-high budget surplus, the May Revise also forecasts $46.2 billion for one-time spending initiatives and $37.1 billion for reserves. Major components included in the May Revise that may impact CalOptima include:

- $18.1 billion in an inflation relief package, including $933 million for retention payments to frontline hospital and skilled nursing facility workers
- Additional funding to address reproductive health, children's behavioral health and homelessness, including implementation of Community Assistance, Recovery and Empowerment (CARE) Court

- Ensuring continuity of Medi-Cal coverage during redeterminations, including funding to support additional county workloads, Health Enrollment Navigators Project expansion, and media and outreach campaigns to collect updated member contact information
- Medi-Cal expansion for ages 26–49, regardless of immigration status, effective January 1, 2024
- Permanent extension of certain COVID-19 flexibilities, including but not limited to:
    - Medicare reimbursement rates for the COVID-19 vaccine, COVID-19 lab services, and oxygen and respiratory durable medical equipment
    - Presumptive Medi-Cal eligibility for older adults and individuals with disabilities.

Next, Gov. Newsom and the State Legislature will begin negotiating a final budget, which must pass both houses of the Legislature by June 15 and be signed by Gov. Newsom by June 30. A full analysis of the May Revise follows this report.

c. Kaiser Medi-Cal Contract Proposal Included in Governor's May Revise

The FY 2022–23 May Revise includes the proposed statewide Kaiser Medi-Cal contract, indicating that Gov. Newsom still intends to advance the proposal through a budget trailer bill rather than a policy bill (AB 2724). It is not yet clear whether legislative leaders will accommodate the governor's request or continue to use AB 2724 as a vehicle. Regardless, given the accelerated timeline of the state budget process, it is critical that CalOptima enhance its advocacy efforts. As such, staff has contracted with a supplemental state lobbying firm, Rostrum LLC, to provide additional resources on top of current advocacy efforts by Local Health Plans of California and CalOptima's primary state lobbyist, Edelstein Gilbert Robson and Smith LLC (EGRS), which represents nearly all of California's County Organized Health Systems. This will enable a more focused, tailored effort on CalOptima-specific strategies with Orange County's legislative delegation. Ratification of Rostrum's contract will be considered by your Board on June 2. In a positive sign, the National Union of Healthcare Workers recently announced their opposition to the Kaiser proposal. EGRS and Rostrum are amplifying this with Orange County's Assembly delegation ahead of a floor vote on AB 2724 by May 27.

d. CalOptima Requests Federal Earmark Funding

U.S. Reps. Young Kim and Lou Correa are sponsoring CalOptima's request for $5 million in FY 2023 federal funding for the agency's Care Traffic Control initiative, which would develop a single coordinated data system to digitally manage member health across the continuum of care. CalOptima is still awaiting decisions from U.S. Senators regarding potential sponsorship of CalOptima's second $5 million funding request to support delivery of street medicine for individuals experiencing homelessness in Orange County. While this is promising news, it is still an early step in the federal budget process. The Senate and House Appropriations Committees are now reviewing submissions from Members of Congress before negotiating their inclusion in final appropriations bills.

e. Community Events Help Members Sign up for CalFresh

CalOptima is holding three CalFresh Enrollment Event and Resource Fairs on the following Saturdays from 10 a.m. to 2 p.m.: June 11 in Anaheim, June 18 in La Habra and June 25 in Garden Grove. Due to anticipated high demand, additional staff from the County of Orange Social Services Agency (SSA) and representatives from community-based organizations will be on site to process enrollments. CalOptima has started calling and texting members who are potentially eligible to enroll in CalFresh, either through a warm line transfer to SSA or by visiting www.caloptima.org/calfresh.

f. Members' Use of Enhanced Care Management and Community Supports Increases

Since California Advancing and Innovating Medi-Cal (CalAIM) launched January 1, CalOptima now has 1,500 members receiving Community Supports and 1,700 members receiving Enhanced Care Management (ECM). ECM is available for those experiencing homelessness, suffering from Serious Mental Illness or Substance Use Disorder, and other members who are most frequently in need of Medi-Cal services. Community Supports include housing transition navigation services, housing deposits, housing tenancy and sustaining services, and recuperative care. Eligibility for ECM will expand in future phases of CalAIM, and additional Community Supports will become available July 1. This includes short-term post-hospitalization housing, day habilitation programs, meals/medically tailored meals, personal care/homemaker services, and sobering centers.

g. Information Technology Services (ITS) Deploys Security Enhancements

A new security software called Crowdstrike was fully deployed in May, providing continuous active monitoring and threat protection against malware and ransomware. Other important elements to the security enhancements include blocking malicious access attempts from outside the United States and conducting assessments to better understand our security posture and adherence to HIPAA requirements. The ITS team is also planning a test to study the effect an attempted attack or intrusion could have on CalOptima systems. This test will help improve our current protection capabilities and identify areas that can be enhanced.

h. Advertising Campaign Focuses on Preventive Health

From February to June, CalOptima's will run its FY22 Preventive Health advertising campaign. This is a collaboration between the Population Health Management (PHM) and the Communications departments. Advertising is one element of the PHM multimodal communications strategy, and the goals are to: 1) raise member and community understanding about the importance of preventive health and other wellness topics; 2) support current HEDIS quality measures; and 3) increase awareness about CalOptima in Orange County. The data-driven campaign focuses on reaching members with the highest noncompliance rates for preventive care as well as general community members living in high-density areas affected by the social determinants of health.

i. New Initiative to Create a Culture of Equity

CalOptima has formed an Equity Initiative that will launch in June, to help instill a culture of equity throughout the agency by periodically reviewing data, policies and practices to identify equity issues and then take action to tailor strategies to address them. The initiative involves 62 employees across the following workgroups:

- Communications, Cultural and Narrative Change
- Diversity, Equity and Inclusion in Workforce Development
- Health Equity and Social Determinants of Health
- Stakeholder Engagement

j. Federal Government Introduces Maternal Mental Health Hotline

On May 8, the U.S. Department of Health and Human Services (HHS) launched the first phase of the Maternal Mental Health Hotline, a new, confidential, toll-free hotline for expectant and new mothers experiencing mental health challenges. Callers can receive a range of support, including brief interventions from trained counselors who are culturally and trauma-informed, as well as referrals to both community-based and telehealth providers as needed. The hotline is accessible by phone or text at 1-833-9-HELP4MOMS (1-833-943-5746) in English and Spanish.

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k. Two New Executives Join CalOptima in May

Kelly Bruno-Nelson, Executive Director, Medi-Cal/CalAIM, is focusing on CalAIM initiatives, including recuperative care, housing navigation and deposits, and Community Supports programs. Kelly brings more than 25 years of experience serving vulnerable populations in Southern California through innovative work in health care and nonprofit organizations.

Deanne Thompson, Executive Director, Marketing and Communications, is responsible for overseeing the efforts of the Communications and Community Relations departments, which focus on advancing CalOptima's member-focused mission and key messages through internal and external communications, marketing and advertising, media relations, and community engagement. Deanne brings more than 20 years of leadership experience from marketing and communications roles in the health care field.

l. CalOptima Gains Media Coverage

- On May 11, CalMatters published a report on COVID-19 vaccination rates among the state's Medi-Cal population. CalOptima data was included in a chart.
- On May 13, Health Plan Weekly published an article on the expansion of postpartum care coverage quoting Chief Medical Officer Richard Pitts, D.O., Ph.D. discussing CalOptima's maternity health program called Bright Steps.
- On May 25, CxO Tech Magazine published an article written by Wael Younan, CalOptima's Chief Information Officer/Chief Information Security Officer.

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FY 2022–23 California State Budget:
Analysis of the May Revise

Introduction
On May 13, 2022, Gov. Gavin Newsom released the Fiscal Year (FY) 2022–23 Revised Budget Proposal (May Revise) at a total of $300.7 billion, including $227.4 billion in General Fund (GF) spending. This represents an increase of $14.3 billion compared to his original budget proposal released in January and $38.1 billion compared with the current FY 2021–22 enacted budget. The proposed budget also includes a record-high $49.2 billion discretionary surplus and $37.1 billion in budget reserves. 94% of the surplus would be allocated towards one-time spending. This analysis discusses major proposed initiatives, with a focus on key changes from the January Proposed Budget, that may impact CalOptima.

Overview
Gov. Newsom proposes an overall Medi-Cal budget of $135.5 billion ($36.6 billion GF), an 11.2% increase from FY 2021–22, with an assumption that caseload will increase by 0.6% as eligibility redeterminations resume following termination of the COVID-19 public health emergency (PHE) this fall. An average of 14.5 million Californians are expected to be covered in FY 2022–23.

California Advancing and Innovating Medi-Cal (CalAIM)
Gov. Newsom's proposal includes $3.1 billion ($1.2 billion GF) in FY 2022–23 to implement CalAIM. CalAIM initiatives being implemented in FY 2022–23 continue to include:

- Discontinuation of the Cal MediConnect pilot program and transition to exclusively aligned Dual Eligible Special Needs Plans (D-SNPs)
- Population Health Management (PHM) program
- Pre-release Medi-Cal eligibility screenings and 90 days of targeted in-reach services
- Providing Access and Transforming Health (PATH) initiative

Updates in the May Revise include the identification of additional aid codes that will transition from Medi-Cal fee-for-service to managed care starting January 1, 2023, expanding in-reach service for justice-involved individuals to include full-scope Medi-Cal pharmacy benefits and delaying the launch of the statewide PHM service from January 1, 2023, until July 1, 2023.

COVID-19
As the COVID-19 pandemic enters its endemic phase, the governor has proposed investments to ensure ongoing preparedness for potential future surges of additional COVID-19 variants. This includes $100 million for medical surge staffing, $40 million for vaccine staff to prepare for children under five and boosters, and $530 million for additional tests in schools and rapid sites.

In addition, with the PHE expected to terminate in fall 2022, the May Revise includes funding to ensure continuity of Medi-Cal coverage as eligibility redeterminations resume. Proposed funding would support additional county workloads, Health Enrollment Navigators Project expansion and media and outreach campaigns to collect updated member contact information.

Finally, the budget proposes to permanently extend certain COVID-19 flexibilities that have proven to be beneficial to Medi-Cal beneficiaries regardless of the existence of a pandemic. These include the following, though additional flexibilities may be identified at a later date:

- Separate payments to Federally Qualified Health Centers (FQHCs) for COVID-19 vaccinations
- 10% rate increase for Intermediate Care Facilities for Developmentally Disabled (ICF-DD)
- Medicare reimbursement rates for COVID-19 vaccines, COVID-19 lab services and oxygen and respiratory durable medical equipment
- Presumptive Medi-Cal eligibility for older adults and individuals with disabilities

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California State Budget Analysis *(continued)*

Inflation Relief
In an effort to provide direct relief for rising costs due to inflation, the May Revise proposes an $18.1 billion relief package, including the following elements:

- $933 million for retention payments of up to $1,500 each for 600,000 patient-facing hospital and skilled nursing facility (SNF) workers
- $304 million for health care premium assistance for individuals purchasing health care coverage through Covered California

These are expected to result in direct positive impacts to CalOptima's health network and provider workforces as well as members who churn on and off of Medi-Cal eligibility.

Kaiser Medi-Cal Contract
As expected, the May Revise includes the Department of Health Care Services proposal to enter into a direct, statewide contract with Kaiser Permanente to provide Medi-Cal services in any county, starting January 1, 2024. If such proposal is finalized, it is expected to result in significant negative impacts to CalOptima and its members, providers and stakeholders as well as the broader safety net health system. CalOptima and the County of Orange have therefore adopted positions of *Oppose Unless Amended* to prohibit a direct contract in counties with County Organized Health Systems, such as CalOptima.

Key Funding Increases
With higher-than-expected state revenues, the May Revise invests significant additional funding to expand previously proposed programs addressing homelessness, reproductive health and children's behavioral health.

Specifically, the budget includes $700 million in additional funding to address homelessness through expansion of Project Homekey, building "tiny homes" as interim crisis response housing and implementing Community Assistance, Recovery, and Empowerment (CARE) Court. CARE Court would facilitate delivery of mental health and substance use disorder services to individuals with schizophrenia spectrum or other psychotic disorders who lack medical decision-making capabilities. The program would connect a person in crisis with a court-ordered care plan for up to 24 months as a diversion from homelessness, incarceration or conservatorship. Care plans could include court-ordered stabilization medications, wellness and recovery supports, and connection to social services and a housing plan.

The May Revise also includes additional funding of $57 million to improve access to reproductive health services through grants to such providers as well as community-based organizations to increase education and outreach. An extra $290 million is also proposed to address children's behavioral health needs through remote digital supports, wellness programs, parent training and education, and school-based crisis response pilots to prevent youth suicide.

Medi-Cal Eligibility
Notably, the May Revise continues to include the governor's January proposal to expand full-scope Medi-Cal benefits to income-eligible adults ages 26–49 regardless of immigration status no sooner that January 2024. This would extend eligibility to include all ages following prior action to expand coverage for those under age 26 as of January 1, 2020, and those ages 50 and older as of May 1, 2022. Along with the latter expansion, this proposal could increase CalOptima's membership by approximately 75,000–80,000 individuals.

The proposed budget also continues to include funding to eliminate Medi-Cal premiums for approximately 500,000 pregnant women, children and disabled working adults.

Provider Payments
The May Revise includes $700 million for Equity and Practice Transformation Payments (EPTPs), an increase of $300 million from the January Proposed Budget. EPTPs would be one-time provider payments focused on advancing equity, supporting upstream interventions to address social determinants of health and improving quality in children's preventive, maternity, and integrated behavioral health care. It is anticipated that some if not all of these payments would flow through managed care plans, but key details on implementation have not been shared.

The revised budget also includes $280 million for a new Workforce and Quality Incentive Program that would provide directed payments to SNFs that meet quality benchmarks or who have demonstrated substantial improvement. Medi-Cal managed care plans would coordinate program implementation and issue payments.

Miscellaneous
Gov. Newsom's budget also includes the following provisions that may impact CalOptima:

- $350 million to recruit, train and certify 25,000 new community health workers by 2025

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California State Budget Analysis *(continued)*

- $100 million for the CalRX Biosimilar Insulin Initiative, which would create public-private partnerships to increase generic insulin manufacturing and lower insulin costs
- $50 million in technical assistance grants for small and under-resourced providers to improve data exchange capabilities
- Cancellation of the proposed Community-Based Residential Continuum Pilots for Vulnerable, Aging and Disabled Populations
- Continuation of all current Proposition 56 payment programs
- Delayed implementation of the doula benefit from July 1, 2022, until January 1, 2023
- Elimination of AB 97 rate reductions for additional provider types
- Reclassification of diabetic products as pharmacy benefits covered under Medi-Cal Rx

Next Steps

Next, Gov. Newsom and the State Legislature will begin negotiating a final budget, which must pass both houses of the Legislature by June 15 and be signed by Gov. Newsom before the July 1 start of FY 2022–23. CalOptima will continue to closely follow ongoing discussions and provide updates on issues that support the advancement of CalOptima's legislative priorities.

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 regarding the above information, please contact GA@caloptima.org.

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MINUTES
REGULAR MEETING
OF THE
CALOPTIMA BOARD OF DIRECTORS

May 5, 2022

A Regular Meeting of the CalOptima Board of Directors was held on May 5, 2022, at CalOptima, 505 City Parkway West, Orange, California. The meeting was held via teleconference (Zoom) in light of the COVID-19 public health emergency and Assembly Bill (AB) 361 (Chaptered September 16, 2021), which allows for temporary relaxation of certain Brown Act requirement related to teleconferenced meetings. Chairman Andrew Do called the meeting to order at 2:05 p.m. and Director Blair Contratto led the Pledge of Allegiance.

ROLL CALL

Members Present: Supervisor Andrew Do, Chairman; Clayton Corwin, Vice Chair; Supervisor Doug Chaffee; Isabel Becerra; Clayton Chau, M.D. (non-voting); Blair Contratto; José Mayorga, M.D.; Scott Schoeffel; Nancy Shivers; Trieu Tran, M.D.
(All Board Members participated in person except Supervisor Doug Chaffee, Dr. Clayton Chau, and Director Nancy Shivers who participated remotely)

Members Absent: None

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

Chairman Do announced that he will not be participating in Agenda Items 21, 23 and 25 due to conflicts of interest related to campaign contributions under the Levine Act and will pass the gavel to Vice Chair Corwin for those agenda items.

PRESENTATIONS/INTRODUCTIONS

None

MANAGEMENT REPORTS

1. Chief Executive Officer Report

Michael Hunn, Chief Executive Officer, highlighted several items from his report.

CalFresh Program

Mr. Hunn updated the Board on the outreach efforts regarding the CalFresh Program. He noted that in the month of March 13,837 individuals were enrolled. This is about 14% of CalOptima's goal of enrolling 100,000 members by December 31, 2022. CalOptima believes that there are about 22,000 members who are immediately eligible without needing to go through the Social Services Agency (SSA), which is the agency that determines eligibility. Mr. Hunn noted that in addition to outreach

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events and direct mailers, staff is working very closely with SSA, community clinics, provider's offices, and schools to distribute information regarding the CalFresh program. Mr. Hunn also noted that according to SSA, previously there was an abandonment rate of about 40% where members would start the enrollment process and not complete it. Working together with SSA and other community stakeholders CalOptima is hoping to reduce the rate of abandonment when enrolling eligible members in the CalFresh program.

Homeless Health Grant Award

Mr. Hunn reported that CalOptima received notice from the California Department of Health Services (DHCS) that its letter of intent (LOI) to provide housing and homelessness services and programs was awarded $83,755,558.00. The funds will be received over the next two years, with approximately $38 million in year one and $46 million in year two. The state had a total of $1.3 billion to award and the maximum that any health plan could receive was 6.5% and CalOptima received the full amount. DHCS has decided that the health plans will distribute the dollars to community stakeholders that will fulfill the health plan's specific initiatives. In CalOptima's case, the three initiatives outlined in its LOI, are as follows: 1) Street medicine model that provides preventative and urgent care, promoting continuity of care; 2) Increasing Medi-Cal enrollment among individuals experiencing homelessness; and 3) Investing and integrating CalOptima's system with existing coordination entry systems for getting individuals into housing by established effective matching and sharing standard operating procedures. This funding will be disbursed by CalOptima to various community organizations in the county that it works with for providing these various services to the homeless.

Care Court

Mr. Hunn also provided an update on the Governor's Care Court proposal, which is gaining some traction. Identical bills were introduced in April, Senate Bill (SB) 1338 and Assembly Bill (AB) 2830 that would implement Governor Newsom's proposed community assistance recovery empowerment or Care Court program. If enacted by the legislature, the Care Court would facilitate the delivery of mental health and substance use disorders services to the most severely impaired Californians, such as those with schizophrenia spectrum and other psychotic disorders who often also experience homelessness or incarceration without treatment. Care Court would connect a person in crisis with a court ordered care plan for up to 12 months with the option to extend an additional 12 months to prevent conservatorships by intervening prior to the need for those services, the care plan could include court ordered stabilization medications wellness and recovery supports and connection to social services and housing. Mr. Hunn noted that as this begins to unfold it will be imperative that CalOptima coordinates accordingly.

Chairman Do noted that the Care Court proposal is pretty involved, and it is still somewhat unresolved on a legal front and asked Director Chau to weigh in from a county perspective.

Director Chau responded that the Care Court concept is a novel concept and in theory the right way to go; however, the court is still involved and there is a housing component. As everyone knows there are no readily available housing options in Orange County. If there is no progress on the client side the County could be fined, up to an estimate of $1,000 a day. Advocates are very much against court ordered treatment because, technically, anyone could petition the court to enroll people if they met the criteria for the court ordered program. Dr. Chau added that there is quite a bit of concern because the financial responsibility is not yet clear and also many pieces of the treatment are also not clear. For example, the individual would need to consent to any treatments, including medication, and even in

outpatient services, you cannot force an individual to receive medication.

Expansion of Medi-Cal to Undocumented Age 50+

Mr. Hunn also provided an update on AB 133, which was signed into law last summer. Staff estimates that approximately 17,000 undocumented individuals aged 50 and over may be eligible for Medi-Cal effective May 1. He noted that undocumented children and young adults under the age of 26 are already eligible. A new proposal that Governor Newsom unveiled in his proposed January budget would further expand eligibility to include the remaining undocumented adults in the 26 to 49 age group, and if approved, the expanded coverage could start as early as 2024.

Redetermination for all Medi-Cal Members

Once the public health emergency ends, the state requires the health plans within 60 days to begin redetermination of eligibility for Medi-Cal. Redetermination has been suspended for two years during the pandemic. CalOptima estimates that in addition to the estimated 17,000 undocumented individuals that will be enrolling, CalOptima will have between 70,000 and 100,000 members who may no longer qualify for Medi-Cal. All individuals across the state will go through redetermination. Mr. Hunn noted that CalOptima would be prepared, and as part of that preparation, later in the agenda is a request to be able to provide insurance on the California Health Exchange (Covered California) to ensure continuity of care for members who may lose eligibility during the redetermination process.

2. FY 2022-23 CalOptima Budget: Part 2

Nancy Huang, Chief Financial Officer, reviewed the second part of the proposed CalOptima Budget for FY 2022-23.

Ms. Huang provided a high-level overview of the budget objectives, which included: enrollment projections, major drivers of medical-related expenditures, and a list of the items that will impact next year's administrative budget. Ms. Huang noted that CalOptima's average membership enrollment is projected to be about 910,000 which is an increase; however, it is expected to slow once the state starts the redetermination process. By June of 2023, staff anticipates a consolidated enrollment of 895,000 with distribution of 98% of all members in the Medi-Cal line of business. She also noted that OneCare Connect membership is projected to be 1.9% and PACE membership is projected to be less than 1%. Next, Ms. Huang reviewed medical-related expenditures, noting this is where most of CalOptima's budget and resources are allocated. She noted that in addition to membership, other factors that went into the budget forecast include utilization trends, program changes, and new initiatives that will be implemented in FY 2022-23, affected CalOptima's consolidated medical loss ratio (MLR), which is projected to be between 94% and 95%. Ms. Huang added that this means that CalOptima will spend more than 94 cents of every dollar on member care. Next, Ms. Huang reviewed the administrative expenses, noting that staff worked with leaders and individual departments to evaluate needs for the upcoming fiscal year. In addition to business needs and regulatory requirements, some of the recent changes that affected the administrative budget include the following: salary schedule adjustments, cost of living increases, market adjustments for some positions, commuter allowance, and holiday premiums, which is why the Board sees an increase in the administrative budget from the previous year's administrative budget. Overall, Ms. Huang reported that CalOptima's administrative loss ratio (ALR) is to remain under 5% for next year. Staff will bring back the complete budget proposal for the Board's consideration at the June Board meeting.

PUBLIC COMMENTS
There was no request for public comment.

CONSENT CALENDAR
3. Minutes

a. Approve Minutes of the April 7, 2022 Regular Meeting of the CalOptima Board of of Directors

4. Adopt Board Resolution No. 22-0505-01, Authorizing Remote Teleconference Meetings for the CalOptima Board of Directors and its Advisory Committees in Accordance with California Government Code section 54953, subdivision (e)

5. Authorize and Direct Execution of Amendment to CalOptima's Primary and Secondary Agreement with California Department of Health Care Services

6. Authorize and Direct Execution of Amendment to Agreement 16-93274 ("Care Coordination Agreement") with California Department of Health Care Services

7. Authorize and Direct Execution of the Cal MediConnect Three-Way Agreement Between CalOptima, the California Department of Health Services and the Centers for Medicare & Medicaid Services

8. Approve Amendment 3 to the Memorandum of Understanding for the Coordination of Behavioral Health Services with the County of Orange
Director Chau did not participate in this item due to his role as the Director of the Orange County Health Care Agency. Director Schoeffel did not participate in this item due to potential conflicts of interest.

9. Authorize Extension and Amendment of State Legislative Advocacy Services Contract with Edelstein Gilbert Robson & Smith LLC

10. Authorize the Chief Executive Officer to Amend the Contract with Kennaday Leavitt PC

11. Ratification of Expenditures Related to Health Insurance Portability and Accountability Act (HIPAA) Security; Authorize Contract with Vendors Providing Security Software Services

12. Authorize Extension of Terms for Members of the CalOptima Board of Directors' OneCare Connect Member Advisory Committee

13. Receive and File the Annual 2021 Utilization Management Program Evaluation and Approve 2022 Utilization Management Program Description

14. Approve Modifications to Policy GG.1101: California Children's Services (CCS)/Whole-Child Model (WCM) – Coordination with County CCS Program

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15. Approve Modifications to CalOptima Grievance and Appeals Resolution Services Policies: GG.1510, HH.1102, HH.1103, HH.1109, HH.1104, MA.9001, MA.9002, MA.9003, MA.9004, MA.9005 and MA.9009

16. Approve Modifications to CalOptima Policy HH.2005: Corrective Action Plan and Addition of CalOptima Policy AA.1275: Department of Health Care Services (DHCS) File and Use Submission Process

17. Approval of Modifications for CalOptima Claims Administration Policies FF.1003, FF.2004, FF.2011, FF.2012 and MA.3101

18. Approve Modifications to CalOptima Policy MA.7007: Access and Availability

19. Receive and File:

a. March 2022 Financial Summary
b. Compliance Report
c. Federal and State Legislative Advocates Reports
d. CalOptima Community Outreach and Program Summary

Action: ***On motion of Director Becerra, seconded and carried, the Board of Directors approved Consent Calendar items as presented. (Motion carried 8-0-0 (except as noted above); Director Schoeffel absent on Agenda Item 8)***

REPORTS/DISCUSSION ITEMS

20. Direct the Chief Executive Officer to Take Actions to Amend CalOptima's Ordinance to Allow for the Participation in the California Health Benefit Exchange

Chairman Do introduced the item providing preliminary comments ahead of CEO Hunn. Chairman Do mentioned Mr. Hunn's comments earlier, noting that CalOptima's membership is expected to increase with the expansion of Medi-Cal to undocumented individuals aged 50 and over and with the many changes the agency has made with a new vision and mission, we are in a position to provide even better care to CalOptima's members. The Chairman also noted that once the redetermination of the membership starts, and as the economy continues to evolve, we know that some people may lose their Medi-Cal eligibility, so with CalOptima joining the Exchange, this will allow those people to have continuity of care and be able to stay will their health care provider.

Mr. Hunn provided background, noting that in 2010 California was the first state to introduce legislation to create the California health benefit exchange, now known as Covered California. In 2011, the Orange County Board of Supervisors, amended the CalOptima ordinance to state that it is not intended that the health authority compete with the private sector health plans, individually or through joint ventures to offer insurance directly to individuals or group private payers procuring their coverage in the commercial non-governmental health care market. Mr. Hunn added that today, May 5, 2022, our Board

of Directors is being asked to consider authorizing CalOptima to seek an amendment to the ordinance that was passed by the Orange County Board of Supervisors. He explained that the reason why CalOptima is asking for the ordinance to be amended is to allow for continuity of care for our members, which is significant in light of the upcoming redetermination. This will also allow people that may be above the federal poverty level (FPL), but still have difficulty finding insurance on the Exchange, an option given their income. Mr. Hunn added that this will take a lot of work to prepare and enter the Exchange including: obtaining a Knox Keene license, setting up infrastructure to receive share of cost premiums, and branding. Mr. Hunn noted that he announced this at health network forums and has been talking individually to CEOs, doctors, and clinics. Not everyone is in favor, but a good consensus is that for continuity of care, it makes sense.

Director Contratto noted that she did receive a call from the Hospital Association of Southern California and that they will be going to the Board to express their concern and opposition.

Action: ***On motion of Director Becerra, seconded and carried, the Board of Directors approved: 1.) Support CalOptima's participation in the California Health Benefit Exchange; and 2.) Directed the Chief Executive Officer to seek an ordinance change from the County of Orange to allow CalOptima to participate in the State Health Insurance Exchange, also known as, Covered California. (Motion carried 9-0-0)***

As mentioned at the top of the meeting, Chairman Do noted that he is abstaining on Agenda Items 21, 23 and 25 and passed the gavel to Vice Chair Corwin. So, we will hear Agenda Items 21, 23, and 25, and then come back to Agenda Items 22 and 24 and the rest of the agenda items.

21. Approval of Actions Related to Homeless Health Care Initiatives

Chairman Do did not participate in the discussion and vote on this item due to conflicts of interest related to campaign contributions under the Levine Act and passed the gavel to Vice Chair Corwin. Director Becerra did not participate in this item due to her affiliation with the Orange County Coalition of Community Health Centers. Director Schoeffel did not participate in this item due to potential conflicts of interest and left the room during the discussion and vote.

Action: ***On motion of Director Contratto, seconded and carried, the Board of Directors: 1.) Regarding the Homeless Clinic Access Program (HCAP) Quality Initiative: a) Authorized the allocation of up to $700,000 from the restricted Homeless Health Initiatives Reserve to continue funding HCAP provider incentives through December 31, 2022; and 2.) Regarding the Street Medicine Pilot Program: a) Approved the Scope of Work (SOW) for the Street Medicine program. (Motion carried 6-0-1; Chairman Do abstained; Director Becerra recused; Director Schoeffel absent)***

22. Approve the Criteria and Process for CalOptima to Contract with a Provider Organization under a Global Risk Health Maintenance Organization (HMO) Health Network Model

Action: ***On motion of Vice Chair Corwin, seconded and carried, the Board of Directors: 1.) Approved the criteria and process for CalOptima to contract with a health network under a Global Risk Health Maintenance Organization (HMO) model; and 2.) Authorized the Chief Executive Officer to approve and implement policies and procedures in accordance with the approved criteria and process. (Motion carried 9-0-0)***

23. Authorize Extension and Amendments of CalOptima Health Network and Fee-for-Service Provider Contracts except Kaiser Foundation Health Plan Inc., ARTA Western California Inc., Monarch Healthcare A Medical Group Inc., Talbert Medical Group P.C., and UC Irvine Health

Chairman Do did not participate in the discussion and vote on this item due to conflicts of interest related to campaign contributions under the Levine Act. Director Schoeffel did not participate in this item due to potential conflicts of interest and left the room during the discussion and vote. Director Tran did not participate in this item due to his service as a specialist physician serving CalOptima members.

Action: ***On motion of Director Contratto, seconded and carried, the Board of Directors: 1.) Authorized the CEO to Amend the Medi-Cal Health Network Full-Risk Health Maintenance Organization (HMO), Shared-Risk Group (SRG), Physician Hospital Consortia Hospital (PHC-H) and Physician Hospital Consortia Physician (PHC-P) contracts, except Kaiser Foundation Health Plan Inc., ARTA Western California Inc., Monarch Healthcare A Medical Group Inc., and Talbert Medical Group P.C., to: a.) Extend the contract term through June 30, 2027; b.) Add language reflecting a contract renewal term of five (5) years, plus five (5) additional one-year (1) automatic extensions, except as directed otherwise by the CalOptima Board of Directors (Board); and c.) Add language reflecting the provision of arbitration where necessary; and 2.) Authorized the CEO to amend the Fee-for-Service (FFS) Medi-Cal, OneCare, and OneCare Connect Medical and Non-Medical Ancillary Services, Hospital, and Professional Services contracts, except UC Irvine Health to: a.) Extend the contract term through June 30, 2027; b.) Add language reflecting a contract renewal term of five (5) years, plus five (5) additional one-year (1) automatic extensions, except as directed otherwise by the Board; c.) Add language reflecting the provision of arbitration as necessary; and d.) Add language for termination without cause after 90 days; and 3.) Authorized the CEO to amend the Kaiser Foundation Health Plan, Inc. HMO contract to: a.) Add language reflecting a contract renewal term of five (5) years, plus five (5) additional one-year (1) automatic extensions, except as directed otherwise by the Board, after the expiration of their contract on June 30, 2023; and b.) Add language reflecting the provision of arbitration as necessary. (Motion carried 6-0-1; Chairman Do abstained; Director Schoeffel absent; Director Tran recused)***

24. Authorize Extension and Amendments of CalOptima Health Network Contracts for ARTA Western California Inc., Monarch Healthcare A Medical Group Inc., Talbert Medical Group P.C., and Fee-for-Service Medi-Cal, OneCare, and OneCare Connect Provider Contracts Except UC Irvine Health

Director Mayorga did not participate in this item due to his role as Executive Director at UC Irvine Health. Director Schoeffel did not participate in this item due to potential conflicts of interest and left the room during the discussion and vote. Director Shivers did not participate in this item due to her affiliation with UnitedHealth Group and Optum.

Action: ***On motion of Supervisor Chaffee, seconded and carried, the Board of Directors: 1.) Authorized the CEO to Amend the Medi-Cal Health Network Full-Risk Health Maintenance Organization (HMO) Shared-Risk Group (SRG), Physician Hospital Consortia Hospital (PHC-H) and Physician Hospital Consortia Physician (PHC-P) contracts for ARTA Western California Inc., Monarch Healthcare A Medical Group Inc., and Talbert Medical Group P.C., to: a.) Extend the contract term through June 30, 2027; b.) Add language reflecting a contract renewal term of five (5) years, plus five (5) additional one-year (1) automatic extensions, except as directed otherwise by the CalOptima Board of Directors (Board); and c.) Add language reflecting the provision of arbitration where necessary; and 2.) Authorized the CEO to amend the Fee-for-Service (FFS) Medi-Cal, OneCare, and OneCare Connect Medical and Non-Medical Ancillary Services, Hospital, and Professional Services contracts except UC Irvine Health to: a.) Extend the contract term through June 30, 2027; b.) Add language reflecting a contract renewal term of five (5) years, plus five (5) additional one-year (1) automatic extensions, except as directed otherwise by the Board; c.) Add language reflecting the provision of arbitration as necessary; and d.) Add language for termination without cause after 90 days; and 3.) Authorized the CEO to amend the Kaiser Foundation Health Plan, Inc. HMO contract to: a.) Add language reflecting a contract renewal term of five (5) years, plus five (5) additional one-year (1) automatic extensions, except as directed otherwise by the Board after the expiration of their contract in 2023; and b.) Add language reflecting the provision of arbitration as necessary. (Motion carried 6-0-0; Directors Mayorga and Shivers recused; Director Schoeffel absent)***

25. Authorize Extension and Amendments of CalOptima Health Network Contracts Except Kaiser Foundation Health Plan Inc. and Provider Contract for UC Irvine Health

Chairman Do did not participate in the discussion and vote on this item due to conflicts of interest related to campaign contributions under the Levine Act. Director Mayorga did not participate in this item due to his role as Executive Director at UC Irvine Health. Director Schoeffel did not participate in this item due to potential conflicts of interest and left the room during the discussion and vote.

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Action: ***On motion of Vice Chair Corwin seconded and carried, the Board of Directors: 1.). Authorized the CEO to Amend the Medi-Cal Health Network Full-Risk Health Maintenance Organization (HMO) Except Kaiser Foundation Health Plan, Inc., Shared-Risk Group (SRG), Physician Hospital Consortia Hospital (PHC-H) and Physician Hospital Consortia Physician (PHC-P) contracts to: a.) Extend the contract term through June 30, 2027; b.) Add language reflecting a contract renewal term of five (5) years, plus five (5) additional one-year (1) automatic extensions, except as directed otherwise by the CalOptima Board of Directors (Board); and c.) Add language reflecting the provision of arbitration where necessary; and 2.) Approved Amendments to the Fee-for-Service Medi-Cal, OneCare, and OneCare Connect Professional Services contracts for UC Irvine Health to: a.) Extend the contract term through June 30, 2027; b.) Add language reflecting a contract renewal term of five (5) years, plus five (5) additional one-year (1) automatic extensions, except as directed otherwise by the Board; c.) Add language reflecting the provision of arbitration as necessary; and d.) Add language for termination without cause after 90 days; and 3.) Authorized the CEO to amend the Kaiser Foundation Health Plan, Inc. HMO contract to: a.) Add language reflecting a contract renewal term of five (5) years, plus five (5) additional one-year (1) automatic extensions, except as directed otherwise by the Board, after the expiration of their contract in 2023; and b.) Add language reflecting the provision of arbitration as necessary (Motion carried 6-0-1; Chairman Do abstained; Director Mayorga recused; Director Schoeffel absent)***

26. Authorize the Chief Executive Officer to Negotiate, Execute and Implement ZeOmega, Inc. Contract for a Care Management System in Support of CalOptima's Digital Transformation Strategy

Action: ***On motion of Director Schoeffel, seconded and carried, the Board of Directors authorized the Chief Executive Officer (CEO) to: 1.) Negotiate and execute the contract with ZeOmega Inc., a health management-payer care management vendor, for an initial term not to exceed five years, with three one-year extension options, exercisable at CalOptima's sole discretion, with each extension option subject to prior Board approval; and 2.) Complete implementation and replacement of the existing care management system. (Motion carried 9-0-0)***

CLOSED SESSION

The Board adjourned to Closed Session at 3:40 p.m. CS-1: Pursuant to Government Code section 54956.87, subdivision (b) HEALTH PLAN TRADE SECRETS: OneCare and CS-2: Pursuant to Government Code section 54956.9, subdivision (d)(1) CONFERENCE WITH LEGAL COUNSEL -EXISTING LITIGATION, Orange County Digestive Center vs. CALOPTIMA, Superior Court of the State of California, County of Orange, Case No. 30-2022-01245381.

The Board reconvened to open session at 4:25 p.m. Chairman Do announced that he and the Directors are back from Closed Session and noted for the record that the Board was going to pause to give the Board members, who are participating remotely, and the members of the public, time to rejoin the Zoom Webinar.

The Clerk reestablished a quorum.

ROLL CALL

Members Present: Supervisor Andrew Do, Chairman; Clayton Corwin, Vice Chair; Supervisor Doug Chaffee; Isabel Becerra, Clayton Chau, M.D. (non-voting); Blair Contratto; José Mayorga M.D.; Nancy Shivers, Trieu Tran, M.D.

(All Board Members participated in person except Supervisor Doug Chaffee, Dr. Clayton Chau, and Director Nancy Shivers who participated remotely)

Members Absent: Scott Schoeffel

The Clerk read the following recommended action for CS-2:

The Board considered the proposed settlement in the matter of Orange County Digestive Center vs. CalOptima. In recognition of the risks inherent with litigation, and in the interest of avoiding unnecessary costs and fees, the Board has agreed to the proposed settlement in the amount of $315,000.00.

27. Authorize the Chief Executive Officer (CEO) to Submit OneCare Bid for Calendar Year 2023 and Execute Contract with the Centers for Medicare & Medicaid Services and the California Department of Health Care Services; Authorize the CEO to Amend/Execute OneCare Health Network Contracts and Take Other Actions as Necessary to Implement (***to follow Closed Session***)
Director Schoeffel did not participate in this item due to potential conflicts of interest and left the room during the discussion and vote.

Action: ***On motion of Director Mayorga, seconded and carried, the Board of Directors authorized the Chief Executive Officer (CEO) to submit OneCare Bid for calendar year 2023 and execute contracts with the Centers for Medicare & Medicaid Services and the California Department of Health Care Services; Authorized the CEO to amend/execute OneCare Health Network Contracts and take other actions as necessary to implement. (Motion carried 8-0-0; Director Schoeffel absent)***

BOARD MEMBER COMMENTS AND BOARD COMMITTEE REPORTS
There were no Board Member comments.

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ADJOURNMENT

Hearing no further business, Chairman Do adjourned the meeting at 4:31 pm.

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Sharon Dwiers
Clerk of the Board

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MINUTES

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

CALOPTIMA
505 CITY PARKWAY WEST
ORANGE, CALIFORNIA

February 17, 2022

A Special Meeting of the CalOptima Board of Directors' Finance and Audit Committee was held on February 17, 2022, at CalOptima, 505 City Parkway West, Orange, California. The meeting was held via teleconference (Go-to-Webinar) in light of the COVID-19 public health emergency and of Assembly Bill (AB) 361 (Chaptered September 16, 2021), which allows for temporary relaxation of certain Brown Act requirements related to teleconferenced meetings.

Chair Isabel Becerra called the meeting to order at 3:01 p.m. and welcomed Blair Contratto to the Finance and Audit Committee. Director Contratto led the Pledge of Allegiance.

ROLL CALL

Members Present: Isabel Becerra, Chair; Blair Contratto; Clayton Corwin (at 3:36 p.m.); Scott Schoeffel (all Members participated remotely)

Members Absent: None

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

MANAGEMENT REPORTS

1. Chief Financial Officer Report

Nancy Huang, Chief Financial Officer, welcomed Director Contratto to the Finance and Audit Committee (FAC). Ms. Huang highlighted two items from her report. The first update relates to the CalAIM waiver approval from the Centers for Medicare & Medicaid Services (CMS), which was received on December 29, 2021, on the 1115 and 1915B waivers. These waivers allowed managed care plans to implement a more integrated and whole-person focused delivery system. In addition, the waivers also increased financial accountability and requires medical loss ratio (MLR) reporting, not only at the plan level, but also at the delegated Health Network level starting in July 2022.

Ms. Huang also provided an update on a recent reporting requirement from the Department of Health Care Services (DHCS). Currently, all of CalOptima's capitation is attributed to medical-related expenses. The new reporting requirements will require CalOptima to separate medical-related expenses from administrative-related expenses. Staff is assessing the implications of this new reporting requirement on CalOptima's financial reporting and on its delegated Health Networks.

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INVESTMENT ADVISORY COMMITTEE UPDATE

2. Treasurer's Report

Ms. Huang presented the Treasurer's Report for the period of October 1, 2021 through December 31, 2021. The portfolio totaled approximately $2.0 billion as of December 31, 2021. Of this amount, $1.4 billion was in CalOptima's operating account and $587 million was included in CalOptima's Board-designated reserves. Meketa Investment Group Inc., CalOptima's investment advisor, completed an independent review of the monthly investment reports and reported that all investments were compliant with Government Code section 53600 *et seq*. and with CalOptima's Board-approved Annual Investment Policy during that period.

PUBLIC COMMENTS

There were no requests for public comment.

CONSENT CALENDAR

3. Approve the Minutes of the November 18, 2021, Regular Meeting of the CalOptima Board of Directors' Finance and Audit Committee and Receive and File Minutes of the October 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 Corwin absent)***

REPORT

4. Appointment to the CalOptima Board of Directors' Investment Advisory Committee

Action: ***On motion of Director Contratto, seconded and carried, the Committee recommended that the Board of Directors approve the appointment of Annie Tran to the Board of Directors' Investment Advisory Committee (IAC) for a two-year term beginning March 4, 2022. (Motion carried 3-0-0; Director Corwin absent)***

5. Approve Authorization of Capital and Operating Expenditures for Various Facilities Items

Action: ***On motion of Director Schoeffel, seconded and carried, the Committee recommended that the Board of Directors: 1.) Authorize unbudgeted expenditures and appropriate funds from existing reserves for the following operating expenditures through June 30, 2022: a.) Up to $10,000 to Medi-Cal – Professional Fees to perform a building operating review; b.) Up to $125,000 to Facilities – Other Operating Expenses for COVID-19 cleaning expenses; and c.) Up to $80,000 to PACE – Other Operating Expenses for PACE renovation expenses; 2.) Authorize unbudgeted expenditures and appropriate funds from existing reserves for the following capital expenditures: a.) Up to $30,000 for 505 Building Improvements - New Roof Membrane Continuation; and b.) Up to $170,000 to PACE – Equipment for PACE renovation expenses; and 3.) Authorize capital project expenditures of up to $50,000 for audio visual enhancement of conference rooms. (Motion carried 3-0-0; Director Corwin absent)***

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6. Revisions to CalOptima's Fiscal Year 2021-22 Multipurpose Senior Services Program Operating Budget

Action: ***On motion of Director Contratto, seconded and carried, the Committee recommended that the Board of Directors Approve parameters for revisions to CalOptima's Fiscal Year (FY) 2021-22 Multipurpose Senior Services Program (MSSP) Operating Budget. (Motion carried 3-0-0; Director Corwin absent)***

7. Approve Modifications to Policy GA 5004: Travel Policy

Action: ***On motion of Director Schoeffel, seconded and carried, the Committee recommended that the Board of Directors Approve modifications to CalOptima Policy GA.5004: Travel Policy. (Motion carried 3-0-0; Director Corwin absent)***

8. Approve Modifications to Policy GA. 3301: Capitalization Policy

Action: ***On motion of Director Contratto, seconded and carried, the Committee recommended that the Board of Directors Approve modifications to CalOptima Policy GA.3301: Capitalization Policy. (Motion carried 3-0-0; Director Corwin absent)***

INFORMATION ITEMS

9. Provider Credentialing Audit Report

Carmen Dobry, Executive Director, Compliance, introduced Hayley Oakes, Manager, Grant Thornton LLP. Grant Thornton LLP is CalOptima's vendor contracted to perform various internal audits.

Ms. Oakes reviewed the results of the Provider Credentialing Audit. The audit goal was to assess CalOptima's provider credentialing process to determine whether current processes are functioning effectively. The audit focused on controls and mechanisms for initial credentialing, re-credentialing and terminations. Grant Thornton found no high-risk observations during the audit. There were low risk observations that involved documentation of processes and using standard language across the credentialing processes to avoid confusion.

CEO Michael Hunn thanked Grant Thornton for their work on this audit and asked if they had provided the CalOptima team with best practice example with regard to the provider terminations formalized document. Ms. Oakes responded that they did discuss best practices and noted that CalOptima staff were already in the process of including the formalized document.

The following items were accepted as presented.

10. November and December Financial Summaries

11. CalOptima ITS Information Security Update

12. Quarterly Operating and Capital Budget Update

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13. Quarterly Reports to the Finance and Audit Committee
    a. Shared Risk Pool Performance Update
    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

Director Contratto thanked CFO Nancy Huang for meeting with her ahead of today's meeting to get acclimated to the responsibilities of the Finance and Audit Committee and its members. She also requested that going forward staff provide high-level month-to-date and year-to-date metrics at each meeting. These numbers are included in the details of agenda items 10 and 12 of today's meeting materials.

Director Schoeffel echoed Director Contratto's request for high level metrics, which would assist the Committee members in their overall review of the materials and make it easier to track progress on various initiatives and programs.

ADJOURNMENT

Hearing no further business, Finance and Audit Committee Chair Becerra adjourned the meeting at 3:39 p.m.

/s/ Sharon Dwiers
Sharon Dwiers
Clerk of the Board

Approved: May 19, 2022

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken June 2, 2022
Regular Meeting of the CalOptima Board of Directors

Consent Calendar

3. Authorize Expenditures in the CalOptima Fiscal Year 2021-22 Operating Budget for Claims Editing Solution

Contacts

Yunkyung Kim, Chief Operating Officer, (714) 246-8408
Ladan Khamseh, Executive Director, Operations, (714) 246-8866

Recommended Action

Authorize unbudgeted operating expenditures and appropriate funds from existing reserves in an amount up to $400,000 to "Medi-Cal: Purchased Services" to fund contingency fees for pre-payment claims editing solutions of professional services claims through June 30, 2022.

Background/Discussion

The recommended budget adjustment for clinical editing solutions is included within the Claims Administration Fiscal Year (FY) 2021-22 Operating budget as summarized below.

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), and 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. Total savings for FY 2020-21 were $9,753,687.82 with contingency fees of $1,901,993.16. In comparison, current savings for FY 2021-22 (July 2021 – March 2022) total $9,368,526 with continency fees of $1,995,968 paid to Cotiviti so far with three invoicing months remaining for FY2021-22. The increase in savings is attributed to claims editing for unbundling codes and provider billing codes beyond the allowed limits. Additionally, claims submitted by providers increased from FY2020-21 to FY2021-22 by an average of 52,000 monthly.

Claims Administration budgeted $2,040,000 for contingency fees with $213,760 remaining for the last three months of FY 2021-22. The requested addition to the budget is to cover estimated additional contingency fees up to $400,000.

Fiscal Impact

The recommended action is unbudgeted. An appropriation of up to $400,000 from existing reserves will fund this action.

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Rationale for Recommendation

Staff recommends approval of the recommended action to ensure CalOptima's continual utilization of claim editing solutions to ensure appropriate and accurate claims payments and recoveries through June 30, 2022.

Concurrence

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

Attachment

1. Claims Administration Budget Request Presentation

/s/ Michael Hunn *05/27/2022*
Authorized Signature **Date**

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CalOptima

Better. Together.

Claims Administration Budget Request

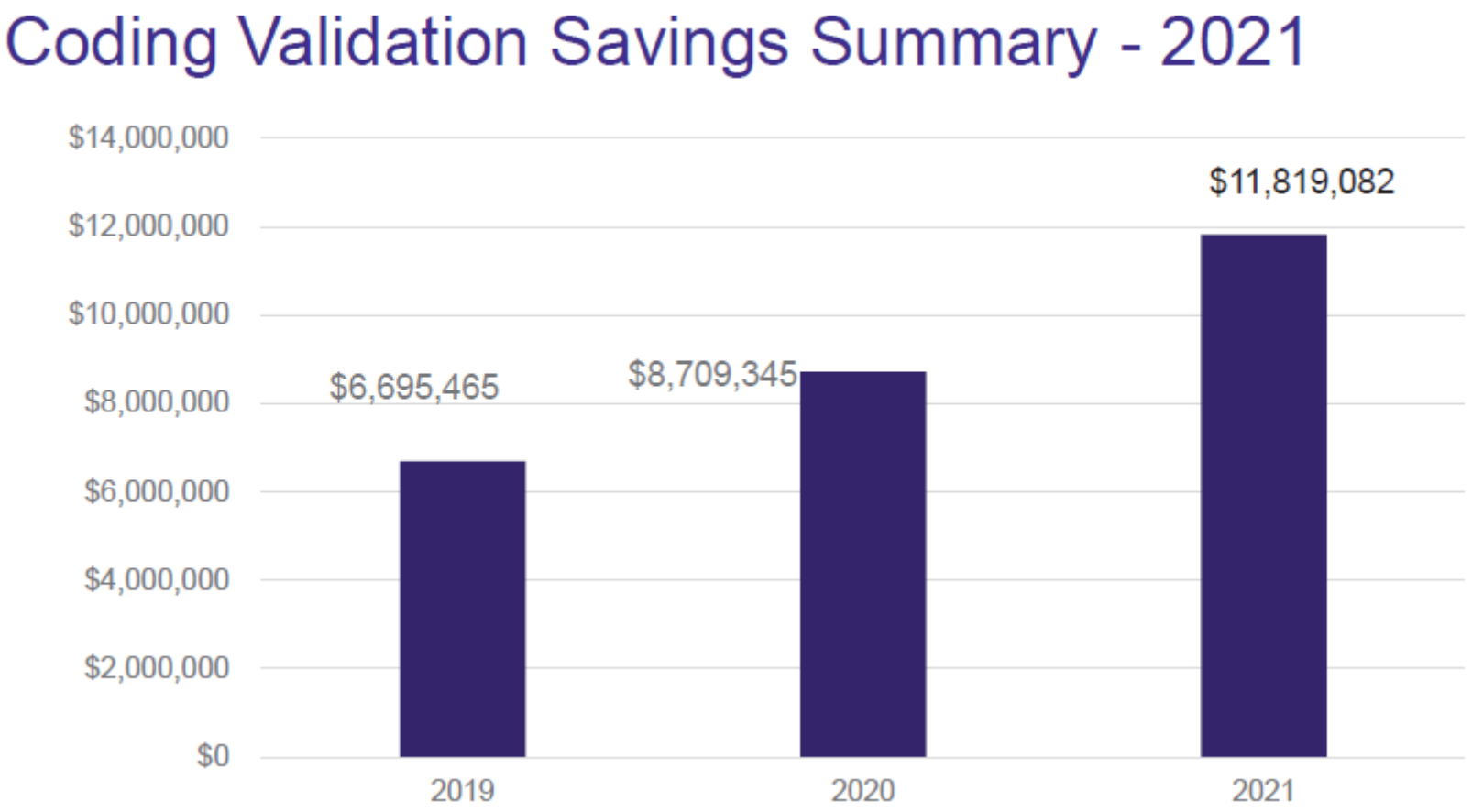
Board of Directors' Finance and Audit Committee Meeting
May 15, 2022

Ladan Khamseh, 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



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Top Five Coding Edits Accepted

- Unbundling
- Frequency
- Same Provider Duplicate
- Frequency Over Time
- Cross Provider Duplicate

Top Five Provider Types

- Pathology
- MD Provider
- Hospital
- Clinical Laboratory
- Internal Medicine

Our Mission

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

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken June 2, 2022
Regular Meeting of the CalOptima Board of Directors

Consent Calendar

4. Adopt Board Resolution No. 22-0602-01, Authorizing Remote Teleconference Meetings for the CalOptima Board of Directors and its Advisory Committees in Accordance with California Government Code section 54953, subdivision (e)

Contact

Michael Hunn, Chief Executive Officer (657) 900-1481

Recommended Action

Adopt Board Resolution No. 22-0602-01, authorizing remote teleconference meetings for the CalOptima Board of Directors and its advisory committees in accordance with Government Code section 54953, subdivision (e).

Background

Under the Ralph M. Brown Act, California Government Code Section 54950 *et seq.*, (Brown Act) meetings of California local public bodies must be open and public. Prior to the COVID-19 pandemic, the Brown Act has generally allowed a local agency to use teleconferencing for public meetings, subject to specific agenda, posting, physical access, and quorum requirements. On March 4, 2020, pursuant to Government Code section 8625, Governor Gavin Newsom declared a state of emergency related to the COVID-19 pandemic, and the declaration of emergency continues in effect and has not been lifted or rescinded.

On March 17, 2020, Governor Newsom signed Executive Order N-29-20, suspending certain provisions of the Brown Act, including, in part, suspending the requirement for in-person legislative meetings and suspending the requirement that each teleconference location be accessible to the public. The Governor's Executive Order expired on September 30, 2021.

Under Assembly Bill (AB) 361, which was signed by Governor Newsom and took effect on September 16, 2021, the Brown Act was amended for a limited time to authorize local agencies to hold teleconference public meetings without complying with certain Brown Act requirements provided that certain conditions are met. These include:

> (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; or
>
> (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; or
>
> (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.

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If meetings are held via teleconference under these special circumstances, the legislative body must ensure that notice of the meetings are given and agendas posted, and that the rights of the public to observe and participate are protected (including delaying action on any items during any period where a disruption prevents the broadcasting of the meeting to the public and or the ability of the public to participate).

Discussion

Pursuant to the language of AB 361, in order for CalOptima to continue holding teleconference meetings, the Board is required to make the following findings by majority vote within 30 days of teleconferencing for the first time under AB 361 and every 30 days thereafter:

(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; or
(ii) State or local officials continue to impose or recommend measures to promote social distancing.

Given the continued active declaration of emergency arising from the COVID-19 pandemic, there is an ongoing need for holding teleconference meetings for the CalOptima Board of Directors and its advisory committees. In addition, the County of Orange Health Officer issued "Orders and Strong Recommendations," updated as of March 24, 2022, to strongly recommend preventative measures such as avoiding gathering and practicing social distancing. For CalOptima to continue the teleconference meetings, the required findings are set forth in the attached Resolution No. 22-0602-01.

In addition, as part of the continued obligations to protect the public's right to participate in the meetings of local legislative bodies, CalOptima is also required to do the following:

- Allow the public to access the meeting and require that the agenda provide an opportunity for the public to directly address the legislative body pursuant to the Brown Act's other teleconferencing provisions.
- In each instance when CalOptima provides notice of the teleconferenced meeting or post its agenda, give notice for how the public can access the meeting and provide public comment.
- Identify and include in the agenda an opportunity for all persons to attend via a call-in or an internet-based service option.
- Conduct teleconference meetings in a manner that protects the statutory and constitutional rights of the public.
- In the event of service disruption that either prevents CalOptima from broadcasting the meeting to the public using the call-in or internet-based service option or a disruption within CalOptima's control that prevents the public from submitting public comments, stop the meeting until public access is restored.
- Not require comments be submitted in advance and provide the opportunity to comment in real time.

- Provide adequate time for public comment, either by establishing a timed public comment period or by allowing a reasonable amount of time to comment, including the time that may be required for an individual to register to log in to the teleconference to provide public comment.

Fiscal Impact

The recommended action to adopt a resolution authorizing remote teleconference meetings for the CalOptima Board of Directors and its advisory committees in accordance with Government Code section 54953, subdivision (e), will have no fiscal impact on CalOptima.

Rationale for Recommendation

The recommended action to allow for teleconference meetings for the CalOptima Board of Directors and its advisory committees will satisfy the requirements of Government Code section 54953, subdivision (e) and allow CalOptima to hold public meetings via teleconference as the statute allows in a manner that will minimize the risks associated with the continuing public emergency related to the COVID-19 pandemic.

Concurrence

Troy R. Szabo, Outside General Counsel, Kennaday Leavitt

Attachments

1. Board Resolution No. 22-0602-01, Authorizing Remote Teleconference Meetings for the CalOptima Board of Directors and its Advisory Committees in Accordance with Government Code section 54953, subdivision (e)
2. March 4, 2020, Proclamation of a State of Emergency
3. March 24, 2022, Orange County Health Officer's Orders and Strong Recommendations
4. Government Code section 54953, as amended by AB 361

/s/ Michael Hunn *05/27/2022*

Authorized Signature **Date**

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RESOLUTION NO. 22-0602-01

RESOLUTION OF THE BOARD OF DIRECTORS
ORANGE COUNTY HEALTH AUTHORITY d.b.a. CalOptima

AUTHORIZING REMOTE TELECONFERENCE MEETINGS FOR THE CALOPTIMA BOARD OF DIRECTORS AND ITS ADVISORY COMMITTEES IN ACCORDANCE WITH GOVERNMENT CODE SECTION 54953, SUBDIVISION (e)

WHEREAS, CalOptima is a local public agency created pursuant to Welfare and Institutions Code section 14087.54 by the County of Orange under Orange County Ordinance No. 3896, as amended, which established CalOptima as a separate and distinct public entity; and

WHEREAS, CalOptima is committed to compliance with the requirements of the Ralph M. Brown Act (Brown Act) to provide transparency, public access, and opportunities to participate in meetings of CalOptima's Board of Directors and its advisory committees.

WHEREAS, on March 4, 2020, pursuant to Government Code section 8625, the Governor of California declared a state of emergency in response to the COVID-19 pandemic;

WHEREAS, on March 17, 2020, the Governor issued Executive Order N-29-20, which suspended certain requirements under the Brown Act and modified the teleconference requirements to allow legislative bodies of public agencies to hold public meetings via teleconference;

WHEREAS, on June 4, 2021, the Governor clarified that the "reopening" of California on June 15, 2021, did not include any change to the declared state of emergency or the powers exercised thereunder;

WHEREAS, on June 11, 2021, the Governor issued Executive Order N-08-21, which extended the provision of Executive Order N-29-20 concerning the conduct of public meetings through September 30, 2021;

WHEREAS, California Assembly Bill (AB) 361 was signed into law effective September 16, 2021, which amended the teleconferencing requirement under the Brown Act provision in Government Code section 54953;

WHEREAS, Government Code section 54953, subdivision (b)(3) permits public meetings by teleconference, but requires: the agendas to be posted at all teleconference locations; each teleconference location be identified in the notice and agenda of the meeting or proceeding; and each teleconference location be accessible to the public;

WHRereas, Government Code section 54953, subdivision (e) provides an alternative to having public meetings in accordance with Government Code section 54953, subdivision (b)(3) when the circumstances of the COVID-19 state of emergency and the following circumstances exist: (1) The state of emergency as a result of COVID-19 continues to directly impact the ability of members of CalOptima's Board of Directors and members of CalOptima committees to meet safely in person; and (2) the State of California and/or the County of Orange continue to impose or recommend measures to promote social distancing;

WHEREAS, as of the date of this Resolution, neither the Governor nor the Legislature have exercised their respective powers pursuant to California Government Code section 8629 to lift the state of emergency either by proclamation or by concurrent resolution of the state Legislature;

WHEREAS, on March 24, 2022, the County of Orange Health Officer issued a revised "Orders and Strong Recommendations," which includes strong recommendations for preventative measures, such as avoiding gathering and practicing social distancing;

WHEREAS, the continued local rates of transmission of the virus and variants causing COVID-19 are such that meeting in person could present imminent risks to the health or safety of attendees of CalOptima's public meetings if teleconference options are not included as an option for participation;

WHEREAS, the CalOptima Board of Directors and advisory committees have met remotely during the COVID-19 pandemic and can continue to do so in a manner that allows public participation and transparency while minimizing health risks to the Board members, staff, and public that would be present with in-person meetings while this state of emergency continues; and

WHEREAS, the Board of Directors has considered all information related to this matter and determined that it is in the best interest of the public and CalOptima that the Board of Directors meetings and advisory committee meetings of other CalOptima bodies be held via teleconference for the next thirty (30) days.

NOW, THEREFORE, BE IT RESOLVED:

I. That the CalOptima Board of Directors has duly considered the active status of the current state of emergency, along with the County of Orange Health Officer's strong recommendation to continue implementing COVID-19 preventative measures, such as social distancing, and has found that the state of emergency continues to directly impact the ability of the CalOptima Board of Directors and its advisory committees to meet safely in person;

II. That, as a result of the continued impact on the safety of the public and CalOptima officials, all CalOptima public meetings for the next thirty (30) days shall be conducted via teleconferencing, and such teleconferencing shall be carried out in compliance with California Government Code Section 54953, including, but not limited to, provisions protecting the statutory and constitutional rights of the public to attend and participate in such meetings;

III. That this Resolution shall take effect immediately upon its adoption and shall be effective until the earlier of (i) thirty (30) days after teleconferencing for the first time pursuant to Government Code section 54953(e), or (ii) such time that the CalOptima Board of Directors adopts a subsequent resolution in accordance with Government Code section 54953, subdivision (e)(3) to extend the time during which CalOptima's Board of Directors and advisory committees may continue to teleconference without compliance with Government Code section 54953, subdivision (e)(3)(b); and

IV. That the Chief Executive Officer of CalOptima is directed to place a resolution substantially similar to this resolution on the agenda of a future meeting of the CalOptima Board of Directors within the next thirty (30) days, or as soon thereafter as the CalOptima Board of Directors shall meet.

APPROVED AND ADOPTED by the Board of Directors of the Orange County Health Authority, d.b.a. CalOptima, this 2nd day of June, 2022.

AYES: _____

NOES: _____

ABSENT: _____

ABSTAIN: _____

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

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

EXECUTIVE DEPARTMENT
STATE OF CALIFORNIA

PROCLAMATION OF A STATE OF EMERGENCY

WHEREAS in December 2019, an outbreak of respiratory illness due to a novel coronavirus (a disease now known as COVID-19), was first identified in Wuhan City, Hubei Province, China, and has spread outside of China, impacting more than 75 countries, including the United States; and

WHEREAS the State of California has been working in close collaboration with the national Centers for Disease Control and Prevention (CDC), with the United States Health and Human Services Agency, and with local health departments since December 2019 to monitor and plan for the potential spread of COVID-19 to the United States; and

WHEREAS on January 23, 2020, the CDC activated its Emergency Response System to provide ongoing support for the response to COVID-19 across the country; and

WHEREAS on January 24, 2020, the California Department of Public Health activated its Medical and Health Coordination Center and on March 2, 2020, the Office of Emergency Services activated the State Operations Center to support and guide state and local actions to preserve public health; and

WHEREAS the California Department of Public Health has been in regular communication with hospitals, clinics and other health providers and has provided guidance to health facilities and providers regarding COVID-19; and

WHEREAS as of March 4, 2020, across the globe, there are more than 94,000 confirmed cases of COVID-19, tragically resulting in more than 3,000 deaths worldwide; and

WHEREAS as of March 4, 2020, there are 129 confirmed cases of COVID-19 in the United States, including 53 in California, and more than 9,400 Californians across 49 counties are in home monitoring based on possible travel-based exposure to the virus, and officials expect the number of cases in California, the United States, and worldwide to increase; and

WHEREAS for more than a decade California has had a robust pandemic influenza plan, supported local governments in the development of local plans, and required that state and local plans be regularly updated and exercised; and

WHEREAS California has a strong federal, state and local public health and health care delivery system that has effectively responded to prior events including the H1N1 influenza virus in 2009, and most recently Ebola; and

WHEREAS experts anticipate that while a high percentage of individuals affected by COVID-19 will experience mild flu-like symptoms, some will have more serious symptoms and require hospitalization, particularly individuals who are elderly or already have underlying chronic health conditions; and

WHEREAS it is imperative to prepare for and respond to suspected or confirmed COVID-19 cases in California, to implement measures to mitigate the spread of COVID-19, and to prepare to respond to an increasing number of individuals requiring medical care and hospitalization; and

WHEREAS if COVID-19 spreads in California at a rate comparable to the rate of spread in other countries, the number of persons requiring medical care may exceed locally available resources, and controlling outbreaks minimizes the risk to the public, maintains the health and safety of the people of California, and limits the spread of infection in our communities and within the healthcare delivery system; and

WHEREAS personal protective equipment (PPE) is not necessary for use by the general population but appropriate PPE is one of the most effective ways to preserve and protect California's healthcare workforce at this critical time and to prevent the spread of COVID-19 broadly; and

WHEREAS state and local health departments must use all available preventative measures to combat the spread of COVID-19, which will require access to services, personnel, equipment, facilities, and other resources, potentially including resources beyond those currently available, to prepare for and respond to any potential cases and the spread of the virus; and

WHEREAS I find that conditions of Government Code section 8558(b), relating to the declaration of a State of Emergency, have been met; and

WHEREAS I find that the conditions caused by COVID-19 are likely to require the combined forces of a mutual aid region or regions to appropriately respond; and

WHEREAS under the provisions of Government Code section 8625(c), I find that local authority is inadequate to cope with the threat posed by COVID-19; and

WHEREAS under the provisions of Government Code section 8571, I find that strict compliance with various statutes and regulations specified in this order would prevent, hinder, or delay appropriate actions to prevent and mitigate the effects of the COVID-19.

NOW, THEREFORE, I, GAVIN NEWSOM, Governor of the State of California, in accordance with the authority vested in me by the State Constitution and statutes, including the California Emergency Services Act, and in particular, Government Code section 8625, **HEREBY PROCLAIM A STATE OF EMERGENCY** to exist in California.

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IT IS HEREBY ORDERED THAT:

1. In preparing for and responding to COVID-19, all agencies of the state government use and employ state personnel, equipment, and facilities or perform any and all activities consistent with the direction of the Office of Emergency Services and the State Emergency Plan, as well as the California Department of Public Health and the Emergency Medical Services Authority. Also, all residents are to heed the advice of emergency officials with regard to this emergency in order to protect their safety.

2. As necessary to assist local governments and for the protection of public health, state agencies shall enter into contracts to arrange for the procurement of materials, goods, and services needed to assist in preparing for, containing, responding to, mitigating the effects of, and recovering from the spread of COVID-19. Applicable provisions of the Government Code and the Public Contract Code, including but not limited to travel, advertising, and competitive bidding requirements, are suspended to the extent necessary to address the effects of COVID-19.

3. Any out-of-state personnel, including, but not limited to, medical personnel, entering California to assist in preparing for, responding to, mitigating the effects of, and recovering from COVID-19 shall be permitted to provide services in the same manner as prescribed in Government Code section 179.5, with respect to licensing and certification. Permission for any such individual rendering service is subject to the approval of the Director of the Emergency Medical Services Authority for medical personnel and the Director of the Office of Emergency Services for non-medical personnel and shall be in effect for a period of time not to exceed the duration of this emergency.

4. The time limitation set forth in Penal Code section 396, subdivision (b), prohibiting price gouging in time of emergency is hereby waived as it relates to emergency supplies and medical supplies. These price gouging protections shall be in effect through September 4, 2020.

5. Any state-owned properties that the Office of Emergency Services determines are suitable for use to assist in preparing for, responding to, mitigating the effects of, or recovering from COVID-19 shall be made available to the Office of Emergency Services for this purpose, notwithstanding any state or local law that would restrict, delay, or otherwise inhibit such use.

6. Any fairgrounds that the Office of Emergency Services determines are suitable to assist in preparing for, responding to, mitigating the effects of, or recovering from COVID-19 shall be made available to the Office of Emergency Services pursuant to the Emergency Services Act, Government Code section 8589. The Office of Emergency Services shall notify the fairgrounds of the intended use and can immediately use the fairgrounds without the fairground board of directors' approval, and

notwithstanding any state or local law that would restrict, delay, or otherwise inhibit such use.

7. The 30-day time period in Health and Safety Code section 101080, within which a local governing authority must renew a local health emergency, is hereby waived for the duration of this statewide emergency. Any such local health emergency will remain in effect until each local governing authority terminates its respective local health emergency.

8. The 60-day time period in Government Code section 8630, within which local government authorities must renew a local emergency, is hereby waived for the duration of this statewide emergency. Any local emergency proclaimed will remain in effect until each local governing authority terminates its respective local emergency.

9. The Office of Emergency Services shall provide assistance to local governments that have demonstrated extraordinary or disproportionate impacts from COVID-19, if appropriate and necessary, under the authority of the California Disaster Assistance Act, Government Code section 8680 et seq., and California Code of Regulations, Title 19, section 2900 et seq.

10. To ensure hospitals and other health facilities are able to adequately treat patients legally isolated as a result of COVID-19, the Director of the California Department of Public Health may waive any of the licensing requirements of Chapter 2 of Division 2 of the Health and Safety Code and accompanying regulations with respect to any hospital or health facility identified in Health and Safety Code section 1250. Any waiver shall include alternative measures that, under the circumstances, will allow the facilities to treat legally isolated patients while protecting public health and safety. Any facilities being granted a waiver shall be established and operated in accordance with the facility's required disaster and mass casualty plan. Any waivers granted pursuant to this paragraph shall be posted on the Department's website.

11. To support consistent practices across California, state departments, in coordination with the Office of Emergency Services, shall provide updated and specific guidance relating to preventing and mitigating COVID-19 to schools, employers, employees, first responders and community care facilities by no later than March 10, 2020.

12. To promptly respond for the protection of public health, state entities are, notwithstanding any other state or local law, authorized to share relevant medical information, limited to the patient's underlying health conditions, age, current condition, date of exposure, and possible contact tracing, as necessary to address the effect of the COVID-19 outbreak with state, local, federal, and nongovernmental partners, with such information to be used for the limited purposes of monitoring, investigation and control, and treatment and coordination of care. The

notification requirement of Civil Code section 1798.24, subdivision (i), is suspended.

13. Notwithstanding Health and Safety Code sections 1797.52 and 1797.218, during the course of this emergency, any EMT-P licensees shall have the authority to transport patients to medical facilities other than acute care hospitals when approved by the California EMS Authority. In order to carry out this order, to the extent that the provisions of Health and Safety Code sections 1797.52 and 1797.218 may prohibit EMT-P licensees from transporting patients to facilities other than acute care hospitals, those statutes are hereby suspended until the termination of this State of Emergency.

14. The Department of Social Services may, to the extent the Department deems necessary to respond to the threat of COVID-19, waive any provisions of the Health and Safety Code or Welfare and Institutions Code, and accompanying regulations, interim licensing standards, or other written policies or procedures with respect to the use, licensing, or approval of facilities or homes within the Department's jurisdiction set forth in the California Community Care Facilities Act (Health and Safety Code section 1500 et seq.), the California Child Day Care Facilities Act (Health and Safety Code section 1596.70 et seq.), and the California Residential Care Facilities for the Elderly Act (Health and Safety Code section 1569 et seq.). Any waivers granted pursuant to this paragraph shall be posted on the Department's website.

I FURTHER DIRECT that as soon as hereafter possible, this proclamation be filed in the Office of the Secretary of State and that widespread publicity and notice be given of this proclamation.

IN WITNESS WHEREOF I have hereunto set my hand and caused the Great Seal of the State of California to be affixed this 4th day of March 2020.

GAVIN NEWSOM
Governor of California

ATTEST:

ALEX PADILLA
Secretary of State

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REGINA CHINSIO-KWONG, DO
COUNTY HEALTH OFFICER

MATTHEW ZAHN, MD
DEPUTY COUNTY HEALTH OFFICER/MEDICAL DIRECTOR CDCD

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COUNTY OF ORANGE HEALTH OFFICER'S ORDERS AND STRONG RECOMMENDATIONS (Revised March 24, 2022)

In light of recent Face Mask Guidance issued by the California Department of Public Health (CDPH) and certain recent orders issued by the State Public Health Officer regarding COVID-19 vaccine requirements, the following Orders and Strong Recommendations shall revise and replace the prior Orders and Strong Recommendations of the County Health Officer that were issued on March 11, 2022. The Orders and Strong Recommendations issued on March 11, 2022, are no longer in effect as of March 24, 2022.

Pursuant to California Health and Safety Code sections 101030, 101040, 101470, 120175, and 120130, the County Health Officer for County of Orange orders and strongly recommends the following:

ORDERS

Effective immediately, and continuing until further notice, the following shall be in effect in unincorporated and incorporated territories of Orange County, California:

I. Self-Isolation of Persons with COVID-19 Order

NOTE: This Self-Isolation Order DOES NOT in any way restrict access by first responders to an isolation site during an emergency.

1. Persons who are symptom-free but test positive for COVID-19.

   If you do not have any COVID-19 symptoms (as defined below in this Order) but test

positive for COVID-19, you shall immediately isolate yourself in your home or another suitable place for at least 5 days from the date you test positive and may end your self-isolation after day 5:

- If you continue not having any COVID-19 symptoms and a diagnostic specimen collected on day 5 or later tests negative.
    - While an antigen test, nucleic acid amplification test (NAAT), or LAMP test are acceptable, use of an antigen test is recommended. Use of Over-the-Counter tests are also acceptable to end isolation.

Exceptions.

1) If you are unable or choose not to test on day 5 or after, or if you test positive after day 5, you shall continue your self-isolation through day 10 from the date of your initial positive test and may end your self-isolation after 10 days from the date of your initial positive test.

2) If you develop COVID-19 symptoms during the time of your self-isolation, you shall isolate yourself for at least 10 days from the date of symptom(s) onset. You may end your self-isolation sooner if a diagnostic specimen collected on day 5 (or later) from the date of symptom(s) onset tests negative.

All persons who test positive for COVID-19 should continue to wear a well-fitting mask at all times around other people through day 10.

2. Persons who have COVID-19 symptoms.

If you have COVID-19 symptoms, you shall immediately isolate yourself in your home or another suitable place for 10 days from the date of your symptom(s) onset and may end your self-isolation sooner under any of the following conditions:

- If your symptoms resolve within the first 24 hours of onset without any fever reducing agents.

- If a diagnostic specimen collected as early as the date of your symptom(s) onset tests negative.
    - While an antigen test, nucleic acid amplification test (NAAT), or LAMP test are acceptable, use of an antigen test is recommended. Use of Over-the-Counter tests are also acceptable to end isolation.
- If you obtain an alternative diagnosis from a healthcare provider.

Exception:

If you have COVID-19 symptoms and test positive for COVID-19, you shall isolate yourself for at least 10 days from the date of symptom(s) onset. You may end your self-isolation sooner if a diagnostic specimen collected on day 5 (or later) from the date of symptom(s) onset tests negative.

You are not required to self-isolate for more than 10 days from the date of your COVID-19 symptom(s) onset regardless of whether your symptoms are present on Day 11.

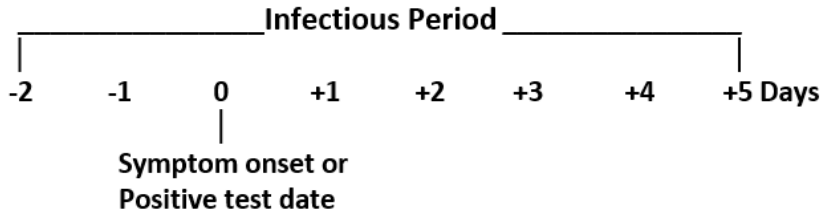
All persons who have COVID-19 symptoms should continue to wear a well-fitting mask at all times around other people through at least Day 10.

Additional Considerations for Self-Isolation.

- A person who is self-isolated may not leave his or her place of isolation except to receive necessary medical care.
- If a more specific and individualized isolation order is issued by the County Health Officer for any county resident, the resident shall follow the specific order instead of the order herein.
- People who are severely ill with COVID-19 might need to stay in self-isolation longer than 5 days and up to 20 days after symptoms first appeared. People with weakened immune systems should talk to their healthcare provider for more information.

Timing for "Day 0"- As noted in CDPH Isolation and Quarantine Q&A, the 5-day clock for isolation period starts on the date of symptom onset or (day 0) for people who test

positive after symptoms develop, or initial test positive date (day 0) for those who remain asymptomatic. If an asymptomatic person develops symptoms, and test positive, date of symptom onset is day 0.



Note: In workplaces, employers and employees are subject to the Isolation and quarantine requirements as stated in the CalOSHA COVID-19 Emergency Temporary Standards (ETS) as modified by the Governor's Executive Order N-5-22 or in some workplaces the Cal/OSHA Aerosol transmissible Diseases (ATD) Standard. Information about CalOSHA COVID-19 Emergency Temporary Standards (ETS) can be found at https://www.dir.ca.gov/dosh/coronavirus.

Definition.

Whenever the term "symptom" or "*COVID-19 symptom*" is used, it shall mean COVID-19 symptom. People with COVID-19 have had a wide range of symptoms reported – ranging from mild symptoms to severe illness. Symptoms may appear 2-14 days after exposure to the virus. Anyone can have mild to severe symptoms. People with these symptoms may have COVID-19:

- Fever or chills
- Cough
- Shortness of breath or difficulty breathing
- Fatigue
- Muscle or body aches
- Headache
- New loss of taste or smell
- Sore throat

- Congestion or runny nose
- Nausea or vomiting
- Diarrhea
- The list above does not include all possible symptoms.

II. Face-Coverings/Masks:

To help prevent the spread of droplets containing COVID-19, all County residents and visitors are strongly recommended to wear face coverings in accordance with and as required by the Guidance for the Use of Face Coverings issued by CDPH, effective March 1, 2022. The Guidance is attached herein as Attachment "**A**" and can be found at:

A: https://www.cdph.ca.gov/Programs/CID/DCDC/Pages/COVID-19/guidance-for-face-coverings.aspx.

Masks are required for all individuals in the following indoor settings, regardless of vaccination status:

- Public Transit and in transportation hubs- Masks guidance/requirement is subject to Federal Requirements and guidance found at https://www.cdc.gov/coronavirus/2019-ncov/travelers/face-masks-public-transportation.html Examples: airplanes, ships, ferries, trains, subways, buses, taxis, and ride-shares) and in transportation hubs (examples: airports, bus terminals, marina, train station, seaport or other port, subway station, or any other area that provides transportation).
- Emergency shelters and cooling and heating centers.
- Healthcare settings (applies to all healthcare settings, including those that are not covered by State Health Officer Order issued on July 26, 2021).
- Local correctional facilities and detention centers.
- Long Term Care Settings & Adult and Senior Care Facilities.

NOTE: In workplaces, employers are subject to the Cal/OSHA COVID-19 Emergency Temporary Standards (ETS) as modified by the Governor's Executive Order N-5-22 or in

some workplaces the Cal/OSHA Aerosol Transmissible Diseases (ATD) Standard and should consult those regulations for additional applicable requirements.

NOTE: In accordance with State Health Officer Order, issued on July 26, 2021, and found at https://www.cdph.ca.gov/Programs/CID/DCDC/Pages/COVID-19/Order-of-the-State-Public-Health-Officer-Unvaccinated-Workers-In-High-Risk-Settings.aspx, in certain healthcare situations or settings, surgical masks are required.

No person shall be prevented from wearing a mask as a condition of participation in an activity or entry into a business.

Exemptions to masks requirements.

- The following individuals are exempt from this mask order:
  - Persons younger than two years old.
  - Persons with a medical condition, mental health condition, or disability that prevents wearing a mask. This includes persons with a medical condition for whom wearing a mask could obstruct breathing or who are unconscious, incapacitated, or otherwise unable to remove a mask without assistance.
  - Persons who are hearing impaired, or communicating with a person who is hearing impaired, where the ability to see the mouth is essential for communication.
  - Persons for whom wearing a mask would create a risk to the person related to their work, as determined by local, state, or federal regulators or workplace safety guidelines.

III. **Health Care Workers COVID-19 Vaccine Requirement Order**:

To help prevent transmission of COVID-19, all workers who provide services or work in facilities described below shall comply with the COVID-19 vaccination and booster dose requirements as set forth in the February 22, 2022, State Health Officer Order. A copy of the State Health Officer Order is attached herein as Attachment "**B**" and can be found at the following link:

B: https://www.cdph.ca.gov/Programs/CID/DCDC/Pages/COVID-19/Order-of-the-State-Public-Health-Officer-Health-Care-Worker-Vaccine-Requirement.aspx

Facilities covered by this order include:

- General Acute Care Hospitals
- Skilled Nursing Facilities (including Subacute Facilities)
- Intermediate Care Facilities
- Acute Psychiatric Hospitals
- Adult Day Health Care Centers
- Program of All-Inclusive Care for the Elderly (PACE) and PACE Centers
- Ambulatory Surgery Centers
- Chemical Dependency Recovery Hospitals
- Clinics & Doctor Offices (including behavioral health, surgical)
- Congregate Living Health Facilities
- Dialysis Centers
- Hospice Facilities
- Pediatric Day Health and Respite Care Facilities
- Residential Substance Use Treatment and Mental Health Treatment Facilities

o. The word, "worker," as used in this Order shall have the same meaning as defined in the State Health Officer's Order, dated December 22, 2021.

IV. Requirements and Guidance for Specific Facilities

Requirements for COVID-19 Vaccination Status Verification, COVID-19 Testing, and Masking for Certain Facilities.

To help prevent transmission of COVID-19, all facilities described below shall comply with the State Health Officer Order, issued on July 26, 2021 and effective August 9, 2021. A copy of the State Health Officer Order is attached herein as Attachment "**C**" and can be found at the following link:

C: https://www.cdph.ca.gov/Programs/CID/DCDC/Pages/COVID-19/Order-of-the-State-Public-Health-Officer-Unvaccinated-Workers-In-High-Risk-Settings.aspx

Facilities covered by this order include:

- Acute Health Care and Long-Term Care Settings:
  - General Acute Care Hospitals
  - Skilled Nursing Facilities (including Subacute Facilities)
  - Intermediate Care Facilities
- High-Risk Congregate Settings:
  - Adult and Senior Care Facilities
  - Homeless Shelters
  - State and Local Correctional Facilities and Detention Centers
- Other Health Care Settings:
  - Acute Psychiatric Hospitals
  - Adult Day Health Care Centers
  - Adult Day Programs Licensed by the California Department of Social Services
  - Program of All-Inclusive Care for the Elderly (PACE) and PACE Centers
  - Ambulatory Surgery Centers
  - Chemical Dependency Recovery Hospitals
  - Clinics & Doctor Offices (including behavioral health, surgical)
  - Congregate Living Health Facilities
  - Dental Offices
  - Dialysis Centers
  - Hospice Facilities
  - Pediatric Day Health and Respite Care Facilities
  - Residential Substance Use Treatment and Mental Health Treatment Facilities

1. **Requirements for COVID-19 Vaccine Status Verification and COVID-19 Testing for School Workers in Transitional Kindergarten through Grade 12**.

   To prevent the further spread of COVID-19 in K-12 school settings, all public and private schools serving students in transitional kindergarten through grade 12 shall comply with the State Health Officer Order, effective August 12, 2021, regarding verification of COVID-19 vaccination status and COVID-19 testing of all workers. A

copy of the State Health Officer Order is attached herein as Attachment "**D**" and can be found at the following link:

D: https://www.cdph.ca.gov/Programs/CID/DCDC/Pages/COVID-19/Order-of-the-State-Public-Health-Officer-Vaccine-Verification-for-Workers-in-Schools.aspx

This Order does not apply to (i) home schools, (ii) child care settings, or (iii) higher education.

2. **Local Correctional Facilities and Detention Centers Health Care Worker Vaccination Requirement**.

To prevent the further spread of COVID-19 in local correctional facilities and detention centers, all individuals identified in the State Health Officer Order, effective December 22, 2021, shall comply with the State Health Officer's Order with regards to obtaining COVID-19 vaccination and booster doses. A copy of the State Health Officer Order is attached herein as Attachment "**E**" and can be found at the following link:

E: https://www.cdph.ca.gov/Programs/CID/DCDC/Pages/COVID-19/Order-of-the-State-Public-Health-Officer-Health-Care-Worker-Vaccine-Requirement.aspx

3. **Adult Care Facilities and Direct Care Worker Vaccination Requirements.**

To help prevent transmission of COVID-19, all individuals specified below shall comply with the COVID-19 vaccination and booster dose requirements as set forth in the February 22, 2022, State Health Officer Order. A copy of the State Health Officer Order is attached herein as Attachment "**F**" and can be found at the following link:

F: https://www.cdph.ca.gov/Programs/CID/DCDC/Pages/COVID-19/Order-of-the-State-Public-Health-Officer-Adult-Care-Facilities-and-Direct-Care-Worker-Vaccine-Requirement.aspx

Individuals covered by this order include:

- All workers who provide services or work in Adult and Senior Care Facilities licensed by the California Department of Social Services;

- All in-home direct care services workers, including registered home care aides and certified home health aides, except for those workers who only provide services to a recipient with whom they live or who are a family member of the recipient for whom they provide services;
- All waiver personal care services (WPCS) providers, as defined by the California Department of Health Care Services, and in-home supportive services (IHSS) providers, as defined by the California Department of Social Services, except for those workers who only provide services to a recipient with whom they live or who are a family member of the recipient for whom they provide services;
- All hospice workers who are providing services in the home or in a licensed facility; and
- All regional center employees, as well as service provider workers, who provide services to a consumer through the network of Regional Centers serving individuals with developmental and intellectual disabilities, except for those workers who only provide services to a recipient with whom they live or who are a family member of the recipient for whom they provide services.

4. **Requirements for Visiting Acute Health Care and Long-Term Care Settings**.

To help prevent transmission of COVID-19, all acute health care and long-term care settings shall comply with the indoor visitation requirements set forth in the State Health Officer issued February 7, 2022. A copy of the State Health Officer Order is attached herein as Attachment "**G**" and can be found at the following link:

G. https://www.cdph.ca.gov/Programs/CID/DCDC/Pages/COVID-19/Order-of-the-State-Public-Health-Officer-Requirements-for-Visitors-in-Acute-Health-Care-and-Long-Term-Care-Settings.aspx

V. Seasonal Flu Vaccination Order:

Seasonal Flu Vaccination for Certain County Residents.

All individuals who reside or work in Orange County and fall under one of the following categories, shall obtain the seasonal flu vaccination unless a medical or religious exemption applies: (i) current providers for congregate settings; (ii) current health care providers; and (iii) current emergency responders. However, nothing herein shall be construed as an obligation, on the part of employers, public or private, to require employees obtain the seasonal flu vaccination as a term or condition of employment.

- *Emergency responder* shall mean military or national guard; law enforcement officers; correctional institution personnel; fire fighters; emergency medical services personnel; physicians; nurses; public health personnel; emergency medical technicians; paramedics; emergency management personnel; 911 operators; child welfare workers and service providers; public works personnel; and persons with skills or training in operating specialized equipment or other skills needed to provide aid in a declared emergency; as well as individuals who work for such facilities employing these individuals and whose work is necessary to maintain the operation of the facility.
- *Health care provider* shall mean physicians; psychiatrists; nurses; nurse practitioners; nurse assistants; medical technicians; any other person who is employed to provide diagnostic services, preventive services, treatment services or other services that are integrated with and necessary to the provision of patient care and, if not provided, would adversely impact patient care; and employees who directly assist or are supervised by a direct provider of diagnostic, preventive, treatment, or other patient care services; and employees who do not provide direct heath care services to a patient but are otherwise integrated into and necessary to the provision those services – for example, a laboratory technician who processes medical test results to aid in the diagnosis and treatment of a health condition. A person is not a health care provider merely because his or her employer provides health care services or because he or she provides a service that affects the provision of health care services. For example, IT professionals,

building maintenance staff, human resources personnel, cooks, food services workers, records managers, consultants, and billers are not health care providers, even if they work at a hospital of a similar health care facility.

STRONG RECOMMENDATIONS

Effective immediately, and continuing until further notice, the following shall be in effect in unincorporated and incorporated territories in Orange County, California:

1. **Self-quarantine of Persons Exposed to COVID-19**

   - If you are known to be exposed to COVID-19 (regardless of vaccination status, prior disease, or occupation), it is strongly recommended to follow CDPH Quarantine guidance found at https://www.cdph.ca.gov/Programs/CID/DCDC/Pages/COVID-19/Guidance-on-Isolation-and-Quarantine-for-COVID-19-Contact-Tracing.aspx.

   - **K-12 Schools and Child Care**

     - Schools/school districts are advised to follow CDPH COVID-19 Public Health Guidance for K-12 Schools in California, 2021-2022 School Year found at: https://www.cdph.ca.gov/Programs/CID/DCDC/Pages/COVID-19/K-12-Guidance-2021-22-School-Year.aspx

     - Child care providers and programs are advised to follow CDPH Guidance for Child Care Providers and Programs found at: https://www.cdph.ca.gov/Programs/CID/DCDC/Pages/COVID-19/Child-Care-Guidance.aspx.

   - **Workplaces**

     - In workplaces, employers and employees are subject to the Quarantine requirement as stated in the CalOSHA COVID-19 Emergency Temporary Standards (ETS) as modified by the Governor's Executive Order N-5-22 or in some workplaces the Cal/OSHA Aerosol Transmissible Diseases (ATD) Standard.

Exposed to COVID-19 or exposure to COVID-19 mean to be within 6 feet of someone who has COVID-19 for a cumulative total of 15 minutes or more over a 24-hour period.

2. **For Vulnerable Populations**. In general, the older a person is, the more health conditions a person has, and the more severe the conditions, the more important it is to take preventive measures for COVID-19 such as getting vaccinated, including boosters, social distancing and wearing a mask when around people who don't live in the same household, and practicing hand hygiene. For more information see https://www.cdc.gov/coronavirus/2019-ncov/need-extra-precautions/people-with-medical-conditions.html.

3. **COVID-19 Vaccination for County Residents**. All Orange County residents should receive COVID-19 vaccination in accordance with the Federal Food and Drug Administration (FDA) and CDC guidance. Minors, who are eligible to receive COVID-19 vaccination in accordance with the applicable CDC guidelines, should be vaccinated in the presence of their parent or legal guardian.

   CDC Guidance can be found at: https://www.cdc.gov/coronavirus/2019-ncov/vaccines/recommendations/specific-groups.html

4. **Seasonal Flu Vaccination for County Residents**. All County residents who are six months of age or older should obtain the seasonal flu vaccination unless a medical or religious exemption applies.

5. **COVID-19 Vaccination and Testing for Emergency Medical Technicians, Paramedics and Home Healthcare Providers**. To help prevent transmission of COVID-19, it is strongly recommended that all Emergency Medical Technicians, Paramedics, and Home Healthcare Providers (including In Home Supportive Services Program workers) remain up-to-date as defined by CDC with COVID-19 vaccination. CDC Guidance can be found at: https://www.cdc.gov/coronavirus/2019-ncov/vaccines/recommendations/specific-groups.html

6. Furthermore, it is strongly recommended that all unvaccinated Emergency Medical Technicians, Paramedics, and Home Healthcare Providers (including In Home Supportive Services Program workers) undergo at least twice weekly testing for COVID-19 until such time they are fully vaccinated.

GENERAL PROVISIONS

1. The Orders and Strong Recommendations, above, shall not supersede any conflicting or more restrictive orders issued by the State of California or federal government. If any portion of this document or the application thereof to any person or circumstance is held to be invalid, the remainder of the document, including the application of such part or provision to other persons or circumstances, shall not be affected and shall continue in full force and effect. To this end, the provisions of the orders and strong recommendations are severable.
2. The Orders contained in this document may be enforced by the Orange County Sheriff or Chiefs of Police pursuant to California Health and Safety Code section 101029, and California Government Code sections 26602 and 41601. A violation of a health order is subject to fine, imprisonment, or both (California Health and Safety Code section 120295).

REASONS FOR THE ORDERS AND STRONG RECOMMENDATIONS

1. On February 26, 2020, the County of Orange Health Officer declared a Local Health Emergency based on an imminent and proximate threat to public health from the introduction of COVID-19 in Orange County.
2. On February 26, 2020, the Chairwoman of the Board of Supervisors, acting as the Chair of Emergency Management Council, proclaimed a Local Emergency in that the imminent and proximate threat to public health from the introduction of COVID-19 created conditions of extreme peril to the safety of persons and property within the territorial limits of Orange County.
3. On March 2, 2020, the Orange County Board of Supervisors adopted Resolutions No. 20-011 and No. 20-012 ratifying the Local Health Emergency and Local Emergency, referenced above.
4. On March 4, 2020, the Governor of the State of California declared a State of Emergency to exist in California as a result of the threat of COVID-19.
5. As of March 23, 2022, the County has reported a total of 546,125 recorded confirmed COVID-19 cases and 6,857 of COVID-19 related deaths.

6. Safe and effective authorized COVID-19 vaccines are recommended by the CDC. According to CDC, anyone infected with COVID-19 can spread it, even if they do NOT have symptoms. The novel coronavirus is spread in 3 ways:1) Breathing in air when close to an infected person who is exhaling small droplets and particles that contain the virus. 2) Having these small droplets and particles that contain virus land on the eyes, nose, or mouth, especially through splashes and sprays like a cough or sneeze. 3) Touching eyes, nose, or mouth with hands that have the virus on them.
   See https://www.cdc.gov/coronavirus/2019-ncov/prevent-getting-sick/how-covid-spreads.html.

7. The CDPH issued a revised Guidance for the Use of Face Coverings, effective March 1, 2022, available at: https://www.cdph.ca.gov/Programs/CID/DCDC/Pages/COVID-19/guidance-for-face-coverings.aspx

8. According to the CDC and CDPH, older adults, individuals with medical conditions, and pregnant and recently pregnant persons are at higher risk of severe illness when they contract COVID-19. See https://www.cdc.gov/coronavirus/2019-ncov/need-extra-precautions/index.html

9. The Orders and the Strong Recommendations contained in this document are based on the following facts, in addition to the facts stated under the foregoing paragraphs: (i) Safe and effective FDA authorized COVID-19 vaccines have become widely available, but many Orange County residents have not yet had the opportunity to be vaccinated, or have not completed their vaccination series to be fully vaccinated or boosted; (ii) there is limited supply of therapeutic options for high-risk individuals who have a high risk of exposure to COVID-19 or have mild-moderate COVID-19 infection; (iii) the current consensus among public health officials for slowing down the transmission of and avoiding contracting COVID-19 is for at-risk persons to complete a COVID-19 vaccination series and receive a booster if eligible, wear well-fitted mask in indoor settings when around others outside of their household, practice distancing, frequently wash hands with soap (iv) some individuals who contract COVID-19 have no symptoms or have only mild symptoms and so are unaware that they carry the virus and are transmitting it to others; (v) current evidence shows that the novel coronavirus can

survive on surfaces and can be indirectly transmitted between individuals; (vi) older adults and individuals with medical conditions are at higher risk of severe illness; (vii) sustained COVID-19 community transmission continues to occur; (viii) the age, condition, and health of a portion of Orange County's residents place them at risk for serious health complications, including hospitalization and death, from COVID-19; (ix) younger and otherwise healthy people are also at risk for serious negative health outcomes and for transmitting the novel coronavirus to others.

10. The orders and strong recommendations contained in this document are necessary and less restrictive preventive measures to control and reduce the spread of COVID-19 in Orange County, help preserve critical and limited healthcare capacity in Orange County and save the lives of Orange County residents.

11. The California Health and Safety Code section 120175 requires the County of Orange Health Officer knowing or having reason to believe that any case of a communicable disease exists or has recently existed within the County to take measures as may be necessary to prevent the spread of the disease or occurrence of additional cases.

12. The California Health and Safety Code sections 101030 and 101470 require the county health officer to enforce and observe in the unincorporated territory of the county and within the city boundaries located with a county all of the following: (a) Orders and ordinances of the board of supervisors, pertaining to the public health and sanitary matters; (b) Orders, including quarantine and other regulations, prescribed by the department; and (c) Statutes relating to public health.

13. The California Health and Safety Code section 101040 authorizes the County of Orange Health Officer to take any preventive measure that may be necessary to protect and preserve the public health from any public health hazard during any "state of war emergency," "state of emergency," or "local emergency," as defined by Section 8558 of the Government Code, within his or her jurisdiction. "Preventive measure" means abatement, correction, removal, or any other protective step that may be taken against any public health hazard that is caused by a disaster and affects the public health.

14. The California Health and Safety Code section 120130 (d) authorizes the County of Orange Health Officer to require strict or modified isolation, or quarantine, for any case

of contagious, infectious, or communicable disease, when such action is necessary for the protection of the public health.

IT IS SO ORDERED:

Date: March 24, 2022

Regina Chinsio-Kwong, DO
County Health Officer
County of Orange

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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CalOptima Board Action Agenda Referral

Action To Be Taken June 2, 2022
Regular Meeting of the CalOptima Board of Directors

Consent Calendar

5. Ratify Contract with Rostrum, LLC for State Advocacy Services and Authorize Related Expenditures for Fiscal Year 2022–23

Contacts

Michael Hunn, Chief Executive Officer, (657) 900-1481
Yunkyung Kim, Chief Operating Officer, (714) 246-8408

Recommended Actions

1. Ratify CalOptima's contract with Rostrum, LLC for state advocacy services, effective May 24, 2022, through no later than December 31, 2022; and
2. Authorize unbudgeted expenditures in an amount up to $60,000 from existing reserves to fund the contract with Rostrum, LLC for the period of July 1, 2022, through no later than December 31, 2022.

Background

On February 17, 2022, the California Department of Health Care Services released a proposal to enter into a direct, statewide contract with Kaiser Permanente (Kaiser) to provide Medi-Cal services in any county, effective January 1, 2024. This would *de facto* terminate the County Organized Health System (COHS) model by allowing an additional Medi-Cal plan to operate in Orange County. On April 7, given the expected negative impacts to CalOptima and its members and providers, the CalOptima Board of Directors (Board) adopted a position of *oppose unless amended* to prohibit a Kaiser contract in any counties with a COHS, such as Orange County. The Orange County Board of Supervisors adopted the same position on April 26.

On May 13, Governor Gavin Newsom released his Fiscal Year (FY) 2022–23 Revised Budget Proposal (May Revise), which included the Kaiser proposal without the requested amendment sought by CalOptima and the County of Orange. Governor Newsom and the State Legislature are currently negotiating a final budget, which must pass both houses of the Legislature by June 15 and be signed by Governor Newsom by June 30.

Discussion

CalOptima currently contracts with Edelstein Gilbert Robson & Smith LLC (EGRS) for state advocacy services. EGRS represents 5 of the 6 COHS in California, including CalOptima, all of whom are engaged in various advocacy efforts related to the Kaiser proposal.

In furtherance of the Board's adopted position, and given the higher levels of targeted CalOptima-specific advocacy needed to defeat or amend the Kaiser proposal before finalization of the FY 2022–23 state budget in June, CalOptima required an immediate contract with an additional state advocacy firm to supplement the services being provided by EGRS. Rostrum, LLC was identified as the sole acceptable firm that CalOptima could identify and onboard to provide such services under the necessary timeline.

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In addition, staff determined that the contract with Rostrum, LLC constituted an emergency purchase necessary to prevent significant provable loss that finalization of the Kaiser proposal would have on CalOptima's members and providers, as well as the broader safety net health system, if not defeated or amended as soon as possible. Staff exercised a bidding exception in accordance with section II.P. of CalOptima Policy GA.5002: Purchasing Policy. CalOptima's Chief Executive Officer subsequently executed the contract on May 24 and hereby requests its ratification by the Board.

As proposed, the recommended action ratifies the executed contract with Rostrum, LLC at a rate of $10,000 per month, which includes direct labor and expenses, overhead costs, fixed fees, subcontracts, leases, materials, and costs arising from or due to termination of the contract. Any additional travel-related expenses will be incurred only if authorized in advance by CalOptima.

The contract will be effective for a limited time until the Kaiser proposal is fully resolved at the state level — either favorably or unfavorably — or until December 31, 2022, whichever is sooner. Staff will consider continuing the contract on a monthly basis depending on the need for such services. Per the agreed upon terms, CalOptima can terminate the contract at any time with or without cause. Consistent with CalOptima's practice, staff will monitor the performance of Rostrum, LLC to ensure that the deliverables outlined in the contract are achieved.

Staff is requesting authorization of expenditures of up to $60,000 from existing reserves to fund the FY 2022-23 contract period from July 1, 2022, through no later than December 31, 2022.

Fiscal Impact

The recommended action to ratify the contract with Rostrum, LLC is an unbudgeted item. The fiscal impact for the period of May 24, 2022, through June 30, 2022, is budget neutral. A budget reallocation of $15,000 within Medi-Cal: Professional Fees in the CalOptima FY 2021-22 Operating Budget will fund this period. An allocation of up to $60,000 from existing reserves will fund the contract for the period of July 1, 2022, through no later than December 31, 2022.

Rationale for Recommendation

Engaging in immediate, targeted advocacy to defeat or amend the proposed statewide DHCS Medi-Cal contract with Kaiser is necessary to avoid significant negative impacts to CalOptima and its members and providers as well as the broader safety net health system.

Concurrence

Troy R. Szabo, Outside General Counsel, Kennaday Leavitt

Attachments

1. Entities Covered by this Recommended Board Action
2. Contract No. 22-10813 with Rostrum, LLC

/s/ Michael Hunn *05/27/2022*
Authorized Signature **Date**

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Attachment to the June 2, 2022 Board of Directors Meeting – Agenda Item 5

ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
Rostrum, LLC	1102 Q Street, Suite 130	Sacramento	CA	95811

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CONTRACT NO. 22-10813
BETWEEN
ORANGE COUNTY HEALTH AUTHORITY, A PUBLIC AGENCY, dba
ORANGE PREVENTION & TREATMENT INTEGRATED MEDICAL ASSISTANCE, dba
CALOPTIMA
And
ROSTRUM, LLC
(CONTRACTOR)

THIS CONTRACT ("Contract") is made and entered into as of the date last signed below ("Effective Date"), by and between the Orange County Health Authority, dba CalOptima, a public agency, hereinafter referred to as "CalOptima" and Rostrum, LLC, a Limited Liability Company (LLC), hereinafter referred to as "CONTRACTOR." CalOptima and CONTRACTOR shall be referred to herein collectively as the "Parties" or individually as a "Party."

RECITALS

A. CalOptima desires to retain a contractor to provide State Legislative and Advocacy 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
Kris Rosa	Partner
Craig Swaim	Partner

3. Insurance.

3.1 Prior to undertaking performance of services under this Contract and at all times during performance hereunder, and entirely at CONTRACTOR's sole expense, CONTRACTOR shall maintain the following insurance, which shall be full-coverage insurance not subject to self-insurance provisions, and CONTRACTOR shall not of its own initiative cause such insurance to be canceled or materially changed during the term of this Contract:

3.1.1 Required Insurance:

3.1.1.1 Commercial General Liability, including Contractual liability and coverage for Independent Contractors on an occurrence basis on an ISO form GC 00 01 or equivalent covering bodily injury and property damage with the following minimum liability limits:

3.1.1.2 Per Occurrence: $1,000,000

3.1.1.3 Personal Advertising Injury: $1,000,000

3.1.1.4 Products Completed Operations: $2,000,000

3.1.1.5 General Aggregate: $2,000,000

3.1.2 Commercial Automobile Liability covering any auto, whether owned, leased, hired, or rented, on an ISO form CA 0001 or equivalent in the amount of $1,000,000 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 ("State") 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

3.2 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:

3.3 Certificate Requirements:

3.3.1 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.

3.3.2 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.

3.3.3 CONTRACTOR's insurance carrier agrees to waive all rights of subrogation against CalOptima and its elected or appointed officers, officials, directors, agents, and employees for losses paid under the terms of any policy which arise from work performed by the CONTRACTOR for CalOptima. This provision applies to the CONTRACTOR's General Liability, Auto Liability and Workers' Compensation and Employers Liability policies.

3.3.4 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.

3.3.5 CONTRACTOR shall furnish CalOptima with original certificates and amendatory endorsements affecting coverage required by this section. 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.

3.3.6 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.

3.3.7 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.

3.3.8 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.

3.3.9 Thirty (30) days prior written notice of cancellation be given to CalOptima.

3.4 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

3.5 The requirement for carrying the required insurance shall not derogate from the provisions for indemnification of CalOptima.

3.6 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.

3.7 "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 ensure 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; or

10.3.4 An organization that employs or is about to employ any of the above.

10.4 CONTRACTOR, and any person designated by CONTRACTOR to make or participate in making a governmental decision on behalf of CalOptima, is considered a "Consultant" pursuant to

CalOptima's Conflict of Interest Code and shall be required to file a statement of economic interests (Fair Political Practices Commission Form 700) with CalOptima annually.

10.5 CONTRACTOR understands that, if this Contract is made in violation of Government Code Section 1090 et seq., the entire Contract is voidable, and CONTRACTOR will not be entitled to any compensation for Services performed pursuant to this Contract and CONTRACTOR will be required to reimburse CalOptima any sums paid to CONTRACTOR. CONTRACTOR further understands that, in addition to the foregoing, CONTRACTOR may be subject to criminal prosecution for a violation of Government Code Section 1090.

10.6 If CONTRACTOR hereinafter becomes aware of any facts, which might reasonably be expected to either create a conflict of interest under the Conflict-of-Interest laws or violate the provisions of this Section, CONTRACTOR shall immediately make full written disclosure of such acts to CalOptima. Full written disclosure shall include, without limitation, identification of all persons, entities and businesses implicated and a complete description of all relevant circumstances.

11. Disclosure of Officers, Owners, Stockholders and Creditors. On an annual basis and within thirty (30) days of any changes, CONTRACTOR shall identify the names of the following persons by listing them on Exhibit I, attached hereto and incorporated by this reference, and submitting the form to CalOptima:

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 No. 11246, Relating to Equal Employment Opportunity," and as supplemented by regulation at 41 CFR part 60, "Office of Federal Contract Compliance Programs, Equal Employment Opportunity, Department of Labor," and the Rehabilitation Act of 1973, and by the rules, regulations, and orders of the Secretary of Labor, or pursuant thereto, and will permit access to its books, records, and accounts by the State and its designated representatives and the Secretary of Labor for purposes of investigation to ascertain compliance with such rules, regulations, and orders.

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 No. 11246 Relating to Equal Employment Opportunity," and as supplemented by regulation at 41 CFR part 60, "Office of Federal Contract Compliance Programs, Equal Employment Opportunity, Department of Labor," or by rule, regulation, or order of the Secretary of Labor, or as otherwise provided by law.

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 No. 11246 Relating to Equal Employment Opportunity," and as supplemented by regulation at 41 CFR part 60, "Office of Federal Contract Compliance Programs, Equal Employment Opportunity, Department of Labor," or Section 503 of the Rehabilitation Act of 1973 or (38 U.S.C. 4212) of the Vietnam Era Veteran's Readjustment Assistance Act, so that such provisions will be binding upon each subcontractor or 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 or replacement by CONTRACTOR at no cost to CalOptima.

14. Compensation.

14.1 Payment.

14.1.1 CalOptima agrees to pay, and CONTRACTOR agrees to accept as full consideration for the faithful performance of this Contract, the rates, charges and other payment terms identified in Exhibit B, which is attached hereto and incorporated herein by this reference.

14.1.2 CalOptima will not reimburse CONTRACTOR any expenses incurred in connection with its performance of the services, unless such reimbursement is specifically authorized in Exhibit B. Each expense reimbursement request, when authorized in Exhibit B must include receipts or other suitable documentation.

14.1.3 CONTRACTOR's requests for payments and reimbursements must comply with the requirements set forth in Exhibit B. CalOptima will not make payment for work that fails

to meet the standards of performance as set forth in the Contract and Exhibit A, Scope of Work that may be reasonably expected by CalOptima. **CALOPTIMA SHALL NOT PAY ANY FEES, EXPENSES OR COSTS WHATSOEVER INCURRED BY CONTRACTOR IN RENDERING ADDITIONAL SERVICES NOT AUTHORIZED IN WRITING UNDER THIS CONTRACT.**

14.1.4 In no event shall the total compensation payable to CONTRACTOR for the services performed under this Contract exceed the maximum cumulative payment obligation, as set forth in the attached Exhibit B, without the express prior written authorization of CalOptima. CONTRACTOR shall at all times monitor its costs and expenditures for work performed under this Contract, and shall monitor its invoices, costs, and expenditures, to ensure it does not exceed the maximum cumulative payment obligation set forth herein. CONTRACTOR shall provide CalOptima with 60 days written notice if at any time during this Contract CONTRACTOR becomes aware that it may exceed the maximum cumulative payment obligation authorized under this Contract. **CONTRACTOR ACKNOWLEDGES AND AGREES THAT CALOPTIMA SHALL NOT BE LIABLE FOR ANY FEES, EXPENSES OR COMPENSATION IN EXCESS OF THE MAXIMUM CUMULATIVE PAYMENT OBLIGATION.**

14.1.5 The maximum cumulative payment obligation includes all applicable federal, state, and local taxes and duties, except sales tax, which is shown separately, if applicable. CONTRACTOR is responsible for submitting any withholding exemption forms (e.g., W-9) to CalOptima. Such forms and information should be furnished to CalOptima before payment is made. If taxes are required to be withheld on any amounts otherwise to be paid by CalOptima to CONTRACTOR due to CONTRACTOR'S failure to timely submit such forms, CalOptima will deduct such taxes from the amount otherwise owed and pay them to the appropriate taxing authority and shall have no liability for or any obligation to refund any payments withheld.

14.2 Contractor Travel Policy. CONTRACTOR agrees to abide by the terms of the CalOptima Travel Policy, attached hereto as Exhibit C, and incorporated herein by this reference.

15. Term. This Contract shall commence on the date last signed below and shall continue in full force and effect through 12/31/2022, 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 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. Time is of the Essence. Time is of the essence in performance of this Contract.

26. 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.

27. 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.

28. 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.

29. 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.

30. 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:
Rostrum, LLC	CalOptima
1102 Q Street, Suite 130	505 City Parkway West
Sacramento, CA 95811	Orange, CA 92868
Attn: Kris Rosa & Craig Swaim	Attn: Ryan Prest
Partners	Purchasing Manager

31. 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.

32. Unavoidable Delays.

32.1 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.

32.2 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.

32.3 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.

33. 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.

34. 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.

35. 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.

36. Headings. The section headings used herein are for reference and convenience only and shall not enter into the interpretation hereof.

37. 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.

38. 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.

39. 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.

40. Debarment and Suspension Certification.

40.1 By signing this Contract, the CONTRACTOR agrees to comply with any and all applicable Federal suspension and debarment regulations.

40.2 By signing this Contract, the CONTRACTOR certifies to the best of its knowledge and belief, that it and its principals:

40.2.1 Are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded by any Federal department or agency;

40.2.2 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;

40.2.3 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;

40.2.4 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;

40.2.5 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

40.2.6 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.

40.3 If the CONTRACTOR is unable to certify to any of the statements in this certification, the CONTRACTOR shall submit an explanation to CalOptima.

40.4 The terms and definitions herein have the meanings set out in the Definitions and Coverage sections of the rules implementing Federal Executive Order 12549.

40.5 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.

41. 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.

42. 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.

43. 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.

44. 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.

45. 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.

46. 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. 22-10813 on the day and year last shown below.

Rostrum, LLC	CalOptima
By:	By: DocuSigned by: Michael Hunn EDDDDCC19C894FB...
Print Name: CRAIG SWAIM	Print Name: Michael Hunn
Title: PARTNER	Title: CEO
Date: 5-19-22	Date: 05/24/2022
By:	By:
Print Name: Kris Rusa	Print Name:
Title: Partner	Title:
Date: 5/19/22	Date:

If CONTRACTOR is a corporation, two officer signatures or a Corporation Resolution or Corporate Seal is required

Exhibit A
SCOPE OF WORK

Purpose
CONTRACTOR shall represent CalOptima's interests, as specified below, in Sacramento and have the responsibility of monitoring and influencing legislative and regulatory policies, building and maintaining positive and mutually beneficial relationships with officials, and providing CalOptima with necessary advocacy services.

Reporting Relationship
The Chief Executive Officer; Chief Operating Officer; Chief of Staff; Executive Director, Public Affairs; and Manager, Government Affairs, and/or their designee(s), will be the primary contacts and will direct the work of the CONTRACTOR.

Objectives/Deliverables
CONTRACTOR agrees to provide to CalOptima, as requested by CalOptima, the following services:

- Register and serve as a legislative advocate for CalOptima pursuant to the rules and procedures of the Fair Political Practices Commission.
- Regularly consult with CalOptima's staff and contracted state and federal advocacy firms regarding CalOptima's government affairs program.
- Provide strategic and tactical recommendations regarding CalOptima's advocacy priorities and activities, as well as strategic planning and legislative/political analysis.
- Proactively identify and engage in opportunities for CalOptima to influence state legislative, regulatory, budgetary, and administrative proposals and policymaking processes for the benefit of CalOptima.
- Advocate for CalOptima's positions on legislation introduced in the California Legislature, as well as administrative, budgetary, and regulatory proposals introduced by state agencies and the Office of the Governor, with legislators, members of the state administration, and their respective staffs.
    - Such legislation and administrative and regulatory proposals include, but are not limited to, Assembly Bill 2724 (2022), Fiscal Year 2022–23 budget trailer bills, and any other forthcoming policy bills relating to proposals for a statewide, direct Medi-Cal contract between the Department of Health Care Services and Kaiser Permanente.
    - Advocacy activities include, but are not limited to, calls, virtual meetings, in-person meetings, drafting amendments, written letters of support and opposition, written and verbal hearing testimony, drafting and submitting amendments, and
- Assist CalOptima in drafting bill amendments to proposed legislation, as well as circulating and securing support for such amendments from legislators and their staffs.
- Develop relationships with state legislators who represent any part of Orange County, as well as their Capitol and district staffs, to improve their awareness and positive perception of CalOptima, secure their alignment with and advocacy for CalOptima's positions, and improve opportunities for current and future collaboration.
- Provide notice and analyses of rumored, anticipated, introduced, and amended state legislation and administrative, budgetary, and regulatory proposals that may impact CalOptima.
- Assist CalOptima to identify witnesses, prepare testimony, develop and implement strategy, create and lead necessary coalitions, and to give testimony as directed before committees of the Legislature.

Performance of Duties
CONTRACTOR agents shall faithfully, industriously, and to the best of their ability, experience, and talents, perform all of the duties that may reasonably be assigned to him or her hereunder and devote such time to the performance of such duties as may be necessary, therefore.

Exhibit B
PAYMENT

A. For CONTRACTOR's full and complete performance of its obligations under this Contract, CalOptima shall pay CONTRACTOR for fees and expenses in accordance with the provisions of this Exhibit and subject to the maximum cumulative payment obligations specified below.

B. CONTRACTOR shall invoice CalOptima on a monthly basis for fees as outlined below. The rate, as defined below, is acknowledged to include CONTRACTOR's base labor rates, overhead and profit. Work completed shall be documented in a monthly progress report prepared by CONTRACTOR, which report shall accompany each invoice submitted by CONTRACTOR. CONTRACTOR shall also furnish such other information as may be requested by CalOptima to substantiate the validity of an invoice. At its sole discretion, CalOptima may decline to make full payment for any work and direct costs until such time as CONTRACTOR has documented, to CalOptima's satisfaction, that CONTRACTOR has fully completed all work required under this Contract and CONTRACTOR's performance is accepted by CalOptima. CalOptima's payment in full for any work shall not constitute CalOptima's final acceptance of CONTRACTOR's work under this Contract.

C. CONTRACTOR shall submit to CalOptima, to the attention of Accounts Payable, accountspayable@caloptima.org, an invoice at the conclusion of every month for the Services performed during the prior thirty (30) days. Each invoice shall cite Contract No. 22-10813; specify the number of hours worked; the specific dates the hours were worked; the description of work performed; the time period covered by the invoice and the amount of payment requested; and be accompanied by a progress report. CalOptima shall remit payment within thirty (30) days of receipt and approval of each invoice.

D. Notwithstanding any provisions of this Contract to the contrary, CalOptima and CONTRACTOR mutually agree that CalOptima shall pay CONTRACTOR a flat Ten Thousand Dollars ($10,000) per month, regardless of hours used that month, 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. If the Contract is signed or terminated mid-month, CalOptima shall pay a prorated amount equal to Three Hundred Thirty-Three Dollars ($333.00) per day for the days active in the first and last month. These rates are 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. CONTRACTOR shall also invoice CalOptima on a monthly basis for travel-related expenses. All expenses charged to CalOptima under this Contract shall be consistent with Exhibit C, CalOptima's Travel Policy. Receipts or reasonable evidence thereof are required for commercial travel, car rental, parking, lodging, and food. When CONTRACTOR personnel visit more than one client on the same trip, the expenses incurred shall be apportioned in relation to time spent with each client. CalOptima shall not pay CONTRACTOR for time spent traveling.

Exhibit B-1

Not applicable for this Contract

Exhibit C

CalOptima Travel Policy

CalOptima
A Public Agency
Better. Together.

Policy #:	GA.5004		
Title:	**Travel Policy**		
Department:	Finance		
Section:	Purchasing		
CEO Approval:		Michael Schrader	MS
Effective Date:	8/1/12	Revised: 9/6/12, 3/1/13	
Board Approval:	9/6/12		

I. PURPOSE

To establish a process for reasonable and equitable reimbursement of approved travel and other related expenses incurred by CalOptima employees, Board members, Standing Committee members, and authorized contractors and consultants while traveling on authorized CalOptima Business.

II. POLICY

A. For the purpose of this policy, Individual shall mean, unless otherwise specified, all persons authorized to submit an Expense Report, including: CalOptima Board members, CalOptima Standing Committee members, CalOptima employees, and; individuals under contract to CalOptima for which the approved contract provides for reimbursement of travel and/or conference expenses, in accordance with CalOptima rules and regulations.

B. CalOptima shall provide an expense reimbursement process to ensure timely and accurate identification, approval, processing, recording, payment, and monitoring of all necessary travel expenses and miscellaneous expenses incurred by authorized Individuals, in accordance with generally accepted accounting principles (GAAP), and in compliance with State and Federal regulations.

C. CalOptima shall reimburse employees for reasonable expenses incurred while traveling on CalOptima business. All travel must be for the benefit of CalOptima, and must be completed at the most reasonable cost based on the facts and circumstances surrounding the travel. This includes making reservations for air travel and other expenses as soon as possible to access better rates. Employees are expected to use good judgment when traveling, seeking to minimize travel costs whenever possible.

1. Travel Expenses shall include the following items:

   a. Transportation: including commercial carriers, rental vehicles, and mileage for use of personal vehicle;

   b. Lodging;

   c. Meals;

   d. Registration Fees: For attending conferences, seminars, conventions, or meetings of professional societies or community organizations;

   e. Insurance for rental vehicles;

   f. Parking fees and tolls fees (i.e., toll roads and necessary parking);

g. Miscellaneous expenses including:

i. Authorized local and long-distance telephone calls;

ii. Baggage fees;

iii. Internet or Wi-Fi charges;

iv. Facsimiles;

v. Expenses in connection with the preparation of authorized company reports or correspondence;

vi. Taxi or public transit fares, required to conduct business; and

vii. Other unforeseen or unusual expenses that are properly justified and substantiated.

D. Board Member/Standing Committee Member Travel

1. CalOptima shall allow Board members and Standing Committee members reasonable and necessary Travel Expenses and miscellaneous expenses incurred when participating in activities as a member of their respective Board or Committee. Eligible Travel Expenses shall be governed by this policy.

a. The CEO or the Chairperson of the CalOptima Board of Directors, or his or her designee, shall review and approve all Board member and Standing Committee member non-local travel.

b. CalOptima shall limit Board member and Standing Committee member travel to the following purposes:

i. CalOptima business-related activities;

ii. Requests to represent CalOptima as a speaker at an approved meeting, seminar or conference; and

iii. Other travel deemed necessary by the CalOptima Board of Directors.

E. Travel Approval

1. Budgeted Travel: All budgeted Travel and miscellaneous expenses for CalOptima employees, Board members, Standing Committee members, and authorized contractors and consultants shall be pre-approved by the appropriate level of CalOptima Management or Board Chair, prior to travel expenses being incurred, according to the following:

Individual	Approver
Employee through Department Manager	Department Director
Department Director	Executive Management
Executive Officer	CEO or designee
CEO	Board Chairperson or designee
Board Member/Standing Committee Member	Board Chairperson, CEO or designee

2. Non-Budgeted Travel: Non-Budgeted Travel and miscellaneous expenses for authorized Individuals shall be pre-approved by the CEO, or his or her designee, prior to Travel Expenses being incurred.

F. Conferences and Seminars

1. Attendance at any given conference and/or seminar shall be:

   a. Limited to the number of Individuals deemed appropriate by the CEO for that particular conference or seminar, and

   b. Approved by Human Resources.

2. Payment of Fees

   a. Conference and/or seminar fees shall be prepaid whenever possible, to take advantage of early registration discounts. An employee shall request prepayment of conference and seminar fees at the time the Travel and Training Authorization form is prepared, and submit necessary registration information to the Purchasing Department.

   b. In the event an Individual must personally pay for conference or seminar registration fees, the Individual shall request reimbursement on an Expense Report with a pre-approved Travel and Training Authorization Form.

G. Meal Expenses

1. Travel Meals are those food items consumed when traveling on CalOptima Business away from the primary workplace.

2. CalOptima shall reimburse authorized Individuals the actual cost of Travel Meals, excluding alcoholic beverages, in an amount not to exceed forty-five dollars ($45.00) per day, excluding taxes and gratuity.

   a. CalOptima shall reimburse employees and Board members for meals that exceed the forty-five dollars ($45.00) per day under the following conditions:

      i. The authorized Individual shall submit a valid receipt for such meals with a brief explanation of the expenditure. Individual meals shall be subject to the above limitations;

ii. The authorized Individual elects to pay for the meals of individuals with whom authorized CalOptima Business was conducted; or

iii. Extraordinary circumstances may cause it to be impractical or unfeasible for the authorized Individual to stay within the established meal rates, and the authorized Individual shall submit receipts for such meals with a brief explanation of the extraordinary expenditure.

iv. Expense reports containing extraordinary meal expenditures shall require approval of the CEO, or his or her designee.

b. CalOptima may negotiate individual meal per diem amounts for individual contractors authorized to receive reimbursement for expenses, as stipulated in this policy. Individual contractor per diem rates may be less than, but shall not exceed, the established employee, Board and Committee member meal reimbursement rate.

3. CalOptima shall reimburse for Business Meals at actual reasonable and necessary expenses for refreshments or meals, excluding alcoholic beverages, provided in conjunction with on-site or off-site meetings (e.g., in-house developed formal training sessions, conferences, seminars, workshops, staff meetings, and board and commission meetings) which extend over normal breaks or meal periods. An Expense Report for Business Meals must include receipt, names of those in attendance, and the business topic.

H. Lodging Expenses

1. CalOptima shall reimburse the cost of a single room at an Approved Lodging Facility for Non-Local Travel.

2. Adequate lodging expenses will be allowed. Price is an issue in selecting "adequate lodging". Prudence and good stewardship should be used when selecting a lodging facility. Comparison shopping is encouraged; booking through online travel Websites, as opposed to directly with the lodging facility, might provide opportunities for reduced cost lodging. Itemized receipts for lodging must be provided to obtain reimbursement.

3. Travelers should seek lodging rates (excluding taxes and fees) at or below the federal government's per diem rate. If such rates are not available, a hotel's discounted government rate shall be allowed. A schedule of federal lodging per diem rates is available on the U.S. General Services Administration (GSA) Website; www.gsa.gov.

4. CalOptima may reimburse additional lodging expenses for Non-Local Travel if:

a. It results in offsetting lower airfare; and

b. The cost of returning to home or office at the conclusion of business exceeds the cost of lodging, rental automobile and meals for the additional stay.

5. Local Travel may qualify for an overnight stay, depending on time constraints. CalOptima may approve Local Travel lodging expenses if:

a. It is not practical or feasible for the authorized Individual to return home due to extremely poor weather conditions; or

b. Less than eight (8) hours will elapse from the time business is concluded on one (1) day and the time business is scheduled to reconvene on the following calendar day; or

c. It is not practical or feasible for the authorized Individual to return home due to an extended commute.

6. Once approved, the Individual or his or her designee shall be responsible for making his or her own travel and lodging arrangements, utilizing the CalOptima travel services provider or another method approved by CalOptima's Purchasing Department.

7. The Individual shall be responsible for necessary cancellation of travel and lodging reservations, in accordance with the respective rules and time limits. CalOptima shall not reimburse Individuals for fees associated with the failure to cancel reservations within the established rules and time limits, unless the failure was due to circumstances beyond the control of the Individual. The Individual must also inform CalOptima's Purchasing Department of any cancellations.

I. Cash advances

1. Under normal circumstances, CalOptima shall not issue cash advances for Travel Expenses.

2. The Executive Management team shall approve cash advances for anticipated authorized travel.

3. CalOptima may authorize cash advances on a limited basis if the traveling Individual does not possess sufficient means of credit or other financial resources to cover the cost of one (1) or more authorized Travel Expenses, as defined in this policy.

4. When authorized, cash advances shall be based on an estimate of reasonable Travel Expenses, including travel, meals, lodging and miscellaneous expenses.

5. Individuals receiving cash advances shall complete an Expense Report within five (5) business days of the Individual's return to home or place of work, whichever occurs first. The Individual shall account for all expenses incurred while traveling on authorized CalOptima Business, and shall indicate any cash amounts due back to CalOptima, in the event the cash advance was greater than actual authorized expenses, or cash amounts due the Individual, in the event actual authorized expenses exceed the amount of the cash advance.

J. Transportation

1. The mode of transportation shall be based on the distance of the final destination from the Individual's home or primary workplace, business schedule, and the cost effectiveness of the various modes of transportation.

2. Cost of arrangements for personal travel in conjunction with a business travel itinerary will be at the authorized Individual's expense. The Individual shall document the incremental travel costs assessed to CalOptima, in accordance with this policy.

3. The Individual shall make transportation arrangements as far in advance as possible using the most economical carrier, and the most economical departure point, within the selected mode of transportation. A Saturday night stay may be required to obtain the lowest possible rate, and may be authorized if the savings will reasonably offset the additional cost of meals, automobile rental and lodging.

    a. Flight arrangements made through CalOptima's travel services provider shall be reviewed by CalOptima's Purchasing Department, and submitted directly to Accounts Payable for payment.

    b. Flight arrangements not made through the CalOptima travel services provider shall be submitted by the Individual on an Expense Report.

    c. Individuals may, for personal convenience, travel to their final destination on an indirect route, or on an interrupted direct route, if approved in advance by the CEO. An Individual shall pay any increase in transportation fares based on indirect or interrupted direct travel routes. Any resulting excess travel time shall not be considered work time, but shall be charged to the appropriate type of leave.

    d. Additional expenses shall not be the responsibility of the Individual if, through no fault or control of the Individual, it is necessary to travel an indirect route, or an interrupted direct route. In such cases, additional time shall be considered work time, and shall not be charged to any type of leave.

    e. Whenever available, all Individuals shall travel via "Coach Class," or similar reduced fare accommodations. "Business Class" reservations shall not be used except in the event that "Coach Class" or similar reduced fare accommodations are unavailable, and departure time is critical to the nature of the reason for travel. Under no circumstances shall "First Class" travel be reserved.

    f. Individuals requesting travel reservations shall not insist on any certain commercial carrier if using the specified carrier will result in a fare which is higher than the lowest available fare.

    g. Any deviation from lowest available rate for commercial carriers shall be at the Individual's expense.

4. The Individual shall be responsible for necessary cancellation of travel reservations, in accordance with the respective carrier rules and time limits. CalOptima shall not reimburse Individuals for fees associated with the failure to cancel reservations within the established carrier rules and time limits, unless the failure was due to circumstances beyond the control of the Individual. The Individual must also inform CalOptima's Purchasing Department of any such cancellations.

5. Use of Privately-Owned Vehicles

    a. An authorized Individual may use a privately-owned vehicle for travel if such use is more economical than the lowest-priced direct commercial carrier fare plus rental car expenses. The Individual must be licensed, and shall carry liability insurance as required by the State of California, at the Individual's sole expense.

b. CalOptima shall reimburse the use of privately-owned vehicles solely based on actual mileage at the Internal Revenue Service (IRS) Standard Mileage Rate. Total mileage reimbursed should consider the Individual's daily commute.

c. CalOptima shall not reimburse costs for fuel, automobile repairs, or other automobile expense items.

d. If more than one authorized Individual is traveling for CalOptima Business in the same personal vehicle, only one person shall be reimbursed for the use of a privately-owned vehicle.

e. Travel shall be by the most practical direct route. Any person traveling by an indirect route shall assume any additional expense incurred.

f. CalOptima shall compensate property damages to an Individual's automobile incurred without fault or cause on the part of the Individual up to two hundred fifty dollars ($250), or the amount of the deductible on the Individual's insurance policy, whichever is the lesser amount, for each accident.

6. Rental Automobiles

a. An Individual may rent automobile when such rental is considered to be more advantageous to CalOptima than other means of transportation.

b. Advance reservations shall be made whenever possible. Reservations for employees, Board and Committee members shall be made in the Individual's name, acting for CalOptima. i.e., John Doe, for CalOptima.

c. The vehicle rental agreement for the authorized Individual shall reference the Individual's name, acting for CalOptima. i.e., John Doe, for CalOptima.

d. Rental automobile approved classes are as follows:

i. Economy Class: An Individual shall select an economy class vehicle whenever four (4) or fewer individuals, including the driver, will be passengers in the rental automobile at any one time.

ii. Mid-size Class: An Individual may select a mid-size class vehicle in the event more than four (4) individuals will be riding in the rental automobile at any one (1) time, or in the event an economy class vehicle is not available, and the nature of the travel requires immediate departure.

iii. Luxury Class: Under no circumstances shall an Individual select a luxury class vehicle.

7. Other Modes of Transportation

a. Taxi Fares: CalOptima shall reimburse taxi fares when public transportation is not practical or available. Examples include travel between hotel and place of business, and from one business to another.

III. PROCEDURE

A. Travel and Training Authorization Form

1. Shall be accessed and completed on-line by all Individuals or their designee using CalOptima's Intranet system (or similar system in place at the time request is made), and shall include all actual or estimated expense amounts related to the request; and

2. Shall be routed for approval systemically based on the Individual's level, cost center, and whether they are a CalOptima employee according to the following:

Individual	Approver
Employee through Department Manager	Department Director
Department Director	Executive Management
Executive Officer	CEO or designee
CEO	Board Chairperson or designee
Board Member/Standing Committee Member	Board Chairperson, CEO or designee

3. Shall also be routed systemically to the Human Resources Department in order to track the Individual's training.

4. Shall also be routed systemically to the Finance Department for confirmation that requested expenses are budgeted, and that enough budget remains to cover requested expenses.

5. Requestors shall receive an automatic e-mail after submitting their request, notifying them of the approval status, and providing a link to the electronic form to track approval progress.

6. The Purchasing Department shall review, authorize for appropriate approvals, and notify the requestors that they may begin making travel commitments.

B. Travel and Training Arrangements

1. Authorizations that include event registration fees shall be pre-paid and processed by CalOptima's Purchasing Department, where possible. CalOptima's Purchasing Department shall verify with the requestor that the registration has not been processed before proceeding with registration of the Individual for the event.

2. The requestor, or his or her designee, shall make air travel arrangements through CalOptima's travel services provider, where possible. Arrangements should be made as far in advance as possible to minimize costs. Exceptions to using CalOptima's travel services provider are subject to approval by CalOptima's Purchasing Department.

3. All other arrangements shall be made with the Individual's personal credit card, either through CalOptima's travel services provider, another approved method, or directly with the establishment(s), subject to CalOptima's Purchasing Department approval.

C. Expense Reimbursement using Expense Report

1. Individuals or designees shall prepare and submit request claims for reimbursement of Travel Expenses on a CalOptima Expense Report. The report shall be completed by the Individual or designee, including all details, and shall be routed with a copy of the previously-approved Travel and Training Authorization Form for appropriate Expense Report approval signatures, if applicable, as follows:

Individual	**Approver**
Employee through Department Manager	Department Director
Department Director	Executive Management
Executive Officer	CEO or designee*
CEO	Board Chairperson or designee*
Board Member/Standing Committee Member	Board Chairperson, CEO or designee*

*Designee authorization is not valid when self approval would result.

2. Receipts

   a. For any expenses in excess of twenty-five dollars ($25.00), the Individual shall include an original credit card receipt, if available, or other computer-generated or hand-written receipt, in the event a credit card receipt is unavailable. CalOptima contractors authorized to receive reimbursement for expenses shall submit receipts for all expenses, regardless of the dollar amount of the expenditure.

   b. Small receipts, such as credit card, gas and airline receipts, shall be attached to an 8 ½ by 11 inch sheet of paper. Hotel receipts and other larger receipts may be submitted as is.

   c. In the absence of credit card receipts, or other proof of actual expenditure, CalOptima shall reimburse lodging expenses only if marked "paid" by the management of the lodging facility.

   d. In most instances, airfare for CalOptima employees and Board members shall be prepaid by CalOptima. CalOptima contractors authorized to receive reimbursement for airfare, and employees and Board members for whom airfare was not prepaid for any reason, shall submit passenger receipts for reimbursement consideration.

   e. If receipts cannot be obtained or have been lost, a statement to that effect shall be made on the Expense Report, along with an appropriate explanation. In the absence of a satisfactory explanation, CalOptima shall not allow the amount.

3. Completed and approved Expense Reports and supporting documentation shall be submitted to the Accounting Department in a timely manner, preferably within thirty (30) days of completion of travel.

4. No reimbursement shall be made for Expense Reports submitted beyond six (6) months after completion of travel.

D. The Accounting Department shall:

1. Review submitted Expense Reports and supporting documentation for completeness;

2. Code expenses to appropriate department and general ledger account numbers; and

3. Process payment for reimbursement.

E. The Purchasing Department shall:

1. Provide travel reports to the CEO, Executive Management, and Department Directors, upon request. Such reports may include a summary of travel by department, purpose, cost, and number of individuals per event, and may be required to distinguish between budgeted and non-budgeted travel.

2. Review details of statements/invoices received from the CalOptima travel services provider for accuracy and reasonableness;

3. Attach appropriate copies of completed Travel and Training Authorization Forms related to travel service provider invoice line items, and submit to Accounts Payable for payment.

4. Review details of statements/invoices received from credit card account used by Purchasing to arrange attendance at conferences, training, and other events, and to make authorized purchases.

5. Attach appropriate copies of completed Travel and Training Authorization Forms related to credit card invoice travel and training line items, and submit to Accounts Payable for payment.

IV. ATTACHMENTS

A. Electronic Travel and Training Authorization Form
B. CalOptima Expense Report
C. Cash Advance Form

V. REFERENCES

A. Internal Revenue Service Publication 463
B. California Government Code Section 53232.2
C. Bylaws of Orange County Health Authority dba Orange Prevention and Treatment Integrated Medical Assistance, Adopted December 6, 1994

VI. APPROVALS OR BOARD ACTION

9/6/12: CalOptima Regular Board Meeting

VII. REVISION HISTORY

A. 9/6/12: GA.5004: Travel Policy
B. 8/1/12: GA.5004: Travel Policy

VIII. KEYWORDS

Approved Lodging
CalOptima Business
Executive Management

Expense Report
Individual
Local Travel
Lodging
Meals
Miscellaneous Expenses
Non-Local Travel
Non-Reimbursable Expenses
Parking, Fees and Tolls
Registration Fees
Reimbursable Expenses
Transportation
Travel
Travel and Training Authorization Form
Travel Expenses

Exhibit D

MEDI-CAL DATA ACCESS AGREEMENT

As a condition of obtaining access to information concerning procedures or other data records utilized/maintained by the Department of Health Care Services and CalOptima, Rostrum, LLC, including any and all individual employees and agents, agrees not to divulge any information obtained in the course of completion of this Contract to any unauthorized persons.

CONTRACTOR further agrees not to publish or otherwise make public any information regarding persons receiving Medi-Cal services such that the persons who receive such services are identifiable.

CONTRACTOR further recognizes that unauthorized release of confidential information may be subject to civil and criminal sanctions pursuant to the provisions of the Welfare and Institutions Code Section 14100.2.

CONTRACTOR further agrees that this Medi-Cal Data Access Agreement shall remain in full force and effect after the termination of this Contract.

By: C.I. Date: 5-19-22

Print Name: CRAIG SWAIM

Title: PARTNER, ROSTRUM

Exhibit E

Not applicable for this Contract

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: ROSTRUM LLC

Business Entity Type: LLC (PARTNERSHIP)
(Sole Proprietorship, Partnership, LLC, California Corporation, etc.)

Business Address: 1102 Q street, Suite 130

City: Sacramento State: CA Zip: 95811

Business Phone: (916) 580-0700 Email: : Kris@RostrumCalifornia.com

President: _____ Contact Person: Kris Rosa

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 %
KRIS ROSA	PARTNER 50%
CRAIG SWAIM	PARTNER 50%

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.

_____ 5-19-22
Authorized Signature Date

CRAIG SWAIM
Name and Title

Exhibit J

Not applicable for this Contract

Exhibit K

Not applicable for this Contract

Exhibit L

Not applicable for this Contract

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken June 2, 2022
Regular Meeting of the CalOptima Board of Directors

Consent Calendar

6. Adopt Resolution Dissolving Existing Board Ad Hoc Committees and Creating New Board Ad Hoc Committees, and Establish a Policy for Administration of Ad Hoc Committees

Contact

Michael Hunn, Chief Executive Officer, (657) 900-1481

Recommended Actions

Adopt resolution to:

1. Dissolve existing Board Ad Hoc Committees;
2. Create new Ad Hoc Board Committees; and
3. Establish a policy for the administration of future ad hoc committees.

Background

The Ralph M. Brown Act (Brown Act) requires open and public meetings by "legislative bodies" of local agencies when conducting the public's business. Under the Brown Act, advisory committees composed solely of the members of the legislative body that are less than a quorum of the legislative body are not "legislative bodies," where those committees are charged with specific tasks for a limited period of time.

When necessary, the Chair of the CalOptima Board of Directors (Board) assigns members to serve as an ad hoc committee to study an item or accomplish a specific task. Accordingly, the Board's ad hoc committees serve for a limited term and are not standing committees. Ad hoc committees serve the Board and the public by allowing members of the Board to efficiently investigate and collaborate on an item of concern consistent with the Brown Act.

Discussion

For administrative clarity, Staff recommends that the Board dissolve all existing ad hoc committees and create the new ad hoc committees listed in the attachment to this proposed resolution, which includes the following information:

- Name of the ad hoc committee;
- Committee's membership;
- Limited scope of the ad hoc committee's task; and
- Date that the ad hoc committee will dissolve.

The proposed resolution establishes the policy for creating and dissolving ad hoc committees. Under the proposed policy, the Board Chair may create an ad hoc committee to serve as an advisory committee on a specific item for a limited period of time. The Chair will identify the committee's membership, scope of work, and date of dissolution. The Clerk of the Board will be charged with maintaining the list and bringing the list and ad hoc committee policy to the Board for review on an annual basis.

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Fiscal Impact
There is no financial impact.

Rationale for Recommendation
This item will provide clarity on CalOptima's use of ad hoc committees in a manner consistent with the Brown Act.

Concurrence
Troy R. Sabo, Outside General Counsel, Kennaday Leavitt

Attachments
1. Proposed Resolution
2. Proposed Ad Hoc List

Board Action(s)
None

/s/ Michael Hunn *05/27/2022*
Authorized Signature **Date**

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RESOLUTION NO. 22-0602-03

RESOLUTION OF THE BOARD OF DIRECTORS
ORANGE COUNTY HEALTH AUTHORITY
d.b.a. CalOptima

RESOLUTION FOR CALOPTIMA BOARD AD HOC COMMITTEES

WHEREAS, the Ralph M. Brown Act is California's "Open Meetings" or "Sunshine" law that requires open and public meetings by legislative bodies of local agencies when conducting the public's business;

WHEREAS, the Brown Act provides that, unless certain conditions are satisfied, a legislative body is prohibited from discussing or acting on any item not appearing on the posted agenda of a public meeting;

WHEREAS, under the Brown Act, advisory committees composed solely of members of the legislative body that are less than a quorum of the legislative body are not "legislative bodies," where those committees do not have a continuing subject matter jurisdiction and do not have a meeting schedule fixed by formal action of the legislative body;

WHEREAS, ad hoc committees serve for a limited period of time on discrete items or tasks as directed by the Chair of the Board;

WHEREAS, advisory committees shall be comprised of no more than four members of the CalOptima Board of Directors and assist the Board and the public it serves in efficiently investigating and collaborating on items of concern; and

WHEREAS, to ensure Brown Act compliance and for administrative clarity, the Board should identify which ad hoc committees are currently active and adopt a policy for the administration of ad hoc committees.

NOW, THEREFORE, BE IT RESOLVED:

1. That the CalOptima Board of Directors hereby:
    a. Dissolves all existing ad hoc committees; and
    b. Creates the ad hoc committees listed in Attachment 2, subject to the membership, scope of work, and dissolution dates listed in Attachment 2.

2. That the Board of Directors hereby adopts the following policy for the administration of ad hoc committees:
    a. At any meeting of the CalOptima Board of Directors, the Chair may create ad hoc committees composed of no more than four Board members to serve as an advisory committee on a specific item for a limited period of time. Where the Chair creates an ad hoc committee, he or she will identify the committee's membership, scope of work, work product, and date of dissolution.

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b. The Clerk of the Board shall maintain a list of active ad hoc committees.
c. On an annual basis, the Clerk of the Board shall place on the Board's meeting agenda a review of the ad hoc committee list and policy.

APPROVED AND ADOPTED by the Board of Directors of the Orange County Health Authority, d.b.a., CalOptima this 2nd day of June 2022.

AYES: _____

NOES: _____

ABSENT: _____

ABSTAIN: _____

/s/_____
Title: Chair, Board of Directors
Printed Name and Title: Andrew Do, Chair, CalOptima Board of Directors

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

CalOptima Board Ad Hoc Committees –
FY 2022 - 2023

Ad Hoc Committee	Ad Hoc Members	Date Established	Scope of Work	Work Product	Dissolution Date
Homeless Health Initiatives Ad Hoc	Andrew Do Doug Chaffee Clayton Corwin Nancy Shivers	6/2/2022	Review the homeless health initiatives consistent with street medicine and the Homeless Health Incentive Program.	Oral Report to the Board.	To be closed at the end of FY 2022-2023.
Audit Ad Hoc	Isabel Becerra Clayton Corwin Clayton Chau Scott Schoeffel	6/2/2022	To review prepared responses, findings, results and corrective action plans issues by CMS and DHCS.	Oral Report to the Board.	To be closed upon receipt of final report from CMS and DHCS or no later than the end of FY 2022-2023.
Legislative Ad Hoc/Ad Hoc will be responsible for the initial review of legislative bills that are in alignment with the Board-approved legislative platform.	Andrew Do Clayton Corwin Scott Schoeffel Clayton Chau	6/2/2022	To review legislative proposals within the jurisdiction of the legislative platform.	Report provided in the CEO Direct Reports.	To be closed upon no later than the end of FY 2022-2023.
Strategic Planning Ad Hoc/ Ad Hoc will review CalOptima's strategic planning and growth.	Andrew Do Blair Contratto Clayton Corwin Scott Schoeffel	6/2/2022	Provide regular input and feedback on the strategic planning effort.	Oral Report to the Board.	To be closed at the end of FY 2022-2023.

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken June 2, 2022
Regular Meeting of the CalOptima Board of Directors

Consent Calendar

7. Approve Modifications to CalOptima Grievance and Appeals Resolution Services Policy HH.1108

Contacts

Yunkyung Kim, Chief Operating Officer, (714) 246-8408
Ladan Khamseh, Executive Director, Operations, (714) 246-8866

Recommended Action

Approve modifications to Grievance and Appeals Resolution Services Policy HH.1108: State Hearing Process and Procedures

Background/Discussion

CalOptima regularly reviews its policies and procedures to ensure they are up-to-date and aligned with federal and state health care program requirements, contractual obligations, and laws as well as CalOptima operations.

Below is description of the impacted policy, followed by a summary of substantive changes, which are reflected in the attached redline. The summary does not include non-substantive changes that may also be reflected in the redlines (i.e., formatting, spelling, punctuation, capitalization, minor clarifying language and/or grammatical changes).

Policy HH.1108: State Hearing Process and Procedures describes CalOptima's process, role, and responsibilities in ensuring a member's rights to access the State Hearing process. This policy was updated to align with the requirements of the CalOptima contract with the Department of Health Care Services (DHCS) for Medi-Cal and DHCS All Plan Letter (APL) 21-011 Grievance and Appeal Requirements, Notice and Your Rights Templates released in August 2021. Such substantive updates include conditions in which an appealing party may request a state hearing, distinguishing state hearing decision timelines between standard and expedited requests, and member assistance in preparing for the State Hearing.

Fiscal Impact

The recommended action to modify CalOptima Policy HH.1108 is operational in nature and has no additional fiscal impact beyond what was incorporated in the CalOptima Fiscal Year 2021-22 Operating Budget.

Rationale for Recommendation

To ensure CalOptima's continuing commitment to conducting its operations in compliance with all applicable state and federal laws and regulations, CalOptima staff recommends that the Board of Directors approve and adopt the presented CalOptima policy and procedure. The updated policy and procedure will supersede prior versions.

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Concurrence
James Novello, Outside General Counsel, Kennaday Leavitt

Attachments
1. Policy HH.1108: State Hearing Process and Procedures (Red Lined and Clean)

/s/ Michael Hunn — *05/27/2022*
Authorized Signature — **Date**

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Policy:	HH.1108
Title:	**State Hearing Process and Procedures**
Department:	Grievance and Appeals Resolution Services
Section:	Not Applicable
CEO Approval:	
Effective Date:	11/01/1999
Revised Date:	TBD
Applicable to:	☒ Medi-Cal ☐ OneCare ☐ OneCare Connect ☐ PACE ☒ Administrative

I. PURPOSE

This policy defines CalOptima's process, role, and responsibilities in ensuring a Member's right to access the State Hearing process.

II. POLICY

A. A Member, or a ~~**Member's**~~Provider or Authorized Representative ~~**or Provider**~~ acting on behalf of the Member and with ~~his or her~~ the Member's written consent, has ~~the~~ a due process right to request a State Hearing when a claim for medical assistance is delayed, modified, denied, or discontinued and/or not acted upon with reasonable promptness. ~~Once the CalOptima-level **Appeal Process** has been exhausted a **Member** may request a **State Hearing**.~~

B. Once the CalOptima-level Appeal Process has been exhausted, a Member, or a Provider or Authorized Representative acting on behalf of a Member and with the Member's written consent, may request a State Hearing:

1. After receiving a Notice of Resolution (NAR) stating that CalOptima's action has been upheld, and the request is made no later than one hundred and twenty (120) calendar days from the date of the NAR; or

2. If the Member is deemed to have exhausted CalOptima's internal Appeal Process due to CalOptima's failure to meet or respond to the thirty (30) calendar day resolution timeline or comply with the notice requirements in accordance with Title 42, Code of Federal Regulations (CFR) section 438.10. In cases of deemed exhaustion, CalOptima shall not request a dismissal of a Fair Hearing based on a failure to exhaust CalOptima's internal Appeal Process.

~~B.~~C. CalOptima is not involved in the Medi-Cal eligibility process, and shall not participate in State Hearings related to eligibility determinations. However, as the Medi-Cal managed care plan in Orange County, CalOptima shall participate in State Hearings that address medical service denials to Members.

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~~C.~~D. CalOptima shall provide a Member with a thorough explanation of the right to request a State Hearing, and shall assist the Member, upon request, in filing his or her request for a State Hearing. Upon request, CalOptima shall provide any and all information that can be of assistance to the Member in preparing for the State Hearing, including all documents, guidelines and clinical criteria CalOptima relied on for the initial denial and anything the CalOptima considered during the internal CalOptima Appeal Process, as well as both regulations and evidence, which might be favorable to the Member's case.

~~D.~~E. A Member shall file a request for a State Hearing with the Department of Social Services (DSS) within one hundred and twenty (120) calendar days after the date of the ~~Notice of Appeal Resolution~~NAR or Appeal resolution timeframe has exhausted.

F. CalOptima shall grant Aid Paid Pending while the State Hearing is pending in accordance with Section III.C. of this Policy.

~~E.~~G. CalOptima shall not unlawfully discriminate against a Member for requesting a State Hearing.

~~F.~~H. The parties to a State Hearing include CalOptima, with the assistance of the Member's Health Network, as well as the Member and the Member's Authorized Representative or representative of a deceased Member's estate. CalOptima shall act on its own behalf as the public agency that administers the Medi-Cal program in Orange County, and may represent its Health Networks, if no other representation is provided. Whenever the issue pertains to a Health Network's action or inaction, representatives from the involved Health Network are requested to attend the hearing.

~~G.~~I. ~~When appropriate,~~ CalOptima shall ~~grant **Aid Paid Pending**, in accordance with CalOptima Policy GG.1510: Appeal Process for Decisions Regarding Care and Services, until a~~ notify Members of the expected State Fair Hearing decision ~~is rendered.~~timelines:

~~H. The DSS will adopt a hearing decision within three (3) working days of the date of the request (for Expedited~~ Standard State Hearing ~~only).~~

1. : The ~~DSS will adopt~~state must issue a ~~hearing~~final decision within ninety (90) calendar days ~~after the earliest filing date, unless the **Member** waives the normal timeline for a decision to be rendered~~of the date of the State Hearing request.

2. Expedited State Hearing: The state must issue a final decision within three (3) business days of the date of the Expedited Hearing request.

~~I.~~J. CalOptima shall maintain all State Hearings case files involving a Member for at least ten (10) years after the resolution of the Appeal.

~~J.~~K. CalOptima shall monitor the number, type, and resolution of State Hearings, and utilize this information to improve its and its Health Networks' provision of ~~service~~services.

III. PROCEDURE

A. CalOptima shall communicate the Appeal Process and the Member's statutory right to a State Hearing to a Member in writing, in accordance with CalOptima Policy GG.1510: Appeal Process ~~for Decisions Regarding Care and Services, to a **Member** in writing~~. This disclosure shall be included in the CalOptima Member Handbook, in accordance with CalOptima Policy DD.2005: Member ~~Handbook~~ Informing Materials Requirements and an explanation of the right to request a State Hearing shall be provided by the CalOptima Customer Service Department, by telephone, as requested by the Member.

B. A Member, or a ~~**Member's**~~Provider or Authorized Representative ~~**or Provider**~~ acting on behalf of the Member and with the Member's written consent, may request a State Hearing for a review of an Adverse Benefit Determination that involves the delay, modification, denial, or discontinuation of service(s) ~~by~~using any of the following methods:

1. ~~Write~~By Mail to:

   California Department of Social Services
   State Hearings Division
   P. O. Box 944243, ~~M.S.~~MS 9-17-37
   Sacramento, CA 94244-2430;

2. ~~Call~~By calling: 1-800-~~952-5253~~743-8525 or, for TDD only, 1-800-952-8349;
   ~~Facsimile~~
3. By Fax to: 1-916-~~651-5210~~309-3487;

~~3.~~4. By Email to: scopeofbenefits@dss.ca.gov; or ~~916-651-2789; or~~

5. ~~Present him or herself to the Department~~Online at www.cdss.ca.gov.

C. Continuation of ~~Social~~Covered Services ~~(i.e., Aid Paid Pending):at:~~

   ~~744 P Street~~
   ~~Sacramento, CA 95814~~

1. ~~————~~CalOptima shall grant Aid Paid Pending while the State Hearing is pending if all of the following conditions are met:

   a. The Member filed their Appeal within the required timeframes set forth in 42 CFR 438.420;

   b. The Appeal involves the termination, suspension, or reduction of previously authorized Covered Services;

   c. The Covered Services were ordered by an authorized Provider;

   d. The period covered by the original authorization has not expired; and

   e. The Member files for continuing Covered Services within ten (10) calendar days of when the NOA was sent, or before the intended effective date of the proposed adverse benefit determination.

2. If CalOptima, at the Member's request, continues or reinstates Covered Services while a State Hearing is pending, such services shall continue until:

   a. The Member withdraws their request for a State Hearing;

   b. The Member fails to request a State Hearing and continuation of Covered Services within ten (10) calendar days; or

   c. The final State Hearing decision is adverse to the Member.

D. State Hearing Process

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1. The DSS Administrative Adjudications Division (AAD) will send a written acknowledgment of the hearing request to the Member, the Member's Authorized Representative (to include completed an authorization for release of protected health information (PHI), Durable Power of Attorney, Legal Guardianship, Conservatorship, and or Executor of Estate~~)~~), or Provider (with a completed~~-~~ – Member confirmation of Appeal) acting on behalf of the Member and with the Member's written consent, and to CalOptima Grievance and Appeals Resolution Services (GARS).

2. The DSS Operations Support Bureau (OSB) shall schedule the hearing, and send written notification that includes the time and location of the hearing to all hearing parties, no later than ten (10) calendar days prior to the hearing.

    a. CalOptima shall notify DSS if an interpreter may be necessary at the hearing and the DSS Staff Development Training Bureau (SDTB) is responsible for making arrangements for interpreters to be present at the hearing, if appropriate.

3. CalOptima GARS shall be responsible for the administrative coordination of CalOptima's responsibilities in the State Hearing process. CalOptima shall ensure it provides accurate contact information for CalOptima's representative to ensure appearance at the State Hearing via telephone or in-person.

E. State Hearing Postponement, Withdrawal and No-show Process:

1. Hearing parties may request a postponement of a scheduled hearing to a subsequent date not more than thirty (30) calendar days beyond the original hearing date. Postponements may be granted for good cause before the hearing date~~,~~ at the discretion of the DSS State Hearing Support Section (SHSS~~),~~) or by the hearing judge on the hearing date. Good cause is established if:

    a. The Member has a death in the family, a personal illness or injury, a sudden and unexpected emergency that prevents the Member or Authorized Representative from appearing, or a conflicting court appearance that cannot be postponed; or

    b. CalOptima does not make a position statement available to the Member at least two (2) business days prior to the date of the scheduled hearing~~,~~ or modifies the position statement.

2. A Member, ~~**Member's**~~or a Provider or Authorized Representative~~, or **Provider**~~, acting on behalf of the Member with the Member's written consent, may also notify DSS of his or her wish to withdraw the hearing request, or to withdraw specific issues identified in the hearing request, at any time prior to a signed decision. If a Member notifies CalOptima of his or her intent to withdraw the hearing request, CalOptima shall assist the Member by providing the phone number to DSS, connecting the Member to DSS via a conference call, or by mailing the Member a Withdrawal of Request for State Hearing form.

3. If the Member or the Member's Authorized Representative fails to appear at the scheduled State Hearing without good cause, the request shall be considered abandoned. If the Member does not request a reinstatement within ten (10) calendar days from the scheduled hearing date, and present good cause, DSS will notify the Member, in writing, as to the specific reasons for the decision or dismissal, and the right to request a rehearing.

F. CalOptima's Pre-Hearing Process~~:~~

1. A CalOptima representative shall research information on the issues presented, contact the Member for clarification of any part of the hearing request that does not clearly set forth the Member's basis for appeal, and make efforts to bring all parties to an agreement on a possible resolution of the matter prior to the hearing.

2. If a CalOptima representative concludes CalOptima's action was correct, the CalOptima representative shall contact the Member to inquire if the Member plans to attend the hearing, determine if there are any further contentions which the Member will attempt to raise at the hearing and provide information that may be of assistance to the Member as described in Section II.~~C~~D. of this ~~policy~~Policy.

3. CalOptima GARS shall determine the issues, review the applicable statutes, regulations, and policies in light of the evidence existing in the case record, and, prior to the hearing, prepare a written position statement, consulting with Legal Affairs as appropriate.

4. Issues at the hearing shall be limited to those reasonably related to the request for hearing, or other issues identified by either the involved agency or the claimant, and jointly agreed upon for discussion prior to or at the State Hearing.

5. Except with regard to an expedited State Hearing, CalOptima shall submit a position statement that summarizes the facts of the case, the regulatory justification of CalOptima's action, any documentary evidence, and recommendation(s) for resolution. The position statement shall be submitted to ~~the DHCS Ombudsman Office, the~~ DSS ~~AAD, the County Hearing Unit~~via ACMS portal and the Member by certified mail at least two (2) business days prior to the hearing date.

6. A Member ~~and the~~ or a Provider or Authorized Representative ~~and/or **Provider**~~ acting on behalf of the Member and with the Member's written consent, may submit a position statement, but are not required to do so, and are not required to make the position statement available to any other hearing party prior to the hearing. If CalOptima does not make the position statement available at least two (2) business days prior to the hearing date, or if CalOptima modifies the position statement in a way that substantively revises the statement after providing the statement to the Member, the hearing shall be postponed upon the request of the Member conditioned upon the waiver of any decision deadlines.

7. In regard to an expedited State Hearing, within two (2) business days of being notified by DHCS or DSS that a Member has filed a request for a State Hearing that meets the criteria for expedited resolution, CalOptima shall ~~deliver directly to the designated/appropriate DSS Administrative Law Judge (ALJ)~~submit all information and documents that either support, or that CalOptima considered in connection with, the action that is the subject of the expedited State Hearing~~.~~ via ACMS portal. This includes, but is not limited to:

   a. Copies of the relevant prior authorization and Notice of Adverse Benefit Determination (NABD)/Notice of Action (NOA).

   b. Any pertinent Notice of Appeal Resolution (NAR) notice. If the NABD/NOA or NAR are not in English, CalOptima shall provide fully translated copies to DSS, along with copies of the original NABD and NAR.

   c. All documents CalOptima relied on for the denial, including clinical criteria and guidelines.

   ~~c.~~d. One (1) or more CalOptima or Health Network staff with knowledge of the Member's condition and the reason(s) for the action that is the subject of the expedited State Hearing shall be available by phone during the scheduled State Hearing.

G. State Hearing Phase

~~1. During the **State Hearing** process, CalOptima or a Health Network shall authorize or provide the disputed services promptly, and as expeditiously as the **Member's** health condition requires, but no later than seventy-two (72) hours from the date CalOptima received the decision, if the **Covered Services** are not furnished while the **Appeal** is pending and CalOptima or a Health Network from the date it receives notice reversing the determination. CalOptima or a Health Network must also pay for disputed **Covered Services** if the **Member** received the disputed **Covered Services** while the **Appeal** was pending.~~

1. At the hearing, CalOptima will be responsible for the presentation of CalOptima's case. The presentation shall include:

   a. Summary of the written position statement;

   b. Examining witnesses;

   c. Cross-examining the Member and the Member's witnesses;

   d. Responding to any questions from the Member or the Member's Authorized Representative, or the ALJ concerning the case; and

   e. Having the case record available at the hearing.

   f. Merits of a pending State Hearing shall not be discussed between the ALJ and a hearing party outside the presence of the other party.

H. Hearing Decision(s)

1. After a hearing, the ALJ will submit a proposed decision for review by the Chief ALJ or Department of Health Care Services (DHCS) Director, who will adopt a final decision. The final decision will be mailed to ~~both~~ the Member and documented via email once uploaded in the ACMS portal to notify CalOptima, and will include notice of the right to judicial review or rehearing. Once rendered, the hearing decision shall be considered the final and only notice to the Member on the resolution of the Member's hearing issue.

2. Once notified of the decision, if partially or wholly in favor of the Member, CalOptima or a Health Network shall authorize or provide the disputed services promptly, and as expeditiously as the Member's health condition requires, but no later than seventy-two (72) hours from the date CalOptima received the decision. CalOptima or a Health Network must also pay for disputed Covered Services if the Member received the disputed Covered Services while the Appeal or State Hearing was pending.

~~2.~~3. A hearing party may request, in writing, another hearing with the DSS AAD no later than thirty (30) calendar days after the hearing party receives the released decision copy. ~~-~~Upon receipt of the hearing decision, CalOptima or the Health Network shall initiate action to comply with the decision, even if a rehearing is requested.

~~3.~~4. If the decision is made wholly or partially in favor of the Member, CalOptima shall submit a compliance report to the AAD, using the County Report of Compliance form, when requested by AAD or DSS.

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4. If the decision is made wholly or partially in favor of the **Member**, CalOptima or a Health Network shall authorize or provide the disputed Services promptly, and as expeditiously as the **Member's** health condition requires, but no later than seventy-two (72) hours if the **Covered Services** are not furnished while the **Appeal** is pending and CalOptima or a Health Network from the date it receives notice reversing the determination. CalOptima or a Health Network must also pay for disputed **Covered Services** if the **Member** received the disputed **Covered Services** while the **Appeal** was pending.

5. If the decision is decided in favor of CalOptima, in cases in which Aid Paid Pending was requested, CalOptima shall terminate any authorization of the continuance of aid. No additional notification to the Member is required.

6. CalOptima's failure to comply with a decision may result in action by DHCS to ensure compliance. In such cases, the Member shall be permitted to request a new State Hearing concerning his or her dissatisfaction with Compliance Issues and Compliance-Related Issues.

7. A Member may contact the DSS verbally, or in writing, if he or she is dissatisfied with the compliance. There is no right to a State Hearing if the request for a hearing is based solely on a Compliance Issue, since the substantive issues have already been resolved, and the remaining issue is one of enforcement only.

8. CalOptima shall maintain a database containing information on the number of State Hearing requests filed, scheduled, and resolved, indicating hearing issue, hearing dates, Health Network involved, and Member information.

IV. ATTACHMENT(S)

A. Withdrawal of Request for State Fair Hearing
B. County Report of Compliance
C. Notice of Appeal Resolution
-Not Applicable

V. REFERENCE(S)

A. California Department of Social Services Manual Letter No. CFC-07-01, Regulation 22-073
California Welfare and Institutions Code, §10950 through 10967
B.A. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal
C.B. CalOptima Policy DD.2005: Member Handbook Informing Materials Requirements
D.C. CalOptima Policy GG.1507: Notification Requirements for Covered Services Requiring Prior Authorization
E.D. CalOptima Policy GG.1510 Appeal Process for Decisions Regarding Care and Services
F.E. CalOptima Policy HH.1102: CalOptima Member ComplaintGrievance
G.F. Department of Health Care Services (DHCS) All Plan Letter 17-006(APL) 21-011: Grievance and Appeal Requirements and Revised, Notice Templates and "Your Rights" AttachmentsTemplates
H.G. Title 22, California Code of Regulations (C.C.R.), §§§ 50951 through 50955
I.H. Title 42, Code of Federal Regulations (C.F.R.), §§ 431.244(f)(1) & (f)(2), 438.10, 438.404(b)(3), & 438.404(c)(3)
I. California Department of Social Services Manual Letter No. CFC-07-01, Regulation 22-073
J. California Welfare and Institutions Code, §§10950 - 10967

VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency	Response
01/05/2010	Department of Health Care Services (DHCS)	Approved as Submitted
06/10/2015	Department of Health Care Services (DHCS)	Approved as Submitted
06/21/2017	Department of Health Care Services (DHCS)	Approved as Submitted
04/06/2022	Department of Health Care Services (DHCS)	Approved as Submitted - AIR

VII. BOARD ACTION(S)

Date	Meeting
03/07/2019	Regular Meeting of the CalOptima Board of Directors
	Regular Meeting of the CalOptima Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	11/01/1999	AA.1203	State Hearing Process and Procedures	Medi-Cal
Revised	07/01/2007	HH.1108	State Hearing Process and Procedures	Medi-Cal
Revised	01/01/2010	HH.1108	State Hearing Process and Procedures	Medi-Cal
Revised	10/01/2011	HH.1108	State Hearing Process and Procedures	Medi-Cal
Revised	01/01/2013	HH.1108	State Hearing Process and Procedures	Medi-Cal
Revised	01/01/2014	HH.1108	State Hearing Process and Procedures	Medi-Cal
Revised	04/01/2015	HH.1108	State Hearing Process and Procedures	Medi-Cal
Revised	06/01/2016	HH.1108	State Hearing Process and Procedures	Medi-Cal
Revised	07/01/2017	HH.1108	State Hearing Process and Procedures	Medi-Cal
Revised	03/07/2019	HH.1108	State Hearing Process and Procedures	Medi-Cal
Revised	TBD	HH.1108	State Hearing Process and Procedures	Medi-Cal

IX. GLOSSARY

Term	Definition
Adverse Benefit Determination	~~Denial,~~Any of the following actions taken by CalOptima: 1. The denial or limited authorization of a requested service, including determinations based on the type or Level of Service, Medical Necessity, appropriateness, setting, or effectiveness of a covered benefit. 2. The reduction, suspension, or termination of a ~~requested~~previously authorized service~~, including~~. 3. The denial, in whole or in part, of payment for a service. A denial, in whole or in part, of a payment for a service solely because the claim does not meet the definition of a ''clean claim'' at 42 CFR section 447.45(b) is not an Adverse Benefit Determination. 4. The failure to provide ~~a decision~~services in a timely manner. ~~1.~~5. The failure to act within the required timeframes~~.~~ for standard Resolution of Grievances and Appeals. 6. For a resident of a rural area with only one MCP, the denial of the Member's request to obtain services outside the network. ~~2.~~7. The denial of a Member's request to dispute financial liability.
Aid Paid Pending	Continuation of Covered Services for a Member who has filed a timely request for a State Hearing as a result of a Notice of Adverse Benefit Determination of intent to terminate, suspend, or reduce an existing authorized service.
Appeal	A ~~request by the Member, Member's Authorized Representative, or Provider for~~ review by CalOptima of an ~~Adverse Benefit Determination that involves the delay, modification,~~adverse benefit determination, which includes one of the following actions: 1. A denial~~,~~ or ~~discontinuation~~limited authorization of a requested service~~.~~, including determinations based on the type or level of service, requirements for Medical Necessity, appropriateness, setting, or effectiveness of a Covered Service; 2. A reduction, suspension, or termination of a previously authorized service; 3. A denial, in whole or in part, of payment for a service; 4. Failure to provide services in a timely manner; or 5. Failure to act within the timeframes provided in 42 CFR 438.408(b).
Appeal Process	The process by which CalOptima and its Health Networks address and provide resolution to all Appeals.
Authorized Representative	~~An individual or organization that has been authorized by the claimant or designated by the Administrative Law Judge or California Department of Social Services pursuant to Regulation Sections 22-085 and 22-101 to act for the claimant in any and all aspects of the state hearing or administrative disqualification hearing.~~A person designated by the Member or a person who has the authority under applicable law to make health care decisions on behalf of adults or emancipated minors, as well as parents, guardians or other persons acting *in loco parentis* who have the authority under applicable law to make health care decisions on behalf of unemancipated minors.

Term	Definition
Complaint	~~An oral or written expression indicating dissatisfaction with any aspect of the CalOptima program.~~A complaint is the same as a Grievance. If CalOptima is unable to distinguish between a Grievance and an Inquiry, it must be considered a Grievance.
Compliance Issue	An allegation by the claimant that the county has failed to abide by a state hearing decision concerning issues clearly resolved in the order where the county did not have to make further determinations regarding the claimant's eligibility or amount of benefits.
Compliance Related Issues	Issues which were not resolved in the prior state hearing decision or resulted from the prior hearing decision requiring the county to make further determinations regarding the claimant's eligibility or amount of benefits.
Covered Services	Those services provided in the Fee-For-Service Medi-Cal program~~,~~ (as set forth in Title 22, CCR, Division 3, Subdivision 1, Chapter 3, beginning with Section 51301~~,~~), the Child Health and Disability Prevention program (as set forth in Title 17, CCR, Division 1, Chapter 4, Subchapter 13, Article 4, beginning with ~~Section 6840, which~~ section 6842), and the California Children's Services (as set forth in Title 22, CCR, Division 2, subdivision 7, and Welfare and Institutions Code, Division 9, Part 3, Chapter 7, Article 2.985, beginning with section 14094.4) under the Whole-Child Model program, to the extent those services are included as Covered Services under CalOptima's Medi-Cal Contract with DHCS and are Medically Necessary, along with chiropractic services (as defined in Section 51308 of Title 22, CCR), podiatry services (as defined in Section 51310 of Title 22, CCR), ~~and~~ speech pathology services and audiology services (as defined in Section 51309 of Title 22, CCR), and Health Homes Program (HHP) services (as set forth in DHCS All Plan Letter 18-012 and Welfare and Institutions Code, Division 9, Part 3, Chapter 7, Article 3.9, beginning with section 14127) for HHP Members with eligible physical chronic conditions and substance use disorders, or other services as authorized by the CalOptima Board of Directors, which shall be covered for Members not~~-~~withstanding whether such benefits are provided under the Fee-For-Service Medi-Cal program~~.~~..
Grievance	~~An oral or written expression of dissatisfaction about any aspect of the CalOptima program, other than an Adverse Benefit Determination.~~An oral or written expression of dissatisfaction about any matter other than an action that is an adverse benefit determination, as identified within the definition of an Appeal, and may include, but is not limited to: the quality of care or services provided, interpersonal relationships with a Provider or CalOptima's employee, failure to respect a Member's rights regardless of whether remedial action is requested, and the right to dispute an extension of time proposed by CalOptima to make an authorization decision.
Member	A Medi-Cal eligible beneficiary as determined by the County of Orange Social Services Agency, the California Department of Health Care Services (DHCS) Medi-Cal Program, or the United States Social Security Administration, who is enrolled in the CalOptima program.
Notice Adverse Benefit Determination (NABD)	As a formal letter informing a beneficiary of an Adverse Benefit Determination.
Notice of Action (NOA)	As a formal letter informing a beneficiary of an Adverse Benefit Determination.

Term	Definition
Notice of Appeal Resolution (NAR)	A NAR is a formal letter informing a beneficiary that an Adverse Benefit Determination has been overturned or upheld.
Provider	A physician, nurse, nurse mid-wife, nurse practitioner, medical technician, physician assistant, hospital, laboratory, ancillary provider, ~~health maintenance organization,~~ or other person or institution that furnishes Covered Services.
State Hearing	A quasi-judicial proceeding based upon administrative law and operated by the California Department of Social Services (DSS) which allows an avenue for Medi-Cal beneficiaries to appeal eligibility determinations and specific denials of medical services under the Medi-Cal program. -All testimony is submitted under oath, affirmation, or penalty of perjury.- The claimant is not required to attend a hearing, but if the claimant will not be present, an Authorized Representative is required to attend on his or her behalf, unless the hearing is a rehearing or a further hearing. -All documents submitted by either the claimant or the involved agency shall be made available to both parties. -Documents provided to the claimant shall be free of charge.

Policy:	HH.1108
Title:	**State Hearing Process and Procedures**
Department:	Grievance and Appeals Resolution Services
Section:	Not Applicable
CEO Approval:	
Effective Date:	11/01/1999
Revised Date:	TBD
Applicable to:	☒ Medi-Cal ☐ OneCare ☐ OneCare Connect ☐ PACE ☒ Administrative

I. PURPOSE

This policy defines CalOptima's process, role, and responsibilities in ensuring a Member's right to access the State Hearing process.

II. POLICY

A. A Member, or a Provider or Authorized Representative acting on behalf of the Member and with the Member's written consent, has a due process right to request a State Hearing when a claim for medical assistance is delayed, modified, denied, or discontinued and/or not acted upon with reasonable promptness.

B. Once the CalOptima-level Appeal Process has been exhausted, a Member, or a Provider or Authorized Representative acting on behalf of a Member and with the Member's written consent, may request a State Hearing:

1. After receiving a Notice of Resolution (NAR) stating that CalOptima's action has been upheld, and the request is made no later than one hundred and twenty (120) calendar days from the date of the NAR; or

2. If the Member is deemed to have exhausted CalOptima's internal Appeal Process due to CalOptima's failure to meet or respond to the thirty (30) calendar day resolution timeline or comply with the notice requirements in accordance with Title 42, Code of Federal Regulations (CFR) section 438.10. In cases of deemed exhaustion, CalOptima shall not request a dismissal of a Fair Hearing based on a failure to exhaust CalOptima's internal Appeal Process.

C. CalOptima is not involved in the Medi-Cal eligibility process, and shall not participate in State Hearings related to eligibility determinations. However, as the Medi-Cal managed care plan in Orange County, CalOptima shall participate in State Hearings that address medical service denials to Members.

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D. CalOptima shall provide a Member with a thorough explanation of the right to request a State Hearing, and shall assist the Member, upon request, in filing his or her request for a State Hearing. Upon request, CalOptima shall provide any and all information that can be of assistance to the Member in preparing for the State Hearing, including all documents, guidelines and clinical criteria CalOptima relied on for the initial denial and anything the CalOptima considered during the internal CalOptima Appeal Process, as well as both regulations and evidence, which might be favorable to the Member's case.

E. A Member shall file a request for a State Hearing with the Department of Social Services (DSS) within one hundred and twenty (120) calendar days after the date of the NAR or Appeal resolution timeframe has exhausted.

F. CalOptima shall grant Aid Paid Pending while the State Hearing is pending in accordance with Section III.C. of this Policy.

G. CalOptima shall not unlawfully discriminate against a Member for requesting a State Hearing.

H. The parties to a State Hearing include CalOptima, with the assistance of the Member's Health Network, as well as the Member and the Member's Authorized Representative or representative of a deceased Member's estate. CalOptima shall act on its own behalf as the public agency that administers the Medi-Cal program in Orange County, and may represent its Health Networks, if no other representation is provided. Whenever the issue pertains to a Health Network's action or inaction, representatives from the involved Health Network are requested to attend the hearing.

I. CalOptima shall notify Members of the expected State Fair Hearing decision timelines:

1. Standard State Hearing: The state must issue a final decision within ninety (90) calendar days of the date of the State Hearing request.

2. Expedited State Hearing: The state must issue a final decision within three (3) business days of the date of the Expedited Hearing request.

J. CalOptima shall maintain all State Hearings case files involving a Member for at least ten (10) years after the resolution of the Appeal.

K. CalOptima shall monitor the number, type, and resolution of State Hearings, and utilize this information to improve its and its Health Networks' provision of services.

III. PROCEDURE

A. CalOptima shall communicate the Appeal Process and the Member's statutory right to a State Hearing to a Member in writing, in accordance with CalOptima Policy GG.1510: Appeal Process. This disclosure shall be included in the CalOptima Member Handbook, in accordance with CalOptima Policy DD.2005: Member-Informing Materials Requirements and an explanation of the right to request a State Hearing shall be provided by the CalOptima Customer Service Department, by telephone, as requested by the Member.

B. A Member, or a Provider or Authorized Representative acting on behalf of the Member and with the Member's written consent, may request a State Hearing for a review of an Adverse Benefit Determination that involves the delay, modification, denial, or discontinuation of service(s) using any of the following methods:

1. By Mail to:

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California Department of Social Services
State Hearings Division
P. O. Box 944243, MS 9-17-37
Sacramento, CA 94244-2430;

2. By calling: 1-800-743-8525 or, for TDD only, 1-800-952-8349;

3. By Fax to: 1-916-309-3487;

4. By Email to: scopeofbenefits@dss.ca.gov; or

5. Online at www.cdss.ca.gov.

C. Continuation of Covered Services(i.e., Aid Paid Pending):

1. CalOptima shall grant Aid Paid Pending while the State Hearing is pending if all of the following conditions are met:

   a. The Member filed their Appeal within the required timeframes set forth in 42 CFR 438.420;

   b. The Appeal involves the termination, suspension, or reduction of previously authorized Covered Services;

   c. The Covered Services were ordered by an authorized Provider;

   d. The period covered by the original authorization has not expired; and

   e. The Member files for continuing Covered Services within ten (10) calendar days of when the NOA was sent, or before the intended effective date of the proposed adverse benefit determination.

2. If CalOptima, at the Member's request, continues or reinstates Covered Services while a State Hearing is pending, such services shall continue until:

   a. The Member withdraws their request for a State Hearing;

   b. The Member fails to request a State Hearing and continuation of Covered Services within ten (10) calendar days; or

   c. The final State Hearing decision is adverse to the Member.

D. State Hearing Process

1. The DSS Administrative Adjudications Division (AAD) will send a written acknowledgment of the hearing request to the Member, the Member's Authorized Representative (to include completed an authorization for release of protected health information (PHI), Durable Power of Attorney, Legal Guardianship, Conservatorship, and or Executor of Estate), or Provider (with a completed – Member confirmation of Appeal) acting on behalf of the Member and with the Member's written consent, and to CalOptima Grievance and Appeals Resolution Services (GARS).

2. The DSS Operations Support Bureau (OSB) shall schedule the hearing, and send written notification that includes the time and location of the hearing to all hearing parties, no later than ten (10) calendar days prior to the hearing.

    a. CalOptima shall notify DSS if an interpreter may be necessary at the hearing and the DSS Staff Development Training Bureau (SDTB) is responsible for making arrangements for interpreters to be present at the hearing, if appropriate.

3. CalOptima GARS shall be responsible for the administrative coordination of CalOptima's responsibilities in the State Hearing process. CalOptima shall ensure it provides accurate contact information for CalOptima's representative to ensure appearance at the State Hearing via telephone or in-person.

E. State Hearing Postponement, Withdrawal and No-show Process:

1. Hearing parties may request a postponement of a scheduled hearing to a subsequent date not more than thirty (30) calendar days beyond the original hearing date. Postponements may be granted for good cause before the hearing date at the discretion of the DSS State Hearing Support Section (SHSS) or by the hearing judge on the hearing date. Good cause is established if:

    a. The Member has a death in the family, a personal illness or injury, a sudden and unexpected emergency that prevents the Member or Authorized Representative from appearing, or a conflicting court appearance that cannot be postponed; or

    b. CalOptima does not make a position statement available to the Member at least two (2) business days prior to the date of the scheduled hearing or modifies the position statement.

2. A Member, or a Provider or Authorized Representative acting on behalf of the Member with the Member's written consent, may also notify DSS of his or her wish to withdraw the hearing request, or to withdraw specific issues identified in the hearing request, at any time prior to a signed decision. If a Member notifies CalOptima of his or her intent to withdraw the hearing request, CalOptima shall assist the Member by providing the phone number to DSS, connecting the Member to DSS via a conference call, or by mailing the Member a Withdrawal of Request for State Hearing form.

3. If the Member or the Member's Authorized Representative fails to appear at the scheduled State Hearing without good cause, the request shall be considered abandoned. If the Member does not request a reinstatement within ten (10) calendar days from the scheduled hearing date, and present good cause, DSS will notify the Member, in writing, as to the specific reasons for the decision or dismissal, and the right to request a rehearing.

F. CalOptima's Pre-Hearing Process

1. A CalOptima representative shall research information on the issues presented, contact the Member for clarification of any part of the hearing request that does not clearly set forth the Member's basis for appeal, and make efforts to bring all parties to an agreement on a possible resolution of the matter prior to the hearing.

2. If a CalOptima representative concludes CalOptima's action was correct, the CalOptima representative shall contact the Member to inquire if the Member plans to attend the hearing, determine if there are any further contentions which the Member will attempt to raise at the

hearing and provide information that may be of assistance to the Member as described in Section II.D. of this Policy.

3. CalOptima GARS shall determine the issues, review the applicable statutes, regulations, and policies in light of the evidence existing in the case record, and, prior to the hearing, prepare a written position statement, consulting with Legal Affairs as appropriate.

4. Issues at the hearing shall be limited to those reasonably related to the request for hearing, or other issues identified by either the involved agency or the claimant, and jointly agreed upon for discussion prior to or at the State Hearing.

5. Except with regard to an expedited State Hearing, CalOptima shall submit a position statement that summarizes the facts of the case, the regulatory justification of CalOptima's action, any documentary evidence, and recommendation(s) for resolution. The position statement shall be submitted to DSS via ACMS portal and the Member by certified mail at least two (2) business days prior to the hearing date.

6. A Member or a Provider or Authorized Representative acting on behalf of the Member and with the Member's written consent, may submit a position statement, but are not required to do so, and are not required to make the position statement available to any other hearing party prior to the hearing. If CalOptima does not make the position statement available at least two (2) business days prior to the hearing date, or if CalOptima modifies the position statement in a way that substantively revises the statement after providing the statement to the Member, the hearing shall be postponed upon the request of the Member conditioned upon the waiver of any decision deadlines.

7. In regard to an expedited State Hearing, within two (2) business days of being notified by DHCS or DSS that a Member has filed a request for a State Hearing that meets the criteria for expedited resolution, CalOptima shall submit all information and documents that either support, or that CalOptima considered in connection with, the action that is the subject of the expedited State Hearing via ACMS portal. This includes, but is not limited to:

   a. Copies of the relevant prior authorization and Notice of Adverse Benefit Determination (NABD)/Notice of Action (NOA).

   b. Any pertinent Notice of Appeal Resolution (NAR) notice. If the NABD/NOA or NAR are not in English, CalOptima shall provide fully translated copies to DSS, along with copies of the original NABD and NAR.

   c. All documents CalOptima relied on for the denial, including clinical criteria and guidelines.

   d. One (1) or more CalOptima or Health Network staff with knowledge of the Member's condition and the reason(s) for the action that is the subject of the expedited State Hearing shall be available by phone during the scheduled State Hearing.

G. State Hearing Phase

1. At the hearing, CalOptima will be responsible for the presentation of CalOptima's case. The presentation shall include:

   a. Summary of the written position statement;

   b. Examining witnesses;

c. Cross-examining the Member and the Member's witnesses;

d. Responding to any questions from the Member or the Member's Authorized Representative, or the ALJ concerning the case; and

e. Having the case record available at the hearing.

f. Merits of a pending State Hearing shall not be discussed between the ALJ and a hearing party outside the presence of the other party.

H. Hearing Decision(s)

1. After a hearing, the ALJ will submit a proposed decision for review by the Chief ALJ or Department of Health Care Services (DHCS) Director, who will adopt a final decision. The final decision will be mailed to the Member and documented via email once uploaded in the ACMS portal to notify CalOptima, and will include notice of the right to judicial review or rehearing. Once rendered, the hearing decision shall be considered the final and only notice to the Member on the resolution of the Member's hearing issue.

2. Once notified of the decision, if partially or wholly in favor of the Member, CalOptima or a Health Network shall authorize or provide the disputed services promptly, and as expeditiously as the Member's health condition requires, but no later than seventy-two (72) hours from the date CalOptima received the decision. CalOptima or a Health Network must also pay for disputed Covered Services if the Member received the disputed Covered Services while the Appeal or State Hearing was pending.

3. A hearing party may request, in writing, another hearing with the DSS AAD no later than thirty (30) calendar days after the hearing party receives the released decision copy. Upon receipt of the hearing decision, CalOptima or the Health Network shall initiate action to comply with the decision, even if a rehearing is requested.

4. If the decision is made wholly or partially in favor of the Member, CalOptima shall submit a compliance report to the AAD, using the County Report of Compliance form, when requested by AAD or DSS.

5. If the decision is decided in favor of CalOptima, in cases in which Aid Paid Pending was requested, CalOptima shall terminate any authorization of the continuance of aid. No additional notification to the Member is required.

6. CalOptima's failure to comply with a decision may result in action by DHCS to ensure compliance. In such cases, the Member shall be permitted to request a new State Hearing concerning his or her dissatisfaction with Compliance Issues and Compliance-Related Issues.

7. A Member may contact the DSS verbally, or in writing, if he or she is dissatisfied with the compliance. There is no right to a State Hearing if the request for a hearing is based solely on a Compliance Issue, since the substantive issues have already been resolved, and the remaining issue is one of enforcement only.

8. CalOptima shall maintain a database containing information on the number of State Hearing requests filed, scheduled, and resolved, indicating hearing issue, hearing dates, Health Network involved, and Member information.

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

A. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal
B. CalOptima Policy DD.2005: Member-Informing Materials Requirements
C. CalOptima Policy GG.1507: Notification Requirements for Covered Services Requiring Prior Authorization
D. CalOptima Policy GG.1510 Appeal Process
E. CalOptima Policy HH.1102: Member Grievance
F. Department of Health Care Services (DHCS) All Plan Letter (APL) 21-011: Grievance and Appeal Requirements, Notice and "Your Rights" Templates
G. Title 22, California Code of Regulations (C.C.R.), §§ 50951 - 50955
H. Title 42, Code of Federal Regulations (C.F.R.), §§ 431.244(f)(1) & (f)(2), 438.10, 438.404(b)(3), & 438.404(c)(3)
I. California Department of Social Services Manual Letter No. CFC-07-01, Regulation 22-073
J. California Welfare and Institutions Code, §§10950 - 10967

VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency	Response
01/05/2010	Department of Health Care Services (DHCS)	Approved as Submitted
06/10/2015	Department of Health Care Services (DHCS)	Approved as Submitted
06/21/2017	Department of Health Care Services (DHCS)	Approved as Submitted
04/06/2022	Department of Health Care Services (DHCS)	Approved as Submitted - AIR

VII. BOARD ACTION(S)

Date	Meeting
03/07/2019	Regular Meeting of the CalOptima Board of Directors
	Regular Meeting of the CalOptima Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	11/01/1999	AA.1203	State Hearing Process and Procedures	Medi-Cal
Revised	07/01/2007	HH.1108	State Hearing Process and Procedures	Medi-Cal
Revised	01/01/2010	HH.1108	State Hearing Process and Procedures	Medi-Cal
Revised	10/01/2011	HH.1108	State Hearing Process and Procedures	Medi-Cal
Revised	01/01/2013	HH.1108	State Hearing Process and Procedures	Medi-Cal
Revised	01/01/2014	HH.1108	State Hearing Process and Procedures	Medi-Cal
Revised	04/01/2015	HH.1108	State Hearing Process and Procedures	Medi-Cal
Revised	06/01/2016	HH.1108	State Hearing Process and Procedures	Medi-Cal
Revised	07/01/2017	HH.1108	State Hearing Process and Procedures	Medi-Cal
Revised	03/07/2019	HH.1108	State Hearing Process and Procedures	Medi-Cal
Revised	TBD	HH.1108	State Hearing Process and Procedures	Medi-Cal

IX. GLOSSARY

Term	Definition
Adverse Benefit Determination	Any of the following actions taken by CalOptima: 1. The denial or limited authorization of a requested service, including determinations based on the type or Level of Service, Medical Necessity, appropriateness, setting, or effectiveness of a covered benefit. 2. The reduction, suspension, or termination of a previously authorized service. 3. The denial, in whole or in part, of payment for a service. A denial, in whole or in part, of a payment for a service solely because the claim does not meet the definition of a ''clean claim'' at 42 CFR section 447.45(b) is not an Adverse Benefit Determination. 4. The failure to provide services in a timely manner. 5. The failure to act within the required timeframes for standard Resolution of Grievances and Appeals. 6. For a resident of a rural area with only one MCP, the denial of the Member's request to obtain services outside the network. 7. The denial of a Member's request to dispute financial liability.
Aid Paid Pending	Continuation of Covered Services for a Member who has filed a timely request for a State Hearing as a result of a Notice of Adverse Benefit Determination of intent to terminate, suspend, or reduce an existing authorized service.
Appeal	A review by CalOptima of an adverse benefit determination, which includes one of the following actions: 1. A denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for Medical Necessity, appropriateness, setting, or effectiveness of a Covered Service; 2. A reduction, suspension, or termination of a previously authorized service; 3. A denial, in whole or in part, of payment for a service; 4. Failure to provide services in a timely manner; or 5. Failure to act within the timeframes provided in 42 CFR 438.408(b).
Appeal Process	The process by which CalOptima and its Health Networks address and provide resolution to all Appeals.
Authorized Representative	A person designated by the Member or a person who has the authority under applicable law to make health care decisions on behalf of adults or emancipated minors, as well as parents, guardians or other persons acting *in loco parentis* who have the authority under applicable law to make health care decisions on behalf of unemancipated minors.
Complaint	A complaint is the same as a Grievance. If CalOptima is unable to distinguish between a Grievance and an Inquiry, it must be considered a Grievance.
Compliance Issue	An allegation by the claimant that the county has failed to abide by a state hearing decision concerning issues clearly resolved in the order where the county did not have to make further determinations regarding the claimant's eligibility or amount of benefits.

Term	Definition
Compliance Related Issues	Issues which were not resolved in the prior state hearing decision or resulted from the prior hearing decision requiring the county to make further determinations regarding the claimant's eligibility or amount of benefits.
Covered Services	Those services provided in the Fee-For-Service Medi-Cal program (as set forth in Title 22, CCR, Division 3, Subdivision 1, Chapter 3, beginning with Section 51301), the Child Health and Disability Prevention program (as set forth in Title 17, CCR, Division 1, Chapter 4, Subchapter 13, Article 4, beginning with section 6842), and the California Children's Services (as set forth in Title 22, CCR, Division 2, subdivision 7, and Welfare and Institutions Code, Division 9, Part 3, Chapter 7, Article 2.985, beginning with section 14094.4) under the Whole-Child Model program, to the extent those services are included as Covered Services under CalOptima's Medi-Cal Contract with DHCS and are Medically Necessary, along with chiropractic services (as defined in Section 51308 of Title 22, CCR), podiatry services (as defined in Section 51310 of Title 22, CCR), speech pathology services and audiology services (as defined in Section 51309 of Title 22, CCR), and Health Homes Program (HHP) services (as set forth in DHCS All Plan Letter 18-012 and Welfare and Institutions Code, Division 9, Part 3, Chapter 7, Article 3.9, beginning with section 14127) for HHP Members with eligible physical chronic conditions and substance use disorders, or other services as authorized by the CalOptima Board of Directors, which shall be covered for Members not-withstanding whether such benefits are provided under the Fee-For-Service Medi-Cal program..
Grievance	An oral or written expression of dissatisfaction about any matter other than an action that is an adverse benefit determination, as identified within the definition of an Appeal, and may include, but is not limited to: the quality of care or services provided, interpersonal relationships with a Provider or CalOptima's employee, failure to respect a Member's rights regardless of whether remedial action is requested, and the right to dispute an extension of time proposed by CalOptima to make an authorization decision.
Member	A Medi-Cal eligible beneficiary as determined by the County of Orange Social Services Agency, the California Department of Health Care Services (DHCS) Medi-Cal Program, or the United States Social Security Administration, who is enrolled in the CalOptima program.
Notice Adverse Benefit Determination (NABD)	As a formal letter informing a beneficiary of an Adverse Benefit Determination.
Notice of Action (NOA)	As a formal letter informing a beneficiary of an Adverse Benefit Determination.
Notice of Appeal Resolution (NAR)	A NAR is a formal letter informing a beneficiary that an Adverse Benefit Determination has been overturned or upheld.
Provider	A physician, nurse, nurse mid-wife, nurse practitioner, medical technician, physician assistant, hospital, laboratory, ancillary provider, or other person or institution that furnishes Covered Services.

Term	Definition
State Hearing	A quasi-judicial proceeding based upon administrative law and operated by the California Department of Social Services (DSS) which allows an avenue for Medi-Cal beneficiaries to appeal eligibility determinations and specific denials of medical services under the Medi-Cal program. All testimony is submitted under oath, affirmation, or penalty of perjury. The claimant is not required to attend a hearing, but if the claimant will not be present, an Authorized Representative is required to attend on his or her behalf, unless the hearing is a rehearing or a further hearing. All documents submitted by either the claimant or the involved agency shall be made available to both parties. Documents provided to the claimant shall be free of charge.

1

☐ **WITHDRAWAL** ☐ **CONDITIONAL WITHDRAWALS**

OF
REQUEST FOR HEARING

Case Name: _____ County Case No: _____

State Hearing No: _____ Filing Date: _____

County: _____ Hearing Date: _____

Hearing Time: _____

I, _____, the undersigned do hereby:

☐ Withdraw my request for a state hearing before the State Department of Social Services. I understand that by withdrawing my request, I lose my right to a hearing on that request. I also understand that by withdrawing my request for hearing, aid which has been paid because of the request will stop without further notice. I may, however, file a new hearing request raising the identical issue provided that the new request is timely per Manual of Policies and Procedures Section 22-009.

☐ Conditionally withdraw my request for a state hearing before the State Department of Social Services. I understand that by conditionally withdrawing my request for hearing, aid which has been paid because of the hearing request will stop without further notice. I understand that the county will issue a redetermination notice within 30 days and that I must request a hearing within **90 DAYS** of the county's notice if I am not satisfied with the county's reconsideration of my case. Upon such renewal, I shall have the same rights I would have had if I had not signed this conditional withdrawal.

NOTE: A conditional withdrawal must provide that the actions of both parties will be completed within 30 days.

The reasons for or conditions of this withdrawal are: _____

Signed

_____
(County Representative) (Date)

_____
(County Address)

_____
(City) (Zip Code)

_____
(Telephone Number)

Signed

_____
(Claimant) (Date)

_____
(Address)

_____
(City) (Zip Code)

_____
(Telephone Number)

NOTE: A Conditional Withdrawal must also be signed by a County Representative or it is invalid.

DPA 315 (7/99)

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COUNTY REPORT OF COMPLIANCE TRANSMITTAL

Due within 30 days of receipt of decision

COUNTY	DATE

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NAME ADDRESS *(if changed)*	STATE HEARING #	ADOPT DATE	COMPLIANCE NOTIFICATION DATE	EFFECTIVE DATE	CODE(S) OR BRIEF STATEMENT

I certify that the above compliance information is true and correct to the best of my knowledge.

NAME	PHONE NUMBER	DATE

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COMPLIANCE CODE OPTIONS

- Use program code (letter) for each program in which a compliance action is required.
- Use one or more action codes (number) for each program code.

PROGRAM CODES:

A. AFDC
B. FS
C. Medi-Cal
D. IHSS
E. AFDC/FC
F. OTHER: List Program

ACTION CODES:

1. Action rescinded –Benefits determined & issued as eligible.
2. Action rescinded – Benefits not determined or issued due to lack of information. Admin Close.
3. Entitlement received as aid pending, (APP).
4. No eligibility for retroactive benefits found.
5. O/P or O/I reduced / cancelled as ordered.
6. Retro benefits reduced or not issued due to balancing against existing O/P, O/I.
7. SOC changed as ordered.
8. County has offered assistance to the claimant in obtaining reimbursement for any Medi-Cal covered expenses incurred.
9. Delayed Compliance (Brief explanation) Wait for followup transmittal.
10. OTHER: (Brief explanation)

"Uphold"

NOTICE OF APPEAL RESOLUTION

[Date]

[Member's Name]
[Address]
[City, State Zip]

Identification Number: [Identification Number]

RE: [Service requested]

You [Or Name of requesting provider or authorized representative on your behalf] appealed the [denial, delay, modification, or termination] of [Service requested] on [Date appeal received].

[CalOptima's Medical Director, Name of Specialty, or Decision Maker] has reviewed the appeal on [date] and has decided to uphold the decision. This request is still denied. This is because [Insert: 1. A clear and concise explanation of the reasons for the decision; 2. A description of the criteria or guidelines used, including a reference to the specific regulations or plan authorization procedures that support the action; and 3. The clinical reasons for the decision regarding medical necessity].

On [Date] at [Time], you were contacted and informed of the decision; OR a message was left informing you of the decision; OR a message was left asking for a call back].

You may ask for free copies of all information used to make this decision. This includes a copy of the actual benefit provision, guideline, protocol, or criteria that we based our decision on. To ask for this, please call [Grievance Resolution Staff Name] at [Phone number].

If you need help reading this letter or have any questions, please call [Grievance Resolution Staff Name] at [Phone number].

If you have questions or need help with your health care services, please call CalOptima's Customer Service department at **1-714-246-8500** or toll-free at **1-888-587-8088**, Monday through Friday, from 8 a.m. to 5:30 p.m. We have staff who speak your language. TDD/TTY users can call toll-free at **1-800-735-2929**. You can also visit our website at **www.caloptima.org**. You may appeal this decision. The enclosed "Your Rights" information notice tells you how. It also tells you where you can get free help. This also means free legal help. You are encouraged

[Case #]

MCAL MM-17-37_DHCS Approved 04.07.2020_NAR Uphold (GARS)(COVID-19)

to send in any information that could help your case. The "Your Rights" notice tells you the cut off dates to ask for an appeal.

During the coronavirus (COVID-19) public health emergency, you have an additional 120 days over and above the initial 120 days allowed to request a State Hearing. This gives you 240 days from the date of this Notice of Appeal Resolution to request a State Hearing.

The State Medi-Cal Managed Care "Ombudsman Office" can help you with any questions. You may call them at 1-888-452-8609. You may also get help from your doctor, or call CalOptima's Customer Service department at **1-714-246-8500**, or toll-free at **1-888-587-8088**, Monday through Friday, from 8 a.m. to 5:30 p.m.

This notice does not affect any of your other Medi-Cal services.

Sincerely,

[Grievance Resolution Staff Name], [Title]
Grievance and Appeals

Enclosed: Your Rights under Medi-Cal Managed Care
Notice of Non-Discrimination
Language Assistance Taglines

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken June 2, 2022
Regular Meeting of the CalOptima Board of Directors

Consent Calendar

8. Approve Proposed Changes to the CalOptima Medical Affairs Policy Related to Long Term Care Authorization Processes

Contacts

Kelly Giardina, MSG, CCM, Executive Director, Clinical Operations, (657) 900-1013
Scott Robinson, MSN, RN, CCM, Director, Long-Term Services and Supports, (657) 900-1457

Recommended Action

Approve proposed changes to Medical Affairs Long-Term Services and Supports policy GG.1803 related to long term care authorization processes.

Background

As part of the annual review process, Medical Affairs CalOptima is updating policy GG.1803: Authorization Process and Criteria for Admission to Continued Stay in, and Discharge from a Subacute Facility – Adult/Pediatric to improve clarity.

Discussion

CalOptima revised Medical Affairs Long-Term Services and Supports policy GG.1803 that was last revised on November 1, 2017. The table below outlines a list of substantive changes. The list does not include the non-substantiative changes reflected in the policy redlines.

Section	Proposed Change	Rationale
II.B (p. 1)	Added language: "For initial LTC authorizations, a subacute Facility shall submit a completed Long Term Care (LTC) Authorization Request Form (ARF) within twenty-one (21) calendar days from the start date of CalOptima LTC coverage along with all necessary supporting documentation to make a Medical Necessity determination. For reauthorizations of a continued stay, the subacute Facility shall also submit a completed LTC ARF along with all necessary documentation to justify continued stay at least twenty-four (24) hours prior to the expiration of the active…"	Detail added to improve clarity
II.C.1-2 (p.1-2)	Clarified language "onsite authorization review." Identified criteria used to determine if a facility has onsite reviews.	Edited for clarity
II.D (p. 2)	Added language: "CalOptima's approval of a facility's authorization request is subject to the facility being…"	Linked authorization to facility requirements

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Section	Proposed Change	Rationale
II.E (p. 2)	Added language: "CalOptima shall ensure that Members in need of nursing facility services are placed in a health care facility that provided the level of care most appropriate to the Member's medical needs. These health care facilities include Skilled Nursing Facilities, Subacute Facilities, Pediatric Subacute facilities, and Intermediate Care Facilities."	Included reference to levels of care
III.A (p. 4)	Revised the modifier "if available" to apply only to the Minimum Data Set.	Edited for clarity
III.E-F (p. 5)	Added language: "If the CalOptima Medical Director, or authorized physician designee, denies or modifies the LTC ARF, the CalOptima LTSS Department shall notify the Facility and the Member, or Member's Authorized Representative in accordance with CalOptima Policy GG.1510: Appeals Process for Decisions Regarding Care and Services." Upon the receipt of an ARF modification or denial, the Subacute Facility may file an appeal, or complaint, in accordance with CalOptima Policy GG.1510: Appeals Process for Decisions Regarding Care and Services.	Added detail
Section III.H-J (p. 6)	Added detail to deferral process when adequate information is not submitted.	Edited for clarity
Section III.M.1-2 (p. 7)	Added details of the discharge planning process.	Edited for clarity
Section V (p. 9)	Updated references.	Edited to provide accurate references
Attachment A	Updated to current LTC ARF.	Updated to current form
Section IX	Added definition for 21-Day List.	Added applicable definition

These modifications to GG.1803 ensure CalOptima's continuing commitment to conducting its operations in compliance with ethical and legal standards and all applicable laws, regulations, rules, and accreditation standards.

Fiscal Impact

The recommended action to approve revisions to CalOptima Policy GG.1803 is operational in nature and has no additional fiscal impact beyond what was incorporated in the proposed CalOptima Fiscal Year 2022-23 Operating Budget.

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Rationale for Recommendation

The recommended actions will ensure CalOptima is compliant with contractual and regulatory guidance provided by its regulators (e.g., Department of Health Care Services and Centers for Medicare & Medicaid Services). The updated policies will supersede the prior versions.

Concurrence

Troy R. Szabo, Outside General Counsel, Kennaday Leavitt

Attachments

1. Policy GG.1803: Authorization Process and Criteria for Admission to, Continued Stay in, and Discharge from a Subacute Facility – Adult/Pediatric (redline and clean).

/s/ Michael Hunn — *05/27/2022*

Authorized Signature — **Date**

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Policy:	GG.1803
Title:	**Authorization Process and Criteria for Admission to, Continued Stay in, and Discharge from a Subacute Facility-Adult/Pediatric**
Department:	Medical Management
Section:	Long Term Services and Supports
CEO Approval:	*/s/*
Effective Date:	06/01/1998
Revised Date:	TBD
Applicable to:	☒ Medi-Cal ☐ OneCare ☒ OneCare Connect ☐ PACE ☐ Administrative

I. PURPOSE

This policy outlines the requirements for reviewing and processing a Long-Term Care (LTC) Authorization and the criteria for a Member's admission to, continued stay in, or discharge from a Subacute Facility-Adult, or Subacute Facility-Pediatric.

II. POLICY

A. The CalOptima Long-Term Services and Supports (LTSS) Department shall process all requests for admission to, continued stay in, or discharge from a Subacute Facility-Adult, or Subacute Facility-Pediatric, pursuant to the Title 22, California Code of Regulations, ~~Sections~~sections 51335.5 and 51335.6 and the California Department of Health Care Services (DHCS) standard criteria for subacute programs.

~~B.~~ The initial and reauthorization requests shall be initiated by the subacute facilities.

B. For initial LTC authorizations, a subacute Facility shall submit a completed Long-Term Care (LTC) Authorization Request Form (ARF) within twenty-one (21) calendar days from the start date of CalOptima ~~shall approve~~LTC coverage along with all necessary supporting documentation to make a Medical Necessity determination. For re-authorizations of a continued stay, the subacute Facility shall also submit a completed LTC ARF along with all necessary documentation to justify continued stay at least twenty-four (24) hours prior to the expiration of the active authorization.

1. If a ~~requests to Subacute Facilities-Adult~~subacute Facility submits an LTC ARF after the required timeframe, but the LTC ARF meets the level of care requested, CalOptima shall subject the authorization to a fifteen percent (15%) payment reduction.

C. CalOptima may decide, at its discretion, to perform an onsite authorization review to make a Medical Necessity determination for an LTC ARF. This determination shall follow an in-person assessment of the Member and ~~Subacute Facilities-Pediatric that are~~a thorough review of the medical orders, care plan, therapist treatment plan, the subacute Facility's multidisciplinary team

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notes, or other clinical data appropriate to support making the determination on the authorization request.

1. If a subacute Facility is designated for regular onsite authorization reviews, the subacute Facility shall notify CalOptima's LTSS Department of initial admissions, through the submission of Member information on the 21-Day List via email, fax or US mail, within twenty-one (21) calendar days from the start date of CalOptima LTC coverage. For re-authorizations of a continued stay at a subacute Facility designated for regular onsite authorization reviews, the Facility shall also submit Member information on the 21-Day List at least twenty-four (24) hours prior to the expiration of the active LTC ARF. The completed LTC ARF and all necessary supporting documentation do not need to be sent to CalOptima LTSS Department at the same time as the submission of the 21-Day List. However, subacute facilities designated for regular onsite authorization reviews must have the completed ARF and all necessary supporting documentation ready for onsite review by the CalOptima Medical Case Manager on the day of the scheduled visit.

2. If a subacute Facility designated for regular onsite authorization reviews submits Member information on the 21-Day List after the required timeframe, but the LTC ARF meets the level of care requested, CalOptima shall subject the authorization to a fifteen percent (15%) payment reduction.

D. CalOptima's approval of a facility's authorization request is subject to the facility's being licensed by the California Department of Public Health (CDPH), ~~meet~~meeting acceptable quality standards, and ~~agrees~~its agreement to CalOptima contracted rates, in accordance with CalOptima Policy EE.1135: Long-Term Care Facility Contracting.

E. CalOptima shall ensure that Members in need of nursing facility services are placed in a health care facility that provided the level of care most appropriate to the Member's medical needs. These health care facilities include Skilled Nursing Facilities, Subacute Facilities, Pediatric Subacute facilities, and Intermediate Care Facilities.

~~E.~~F. CalOptima shall ensure continuity of care for Members residing in a Subacute Facility-Adult, or Subacute Facility-Pediatric, in accordance with CalOptima Policies GG.1325: Continuity of Care for ~~Medi-Cal Beneficiaries Who Transition~~Members Transitioning into CalOptima Services and CMC.6021a: Continuity of Care for New Members.

~~C.~~A. ~~A Subacute Facility-Adult, or Subacute Facility-Pediatric, shall submit a completed Long Term Care (LTC) Authorization Request Form (ARF) (Sections I through IV); Minimum Data Set (MDS); Provider Utilization Committee Determination (Medicare denial), as appropriate; primary insurance denial, as appropriate; Preadmission Screening and Resident Review (PASRR) Level I Screening Document; and 6200-A/ 6200 forms, within twenty-one (21) calendar days after a Member's admission to the Facility.~~

~~D. If a Subacute Facility-Adult, or Subacute Facility-Pediatric, submits an LTC ARF after the twenty-one (21) calendar day requirement, but the LTC ARF meets the level of care requested, CalOptima shall subject the LTC ARF to a fifteen percent (15%) payment reduction.~~

~~F.~~G. CalOptima may grant the initial authorization and reauthorization requests for six (6) months at a time.

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1. A Subacute Facility-Adult, or Subacute Facility-Pediatric, shall submit a reauthorization request prior to the expiration of the active LTC ARF. The facility may submit the reauthorization request up to thirty (30) calendar days prior to expiration of the active LTC ARF. The reauthorization requests shall include a completed LTC ARF (Sections I, III [as applicable] and IV) signed by the physician, a signed 6200-A/6200 form, and sufficient documentation to determine the level of care and justify a continued stay.

E. If the CalOptima Medical Director, or authorized physician designee, denies or modifies the LTC ARF, the CalOptima LTSS Department shall notify the Facility, the Member, or Member's Authorized Representative in accordance with CalOptima Policy GG.1510: Appeals Process for Decisions Regarding Care and Services.

F. Upon the receipt of an ARF modification, or denial, the Facility shall have the ability to file an appeal, or complaint, in accordance with CalOptima Policy GG.1510: Appeals Process for Decisions Regarding Care and Services.

1. A Subacute Facility may modify its care or discharge a Member if the Subacute Facility determines that the following specified circumstances are present:

a. The Subacute Facility is no longer capable of meeting the Member's health needs; or

1. The Member's health care has improved sufficiently so that the Member no longer needs Subacute Facility services; or

b.a. The Member poses a risk to the health, or safety, of individuals in the Subacute Facility.

M. Discharge Planning:

2.1. CalOptima or a Health Network shall be responsible for ensuring the provision of a Member's medical needs, supports, and services throughout the post-discharge and transition to community-based care period. The discharge planning may include, but is not limited to:

a. Documentation of pre-admission, or baseline, status;

b.a. Initial set up of services needed after discharge, including but not limited to medical care, medication, durable medical equipment, identification and integration of community based LTSS programs;

c.a. Initial coordination of care, as appropriate with the Member's caregiver, other agencies and knowledgeable personnel, as well as ensuring the Member's care coordinator contact information for hospitals; and

d.a. Provision of information for making follow-up appointments.

3. CalOptima or a Health Network shall be responsible for ensuring that all Medically Necessary services are provided in a timely manner upon discharge, and that a Member's transition to the most appropriate level of care and community-based care occurs, from the Subacute Facility, that meets the Member's medical and social needs.

~~G.~~H. For supplemental rehabilitation therapy and ventilator weaning services for a pediatric Member in a Subacute Facility, the Subacute Facility must submit a separate authorization request to the LTSS Department.

~~H.~~I. A Member may elect to use their Share of Cost (SOC) funds to pay for necessary, Non-Covered Medical Services, or remedial care services, supplies, equipment and prescription drugs that are prescribed by a physician and part of the Plan of Care authorized by the Member's attending physician. The medical service is considered a non-covered benefit if one (1) of the following occurs:

1. The medical service is rendered by a non-Medi-Cal provider; or

2. The medical service does not meet Medical Necessity and results in a denial. The CalOptima ~~LTSS~~Utilization Management Department will issue the Notice of Action (NOA) to the Subacute Facility which includes information on a Member's appeal rights. The NOA shall remain valid until a change of Member's condition is apparent and the Subacute Facility has submitted a new request with additional medical documentation that substantiates Medical Necessity.

III. PROCEDURE

A. ~~New Admission: A Subacute Facility-Adult, or Subacute Facility-Pediatric,~~New admission for subacute facilities that are not assigned for regular onsite authorization reviews: The subacute Facility shall submit to the CalOptima LTSS Department the following within twenty-one (21) calendar days after a Member's admission:

1. Completed LTC ARF (Sections I through ~~IV~~V);

2. A copy of the online Preadmission Screening and Resident Review (PASRR) Level I Screening Document;

3. Medicare, Facility, or other insurance denial, if ~~appropriate~~applicable;

4. Minimum Data Set (MDS~~)~~), if available, and sufficient chart documentation to support the Medical Necessity for the level of care requested; and

5. Completed DHCS 6200-A form, Information for Authorization/ Reauthorization of Subacute Care Services – Adult Subacute Program, or the DHCS 6200 Form, Information for Authorization/ Reauthorization of Subacute Care Services – Pediatric Subacute Program.

B. For new admission at subacute facilities that are assigned for regular onsite authorization reviews, the subacute Facility shall:

1. Notify CalOptima's LTSS Department of initial admissions, through the submission of Member information on the 21-Day List via email, fax or US mail, within twenty-one (21) calendar days from the start date of CalOptima LTC coverage.

2. Prepare the documents listed in Section III.A. of this Policy for review by the CalOptima onsite medical case manager during the scheduled onsite review appointment.

~~B.~~C. Reauthorization~~: The Subacute Facility-Adult, or Subacute Facility-Pediatric,~~ for subacute facilities that are not assigned for regular onsite authorization reviews shall submit to the CalOptima LTC Authorization Unit:

1. A completed LTC ARF (Sections I, III [as applicable] and IV), which shall be submitted prior to the expiration of the active LTC ARF, and may be submitted up to thirty (30) calendar days prior to expiration of the active LTC ARF;

2. The DHCS 6200-A Form, or the DHCS 6200 Form, as appropriate;

3. A detailed summary of acute care hospitalizations for the Member during the previous authorization period; ~~and~~

4. Sufficient documentation to determine the level of care and justify a continued stay; and

~~4.~~5. A copy of the weekly physician progress notes covering the month prior to the LTC ARF submission.

D. For reauthorization at subacute facilities that are assigned for regular onsite authorization reviews, the subacute Facility shall:

1. Notify CalOptima's LTSS Department of initial admissions, through the submission of Member information on the 21-Day List via email, fax or US mail, at least twenty-four (24) hours prior to the expiration of the active authorization.

2. Prepare the documents listed in Section III.C. of this Policy for review by the CalOptima on-site medical case manager during the scheduled onsite review appointment.

E. If the CalOptima Medical Director, or authorized physician designee, denies or modifies the LTC ARF, the CalOptima LTSS Department shall notify the Facility and the Member, or Member's Authorized Representative in accordance with CalOptima Policy GG.1510: Appeals Process for Decisions Regarding Care and Services.

F. Upon the receipt of an ARF modification, or denial, the Subacute Facility may file an appeal, or complaint, in accordance with CalOptima Policy GG.1510: Appeals Process for Decisions Regarding Care and Services.

~~E.~~G. Pediatric Supplemental Rehabilitation Therapy and Ventilator Weaning Services

1. The Subacute Facility-Pediatric shall submit the initial authorization request to the CalOptima LTSS Department within ten (10) business days of the development of a treatment plan~~:~~.

2. For supplemental rehabilitation therapy, the Subacute Facility-Pediatric shall:

   a. Complete LTC ARF (Sections I through ~~IV~~V);

   b. Specify type, number, and frequency of direct therapy services to be performed by, or under the supervision of, the therapist;

   c. State the therapeutic goals of the services provided by each discipline and anticipated duration of treatment; and

d. Provide the attending physician's order and evaluation report.

3. For ventilator weaning, the Subacute Facility-Pediatric shall

a. Complete LTC ARF (Sections I through ~~IV~~V);

b. Clearly state "Ventilator Weaning;" and

c. Provide the attending physician's order and evaluation report.

~~F.~~H. If the LTC ARF and required documents are incomplete, the CalOptima LTSS Department shall ~~defer~~delay the approval process and return the incomplete LTC ARF and attachments to the ~~Subacute~~subacute Facility for review and resubmission ~~with~~ completed documentation, including any additional clinical documents. ~~CalOptima~~CalOptima's LTSS Department will ~~send~~verbally notify the ~~Subacute~~ Facility ~~a "NOA Delay" letter~~ within twenty-four (24) hours of decision to delay. The ~~Subacute~~subacute Facility shall resubmit the LTC ARF ~~within fourteen (~~before the end of 14~~)~~ calendar days after the submission of the initial LTC ARF or the LTC ARF shall be subject to denial~~.~~. When unable to make a decision, the CalOptima LTSS Department will document the need for additional information, what information is ~~needed~~needed, and that the subacute Facility will have fourteen (14) calendar days from the presentation of the ARF to provide the documents in the CalOptima Medical Record system.

I. If, within fourteen (14) calendar days after CalOptima's return of an incomplete LTC ARF and its attachments, the subacute Facility has not provided the additional requested documents, the subacute Facility staff can request a deferral to receive an additional fourteen (14) calendar days to collect the required documents. CalOptima will initiate the process with a written Integrated Denial Notice/Notice of Action Delay letter that will be faxed to the subacute Facility and mailed to the Member. After a total of twenty-eight (28) calendar days, CalOptima will make a decision based on the documentation provided.

J. For Medical Necessity determinations only, if CalOptima's LTSS Department is unable to approve the ARF due to insufficient documentation, the CalOptima LTSS Department shall submit the LTC ARF and accompanying documentation to the CalOptima Medical Director, or authorized physician designee, for review and determination.

1. If CalOptima's Medical Director, or physician designee, approves the LTC ARF, the CalOptima LTSS Department shall send an approval letter with the copy of the approved LTC ARF to the Facility.

2. If CalOptima's Medical Director, or physician designee, denies or modifies the LTC ARF, the CalOptima LTSS Department shall notify the Facility and the Member, or the Member's Authorized Representative in accordance with CalOptima Policies GG.1814: Appeals Process for Long-Term Care Facility Daily Rate Denial and GG.1508: Authorization and Processing of Referrals.

~~J.~~K. CalOptima LTSS shall provide Members and Providers with a written Integrated Denial Notice, or Notice of Action, as appropriate, for any decision to deny or modify a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested.

L. A Subacute Facility shall be responsible for:

1. Performing an eligibility verification each month for a CalOptima Member who is residing in the Subacute Facility;

2. Performing SOC clearance transactions when a CalOptima Member with an unmet SOC is admitted or SOC exceeds the total charges of the contracted rate for a given month's stay;

3. Billing CalOptima's Member for the entire SOC if CalOptima Member has not spent any of the SOC in the month's stay; and

4. Maintaining the physician's prescriptions for SOC expenditures in CalOptima's Member's medical record.

M. Discharge Planning:

1. ~~F.~~ CalOptima or a Health Network shall work with the subacute Facility to ensure the provision of a Member's medical needs, supports, and services throughout the post-discharge and transition to community-based care period. The discharge planning may include, but is not limited to:

   a. Documentation of pre-admission, or baseline, status;

   b. Initial set up of services needed after discharge, including but not limited to medical care, medication, durable medical equipment, identification and integration of community based LTSS programs;

   c. Initial coordination of care, as appropriate with the Member's caregiver, other agencies and knowledgeable personnel, as well as ensuring the Member's care coordinator contact information for hospitals; and

   d. Provision of information for making follow-up appointments.

2. A Subacute Facility may modify its care or discharge a Member if the Subacute Facility determines that the following specified circumstances are present:

   a. The Subacute Facility is no longer capable of meeting the Member's health needs; or

   b. The Member's condition has improved sufficiently so that the Member no longer needs Subacute Facility services; or

   c. The Member poses a risk to the health, or safety, of individuals in the Subacute Facility.

3. CalOptima or a Health Network shall be responsible to work with the subacute Facility to ensure that all Medically Necessary services are provided in a timely manner upon discharge, and that a Member's transition to the most appropriate level of care and community-based care occurs, from the Subacute Facility, that meets the Member's medical and social needs.

4. Upon notification by the Facility of the Member's discharge, the CalOptima LTSS Department shall close the active LTC ARF effective the day of discharge. The Facility shall notify CalOptima within one (1) business ~~days~~day of a Member's discharge by sending the Discharge Disposition Form to CalOptima LTSS Department and submit a completed Medi-Cal Long-~~-~~Term Care Facility Admission and Discharge Notification (MC 171 form) to the appropriate agency.

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IV. ATTACHMENT(S)

A. CalOptima Long-Term Care (LTC) Authorization Request Form (ARF)
B. Information for Authorization/ Reauthorization of Subacute Care Services – Adult Subacute Program (DHCS 6200-A)
C. Information for Authorization/ Reauthorization of Subacute Care Services – Pediatric Subacute Program (DHCS 6200)
D. Discharge Disposition Form

V. REFERENCE(S)

A. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal
B. CalOptima Three-Way Contract with the Department of Health Care Services (DHCS) and Centers for Medicare & Medicaid Services (CMS) for Cal MediConnect
~~B.~~C. CalOptima Long-Term Care Provider Resource Manual
D. CalOptima Policy CMC.6021a: Continuity of Care for New Members
E. CalOptima Policy EE.1135: Long-Term Care Facility Contracting
~~C.~~F. CalOptima Policy GG.1325: Continuity of Care for ~~Medi-Cal Beneficiaries Who Transition~~Members Transitioning into CalOptima Services
G. CalOptima Policy GG.1508: Authorization and Processing of Referrals
~~D.~~H. CalOptima Policy GG.1510: Appeals Process for Decisions Regarding Care and Services
~~E.~~I. CalOptima Policy GG.1800: Authorization Request Form (ARF) Process and Criteria for Admission to, Continued Stay in, Discharge from a Skilled Nursing Facility (SNF) and Intermediate Care Facility (ICF)
J. CalOptima Policy GG.1814: Appeals Process for Long-Term Care Facility Daily Rate Denial
~~F.~~K. CalOptima Policy GG.1825: Long-Term Care Facility Contracting
~~G.A. CalOptima Three-Way Contract with the Department of Health Care Services (DHCS) and Centers for Medicare & Medicaid Services (CMS) for Cal MediConnect~~
~~H.~~L. CalOptima Utilization Management Program
~~I.~~M. Department of Health Care Services (DHCS) All Plan Letter (APL) ~~17-006~~21-011: Grievance and Appeal Requirements and Revised Notice Templates and Your Rights
~~J.~~N. Department of Health Care Services (DHCS) Dual Plan Letter (DPL)16-003: Discharge Planning for Cal MediConnect
~~K.~~O. Manual of Criteria for Medi-Cal Authorization, Medi-Cal Policy Division
~~L.~~P. Medi-Cal Long-Term Care Provider Manual: Subacute Care Programs
~~M.~~Q. Title 22, California Code of Regulations (CCR), §§ 51003(e), 51118, 51120, 51120.5, 51121, 51124.5, ~~51124.6,~~ 51215.5, 51215.6, 51215.8, 51334, 51335, 51335.5 and 51335.6
~~N.~~R. Welfare and Institution Code, §§ 14103.6 and 14186.1(b~~)(1)-(4)~~ & (c)

VI. ~~VII.~~ REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency
05/26/2016	Department of Health Care Services

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	07/15/1998	GG.1803	ARF Process and Criteria for Admission to, Continued Stay in, or Discharge from a Subacute Facility-Adult/Pediatric	Medi-Cal
Revised	02/01/2007	GG.1803	ARF Process and Criteria for Admission to, Continued Stay in, or Discharge from a Subacute Facility-Adult/Pediatric	Medi-Cal
Revised	07/01/2015	GG.1803	ARF Process and Criteria for Admission to, Continued Stay in, or Discharge from a Subacute Facility-Adult/Pediatric	Medi-Cal
Revised	09/01/2015	GG.1803	Authorization Process and Criteria for Admission to, Continued Stay in, or Discharge from a Subacute Facility-Adult/Pediatric	Medi-Cal OneCare Connect
Revised	10/01/2016	GG.1803	Authorization Process and Criteria for Admission to, Continued Stay in, or Discharge from a Subacute Facility-Adult/Pediatric	Medi-Cal OneCare Connect
Revised	11/01/2017	GG.1803	Authorization Process and Criteria for Admission to, Continued Stay in, or Discharge from a Subacute Facility-Adult/Pediatric	Medi-Cal OneCare Connect
Revised	TBD	GG.1803	Authorization Process and Criteria for Admission to, Continued Stay in, or Discharge from a Subacute Facility-Adult/Pediatric	Medi-Cal OneCare Connect

IX. GLOSSARY

Term	Definition
21-Day List	A CalOptima Form. Long-Term Care Facilities designated for onsite authorization reviews will present all CalOptima Member requiring an LTC authorization monthly via the 21-Day List.
Authorized Representative	~~Has the meaning given to the term Personal Representative in section 164.502(g) of title 45 of, Code of Federal Regulations.~~ A person who has the authority under applicable law to make health care decisions on behalf of adults or emancipated minors, as well as parents, guardians or other persons acting in loco parentis who have the authority under applicable law to make health care decisions on behalf of unemancipated minors and as further described in CalOptima Policy HH.3009~~:~~ A: Access by a Member's Authorized Representative.
Facility	Long-~~ ~~Term Care (LTC) ~~facility~~Facility, including a Nursing Facility Level A (NF-A) [Intermediate Care Facility (ICF) or Subacute Facility] and Nursing Facility Level B (NF-B) [Skilled Nursing Facility (SNF).
Health Network	For purposes of this policy, a Physician Hospital Consortium (PHC), physician group under a shared risk contract, or health care service plan, such as a Health Maintenance Organization (HMO) that contracts with CalOptima to provide Covered Services to Members assigned to that Health Network.
Integrated Denial Notice	For the purposes of this policy, a written notice of action of denial, reduction, or modification of services requested by Members enrolled in CalOptima's OneCare Connect program, consistent with applicable regulatory and contract requirements.
Non-Covered Medical Services	Medical services rendered by a non-Medi-Cal provider; or Medical services in the following categories of services for which: 1. An authorization request must be submitted and approved before CalOptima will pay; or 2. An authorization request is not submitted, or an authorization request is submitted but is denied by CalOptima because the service is not considered ~~medically necessary.~~Medically Necessary.
Medically Necessary or Medical Necessity	Medi-Cal: Reasonable and necessary services to protect life, to prevent significant illness or significant disability, or to alleviate severe pain through the diagnosis or treatment of disease, illness, or injury. OneCare Connect: Necessary services to protect life, to prevent significant illness or significant disability, or to alleviate severe pain through the diagnosis or Treatment of disease, illness, or injury. Services must be provided in a way that provides all protections to the Enrollee provided by Medicare and Medi-Cal. Per Medicare, services must be reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body ~~member~~Member, or otherwise ~~medically necessary~~Medically Necessary under 42 U.S.C. § 1395y. In accordance with Title XIX law and related regulations, and per Medi-Cal, ~~medical necessity~~Medical Necessity means reasonable and necessary services to protect life, to prevent significant illness or significant disability, or to alleviate severe pain through the diagnosis or treatment of disease, illness, or injury under WIC Section 14059.5.
Member	A beneficiary of a CalOptima program.

Term	Definition
Notice of Action (NOA)	For the purposes of this policy, a written notice of action of denial, reduction, or modification of services requested by Members enrolled in the CalOptima Medi-Cal program, consistent with applicable regulatory and contract requirements.
Share of Cost	The amount of health care expenses that a recipient must pay for each month before he or she becomes eligible for Medi-Cal benefits. A recipient's Share of Cost is determined by the county Social Services Agency.
Subacute Facility-Adult	A health ~~facility~~Facility that meets the standards set forth in Title 22, Section 51215.5, as an identifiable unit of a SNF accommodating beds including contiguous rooms, a wing, a floor, or a building that is approved by the CDPH for such purpose and has been certified by the DHCS for participation in the Medi-Cal program.
Subacute Facility-Pediatric	A health ~~facility~~Facility that meets the standards set forth in Title 22, Section 51215.8, as an identifiable unit of a certified nursing ~~facility~~Facility licensed as a SNF meeting the standards for participation as a provider under the Medi-Cal program, accommodating beds including contiguous rooms, a wing, a floor, or a building that is approved by the DHCS for such purpose.

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Policy:	GG.1803
Title:	**Authorization Process and Criteria for Admission to, Continued Stay in, and Discharge from a Subacute Facility-Adult/Pediatric**
Department:	Medical Management
Section:	Long Term Services and Supports
CEO Approval:	*/s/*
Effective Date:	06/01/1998
Revised Date:	TBD
Applicable to:	☒ Medi-Cal ☐ OneCare ☒ OneCare Connect ☐ PACE ☐ Administrative

I. PURPOSE

This policy outlines the requirements for reviewing and processing a Long-Term Care (LTC) Authorization and the criteria for a Member's admission to, continued stay in, or discharge from a Subacute Facility-Adult, or Subacute Facility-Pediatric.

II. POLICY

A. The CalOptima Long-Term Services and Supports (LTSS) Department shall process all requests for admission to, continued stay in, or discharge from a Subacute Facility-Adult, or Subacute Facility-Pediatric, pursuant to the Title 22, California Code of Regulations, sections 51335.5 and 51335.6 and the California Department of Health Care Services (DHCS) standard criteria for subacute programs.

B. The initial and reauthorization requests shall be initiated by the subacute facilities. For initial LTC authorizations, a subacute Facility shall submit a completed Long-Term Care (LTC) Authorization Request Form (ARF) within twenty-one (21) calendar days from the start date of CalOptima LTC coverage along with all necessary supporting documentation to make a Medical Necessity determination. For re-authorizations of a continued stay, the subacute Facility shall also submit a completed LTC ARF along with all necessary documentation to justify continued stay at least twenty-four (24) hours prior to the expiration of the active authorization.

1. If a subacute Facility submits an LTC ARF after the required timeframe, but the LTC ARF meets the level of care requested, CalOptima shall subject the authorization to a fifteen percent (15%) payment reduction.

C. CalOptima may decide, at its discretion, to perform an onsite authorization review to make a Medical Necessity determination for an LTC ARF. This determination shall follow an in-person assessment of the Member and a thorough review of the medical orders, care plan, therapist treatment plan, the subacute Facility's multidisciplinary team notes, or other clinical data appropriate to support making the determination on the authorization request.

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1. If a subacute Facility is designated for regular onsite authorization reviews, the subacute Facility shall notify CalOptima's LTSS Department of initial admissions, through the submission of Member information on the 21-Day List via email, fax or US mail, within twenty-one (21) calendar days from the start date of CalOptima LTC coverage. For re-authorizations of a continued stay at a subacute Facility designated for regular onsite authorization reviews, the Facility shall also submit Member information on the 21-Day List at least twenty-four (24) hours prior to the expiration of the active LTC ARF. The completed LTC ARF and all necessary supporting documentation do not need to be sent to CalOptima LTSS Department at the same time as the submission of the 21-Day List. However, subacute facilities designated for regular onsite authorization reviews must have the completed ARF and all necessary supporting documentation ready for onsite review by the CalOptima Medical Case Manager on the day of the scheduled visit.

2. If a subacute Facility designated for regular onsite authorization reviews submits Member information on the 21-Day List after the required timeframe, but the LTC ARF meets the level of care requested, CalOptima shall subject the authorization to a fifteen percent (15%) payment reduction.

D. CalOptima's approval of a facility's authorization request is subject to the facility's being licensed by the California Department of Public Health (CDPH), meeting acceptable quality standards, and its agreement to CalOptima contracted rates, in accordance with CalOptima Policy EE.1135: Long-Term Care Facility Contracting.

E. CalOptima shall ensure that Members in need of nursing facility services are placed in a health care facility that provided the level of care most appropriate to the Member's medical needs. These health care facilities include Skilled Nursing Facilities, Subacute Facilities, Pediatric Subacute facilities, and Intermediate Care Facilities.

F. CalOptima shall ensure continuity of care for Members residing in a Subacute Facility-Adult, or Subacute Facility-Pediatric, in accordance with CalOptima Policies GG.1325: Continuity of Care for Members Transitioning into CalOptima Services and CMC.6021a: Continuity of Care for New Members.

G. CalOptima may grant the initial authorization and reauthorization requests for six (6) months at a time.

H. For supplemental rehabilitation therapy and ventilator weaning services for a pediatric Member in a Subacute Facility, the Subacute Facility must submit a separate authorization request to the LTSS Department.

I. A Member may elect to use their Share of Cost (SOC) funds to pay for necessary, Non-Covered Medical Services, or remedial care services, supplies, equipment and prescription drugs that are prescribed by a physician and part of the Plan of Care authorized by the Member's attending physician. The medical service is considered a non-covered benefit if one (1) of the following occurs:

1. The medical service is rendered by a non-Medi-Cal provider; or

2. The medical service does not meet Medical Necessity and results in a denial. The CalOptima Utilization Management Department will issue the Notice of Action (NOA) to the Subacute Facility which includes information on a Member's appeal rights. The NOA shall remain valid

until a change of Member's condition is apparent and the Subacute Facility has submitted a new request with additional medical documentation that substantiates Medical Necessity.

III. PROCEDURE

A. New admission for subacute facilities that are not assigned for regular onsite authorization reviews: The subacute Facility shall submit to the CalOptima LTSS Department the following within twenty-one (21) calendar days after a Member's admission:

1. Completed LTC ARF (Sections I through V);

2. A copy of the online Preadmission Screening and Resident Review (PASRR) Level I Screening Document;

3. Medicare, Facility, or other insurance denial, if applicable;

4. Minimum Data Set (MDS), if available, and sufficient chart documentation to support the Medical Necessity for the level of care requested; and

5. Completed DHCS 6200-A form, Information for Authorization/ Reauthorization of Subacute Care Services – Adult Subacute Program, or the DHCS 6200 Form, Information for Authorization/ Reauthorization of Subacute Care Services – Pediatric Subacute Program.

B. For new admission at subacute facilities that are assigned for regular onsite authorization reviews, the subacute Facility shall:

1. Notify CalOptima's LTSS Department of initial admissions, through the submission of Member information on the 21-Day List via email, fax or US mail, within twenty-one (21) calendar days from the start date of CalOptima LTC coverage.

2. Prepare the documents listed in Section III.A. of this Policy for review by the CalOptima onsite medical case manager during the scheduled onsite review appointment.

C. Reauthorization for subacute facilities that are not assigned for regular onsite authorization reviews shall submit to the CalOptima LTC Authorization Unit:

1. A completed LTC ARF (Sections I, III [as applicable] and IV), which shall be submitted prior to the expiration of the active LTC ARF, and may be submitted up to thirty (30) calendar days prior to expiration of the active LTC ARF;

2. The DHCS 6200-A Form, or the DHCS 6200 Form, as appropriate;

3. A detailed summary of acute care hospitalizations for the Member during the previous authorization period;

4. Sufficient documentation to determine the level of care and justify a continued stay; and

5. A copy of the weekly physician progress notes covering the month prior to the LTC ARF submission.

D. For reauthorization at subacute facilities that are assigned for regular onsite authorization reviews, the subacute Facility shall:

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1. Notify CalOptima's LTSS Department of initial admissions, through the submission of Member information on the 21-Day List via email, fax or US mail, at least twenty-four (24) hours prior to the expiration of the active authorization.

2. Prepare the documents listed in Section III.C. of this Policy for review by the CalOptima onsite medical case manager during the scheduled onsite review appointment.

E. If the CalOptima Medical Director, or authorized physician designee, denies or modifies the LTC ARF, the CalOptima LTSS Department shall notify the Facility and the Member, or Member's Authorized Representative in accordance with CalOptima Policy GG.1510: Appeals Process for Decisions Regarding Care and Services.

F. Upon the receipt of an ARF modification, or denial, the Subacute Facility may file an appeal, or complaint, in accordance with CalOptima Policy GG.1510: Appeals Process for Decisions Regarding Care and Services.

G. Pediatric Supplemental Rehabilitation Therapy and Ventilator Weaning Services

1. The Subacute Facility-Pediatric shall submit the initial authorization request to the CalOptima LTSS Department within ten (10) business days of the development of a treatment plan.

2. For supplemental rehabilitation therapy, the Subacute Facility-Pediatric shall:

a. Complete LTC ARF (Sections I through V);

b. Specify type, number, and frequency of direct therapy services to be performed by, or under the supervision of, the therapist;

c. State the therapeutic goals of the services provided by each discipline and anticipated duration of treatment; and

d. Provide the attending physician's order and evaluation report.

3. For ventilator weaning, the Subacute Facility-Pediatric shall

a. Complete LTC ARF (Sections I through V);

b. Clearly state "Ventilator Weaning;" and

c. Provide the attending physician's order and evaluation report.

H. If the LTC ARF and required documents are incomplete, the CalOptima LTSS Department shall delay the approval process and return the incomplete LTC ARF and attachments to the subacute Facility for review and resubmission completed documentation, including any additional clinical documents. CalOptima's LTSS Department will verbally notify the Facility within twenty-four (24) hours of decision to delay. The subacute Facility shall resubmit the LTC ARF before the end of 14 calendar days after the submission of the initial LTC ARF or the LTC ARF shall be subject to denial. When unable to make a decision, the CalOptima LTSS Department will document the need for additional information, what information is needed, and that the subacute Facility will have fourteen (14) calendar days from the presentation of the ARF to provide the documents in the CalOptima Medical Record system.

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I. If, within fourteen (14) calendar days after CalOptima's return of an incomplete LTC ARF and its attachments, the subacute Facility has not provided the additional requested documents, the subacute Facility staff can request a deferral to receive an additional fourteen (14) calendar days to collect the required documents. CalOptima will initiate the process with a written Integrated Denial Notice/Notice of Action Delay letter that will be faxed to the subacute Facility and mailed to the Member. After a total of twenty-eight (28) calendar days, CalOptima will make a decision based on the documentation provided.

J. For Medical Necessity determinations only, if CalOptima's LTSS Department is unable to approve the ARF due to insufficient documentation, the CalOptima LTSS Department shall submit the LTC ARF and accompanying documentation to the CalOptima Medical Director, or authorized physician designee, for review and determination.

1. If CalOptima's Medical Director, or physician designee, approves the LTC ARF, the CalOptima LTSS Department shall send an approval letter with the copy of the approved LTC ARF to the Facility.

2. If CalOptima's Medical Director, or physician designee, denies or modifies the LTC ARF, the CalOptima LTSS Department shall notify the Facility and the Member, or the Member's Authorized Representative in accordance with CalOptima Policies GG.1814: Appeals Process for Long-Term Care Facility Daily Rate Denial and GG.1508: Authorization and Processing of Referrals.

K. CalOptima LTSS shall provide Members and Providers with a written Integrated Denial Notice, or Notice of Action, as appropriate, for any decision to deny or modify a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested.

L. A Subacute Facility shall be responsible for:

1. Performing an eligibility verification each month for a CalOptima Member who is residing in the Subacute Facility;

2. Performing SOC clearance transactions when a CalOptima Member with an unmet SOC is admitted or SOC exceeds the total charges of the contracted rate for a given month's stay;

3. Billing CalOptima's Member for the entire SOC if CalOptima Member has not spent any of the SOC in the month's stay; and

4. Maintaining the physician's prescriptions for SOC expenditures in CalOptima's Member's medical record.

M. Discharge Planning:

1. CalOptima or a Health Network shall work with the subacute Facility to ensure the provision of a Member's medical needs, supports, and services throughout the post-discharge and transition to community-based care period. The discharge planning may include, but is not limited to:

a. Documentation of pre-admission, or baseline, status;

b. Initial set up of services needed after discharge, including but not limited to medical care, medication, durable medical equipment, identification and integration of community based LTSS programs;

c. Initial coordination of care, as appropriate with the Member's caregiver, other agencies and knowledgeable personnel, as well as ensuring the Member's care coordinator contact information for hospitals; and

d. Provision of information for making follow-up appointments.

2. A Subacute Facility may modify its care or discharge a Member if the Subacute Facility determines that the following specified circumstances are present:

a. The Subacute Facility is no longer capable of meeting the Member's health needs; or

b. The Member's condition has improved sufficiently so that the Member no longer needs Subacute Facility services; or

c. The Member poses a risk to the health, or safety, of individuals in the Subacute Facility.

3. CalOptima or a Health Network shall be responsible to work with the subacute Facility to ensure that all Medically Necessary services are provided in a timely manner upon discharge, and that a Member's transition to the most appropriate level of care and community-based care occurs, from the Subacute Facility, that meets the Member's medical and social needs.

4. Upon notification by the Facility of the Member's discharge, the CalOptima LTSS Department shall close the active LTC ARF effective the day of discharge. The Facility shall notify CalOptima within one (1) business day of a Member's discharge by sending the Discharge Disposition Form to CalOptima LTSS Department and submit a completed Medi-Cal Long-Term Care Facility Admission and Discharge Notification (MC 171 form) to the appropriate agency.

IV. ATTACHMENT(S)

A. CalOptima Long-Term Care (LTC) Authorization Request Form (ARF)
B. Information for Authorization/ Reauthorization of Subacute Care Services – Adult Subacute Program (DHCS 6200-A)
C. Information for Authorization/ Reauthorization of Subacute Care Services – Pediatric Subacute Program (DHCS 6200)
D. Discharge Disposition Form

V. REFERENCE(S)

A. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal
B. CalOptima Three-Way Contract with the Department of Health Care Services (DHCS) and Centers for Medicare & Medicaid Services (CMS) for Cal MediConnect
C. CalOptima Long-Term Care Provider Resource Manual
D. CalOptima Policy CMC.6021a: Continuity of Care for New Members
E. CalOptima Policy EE.1135: Long-Term Care Facility Contracting
F. CalOptima Policy GG.1325: Continuity of Care for Members Transitioning into CalOptima Services
G. CalOptima Policy GG.1508: Authorization and Processing of Referrals
H. CalOptima Policy GG.1510: Appeals Process for Decisions Regarding Care and Services
I. CalOptima Policy GG.1800: Authorization Request Form (ARF) Process and Criteria for Admission to, Continued Stay in, Discharge from a Skilled Nursing Facility (SNF) and Intermediate Care Facility (ICF)

J. CalOptima Policy GG.1814: Appeals Process for Long-Term Care Facility Daily Rate Denial
K. CalOptima Policy GG.1825: Long-Term Care Facility Contracting
L. CalOptima Utilization Management Program
M. Department of Health Care Services (DHCS) All Plan Letter (APL) 21-011: Grievance and Appeal Requirements and Revised Notice Templates and Your Rights
N. Department of Health Care Services (DHCS) Dual Plan Letter (DPL)16-003: Discharge Planning for Cal MediConnect
O. Manual of Criteria for Medi-Cal Authorization, Medi-Cal Policy Division
P. Medi-Cal Long-Term Care Provider Manual: Subacute Care Programs
Q. Title 22, California Code of Regulations (CCR), §§ 51003(e), 51118, 51120, 51120.5, 51121, 51124.5, 51124.6, 51215.5, 51215.6, 51215.8, 51334, 51335, 51335.5 and 51335.6
R. Welfare and Institution Code, §§ 14103.6 and 14186.1(b) & (c)

VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency
05/26/2016	Department of Health Care Services

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	07/15/1998	GG.1803	ARF Process and Criteria for Admission to, Continued Stay in, or Discharge from a Subacute Facility-Adult/Pediatric	Medi-Cal
Revised	02/01/2007	GG.1803	ARF Process and Criteria for Admission to, Continued Stay in, or Discharge from a Subacute Facility-Adult/Pediatric	Medi-Cal
Revised	07/01/2015	GG.1803	ARF Process and Criteria for Admission to, Continued Stay in, or Discharge from a Subacute Facility-Adult/Pediatric	Medi-Cal
Revised	09/01/2015	GG.1803	Authorization Process and Criteria for Admission to, Continued Stay in, or Discharge from a Subacute Facility-Adult/Pediatric	Medi-Cal OneCare Connect
Revised	10/01/2016	GG.1803	Authorization Process and Criteria for Admission to, Continued Stay in, or Discharge from a Subacute Facility-Adult/Pediatric	Medi-Cal OneCare Connect
Revised	11/01/2017	GG.1803	Authorization Process and Criteria for Admission to, Continued Stay in, or Discharge from a Subacute Facility-Adult/Pediatric	Medi-Cal OneCare Connect

Action	Date	Policy	Policy Title	Program(s)
Revised	TBD	GG.1803	Authorization Process and Criteria for Admission to, Continued Stay in, or Discharge from a Subacute Facility-Adult/Pediatric	Medi-Cal OneCare Connect

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IX. GLOSSARY

Term	Definition
21-Day List	A CalOptima Form. Long-Term Care Facilities designated for onsite authorization reviews will present all CalOptima Member requiring an LTC authorization monthly via the 21-Day List.
Authorized Representative	A person who has the authority under applicable law to make health care decisions on behalf of adults or emancipated minors, as well as parents, guardians or other persons acting in loco parentis who have the authority under applicable law to make health care decisions on behalf of unemancipated minors and as further described in CalOptima Policy HH.3009Δ: Access by a Member's Authorized Representative.
Facility	Long-Term Care (LTC) Facility, including a Nursing Facility Level A (NF-A) [Intermediate Care Facility (ICF) or Subacute Facility] and Nursing Facility Level B (NF-B) [Skilled Nursing Facility (SNF).
Health Network	For purposes of this policy, a Physician Hospital Consortium (PHC), physician group under a shared risk contract, or health care service plan, such as a Health Maintenance Organization (HMO) that contracts with CalOptima to provide Covered Services to Members assigned to that Health Network.
Integrated Denial Notice	For the purposes of this policy, a written notice of action of denial, reduction, or modification of services requested by Members enrolled in CalOptima's OneCare Connect program, consistent with applicable regulatory and contract requirements.
Non-Covered Medical Services	Medical services rendered by a non-Medi-Cal provider; or Medical services in the following categories of services for which: 1. An authorization request must be submitted and approved before CalOptima will pay; or 2. An authorization request is not submitted, or an authorization request is submitted but is denied by CalOptima because the service is not considered Medically Necessary.
Medically Necessary or Medical Necessity	Medi-Cal: Reasonable and necessary services to protect life, to prevent significant illness or significant disability, or to alleviate severe pain through the diagnosis or treatment of disease, illness, or injury. OneCare Connect: Necessary services to protect life, to prevent significant illness or significant disability, or to alleviate severe pain through the diagnosis or Treatment of disease, illness, or injury. Services must be provided in a way that provides all protections to the Enrollee provided by Medicare and Medi-Cal. Per Medicare, services must be reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body Member, or otherwise Medically Necessary under 42 U.S.C. § 1395y. In accordance with Title XIX law and related regulations, and per Medi-Cal, Medical Necessity means reasonable and necessary services to protect life, to prevent significant illness or significant disability, or to alleviate severe pain through the diagnosis or treatment of disease, illness, or injury under WIC Section 14059.5.
Member	A beneficiary of a CalOptima program.

Term	Definition
Notice of Action (NOA)	For the purposes of this policy, a written notice of action of denial, reduction, or modification of services requested by Members enrolled in the CalOptima Medi-Cal program, consistent with applicable regulatory and contract requirements.
Share of Cost	The amount of health care expenses that a recipient must pay for each month before he or she becomes eligible for Medi-Cal benefits. A recipient's Share of Cost is determined by the county Social Services Agency.
Subacute Facility-Adult	A health Facility that meets the standards set forth in Title 22, Section 51215.5, as an identifiable unit of a SNF accommodating beds including contiguous rooms, a wing, a floor, or a building that is approved by the CDPH for such purpose and has been certified by the DHCS for participation in the Medi-Cal program.
Subacute Facility-Pediatric	A health Facility that meets the standards set forth in Title 22, Section 51215.8, as an identifiable unit of a certified nursing Facility licensed as a SNF meeting the standards for participation as a provider under the Medi-Cal program, accommodating beds including contiguous rooms, a wing, a floor, or a building that is approved by the DHCS for such purpose.

CalOptima
A Public Agency
Better. Together.
P.O. Box 11045
Orange, CA 92856
Phone No. 714-246-8444
Fax No. 714-246-8843

For CalOptima Use Only	*For CalOptima Use Only*
REFERENCE NO:	**Status:** ☐ Approved as Requested ☐ Pending
	From: **To:**

Long-Term Care Authorization Request Form (Admissions)

☐ Initial ☐ Re-Authorization ☐ Retroactive Eligibility
☐ Bed Hold/Leave of Absence ☐ Retro-Authorization ☐ Treatment in Place (CCN only)

SECTION I

Bed Hold Start Date: _____ Bed Hold End Date: _____
Bed Hold Start Date: _____ Bed Hold End Date: _____

Date of Admission: **Dates of Service Requested:** **From:** **To:**

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

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

Mailing Address: _____ **City:** _____ **ZIP:** _____ **Phone:** _____

CIN#: _____ **Aid Code:** _____ **County Code:** _____

Facility Name:	**Physician Name:**
Facility Address: **City:** **ZIP:** **Phone:**	**Physician Address:** **City:** **ZIP:** **Phone:**
Fax Number:	**Fax Number:**
Medi-Cal Provider ID #/NPI:	**Physician Medi-Cal ID #:**
Former Facility: **Office Contact:**	**Physician Signature:**
Diagnosis:	**ICD - 10 Code:**

☐ SNF ☐ ICF ☐ ICFDD ☐ ICFDDN ☐ ICFDDH ☐ SUBACUTE-VENT ☐ SUBACUTE-NON-VENT

SECTION II Admitted From:
- ☐ Member's Home
- ☐ Household of Another
- ☐ Board & Care /Assisted Living
- ☐ Acute Hospital — Home, B&C Immediately prior to acute
- ☐ Acute Hospital — SNF/ICF Immediately prior to acute
- ☐ Another SNF/ICF

SECTION III

Date PASRR completed by NF: _____
Level II screening required: YES ☐ NO ☐
Date of referral: _____
Date Level II completed: _____
Pertinent Medications:

SECTION IV Patient's General Condition:
- ☐ Bedridden
- ☐ Ambulatory with Assistance
- ☐ Ambulatory
- ☐ Incontinent of B&B
- ☐ Confined to Wheelchair
- ☐ Maximum Assist with all ADLs

SECTION V

Community placement alternatives considered? YES ☐ NO ☐
If no, select all applicable boxes
- ☐ Community resources unavailable
- ☐ Due to, or change in medical, mental & physical functioning capability
- ☐ Caregiver unavailable
- ☐ Resident, conservator, or family choice
- ☐ Other

DO NOT WRITE BELOW THIS LINE **FOR CalOptima USE ONLY**

COMMENTS:

Signature: **Date:**

DEPARTMENT OF HEALTH CARE SERVICES
1501 Capitol Ave
P. O. BOX 997419
SACRAMENTO, CA 95899-7419
(916) 552-9110

INFORMATION FOR AUTHORIZATION/REAUTHORIZATION OF SUBACUTE CARE SERVICES—*ADULT SUBACUTE PROGRAM*

To expedite your request for authorization/reauthorization of SUBACUTE CARE SERVICES, it is **essential** that you complete the information below. Information may be in a narrative form or **readable** copies of records.

1. Name of beneficiary		2. Birthdate	3. Age
4. Diagnosis			
5. Medi-Cal Identification Number	6. Current level of care	Date of admission	
7. Name of current provider of above level of care			
Address (number, street)	City	State	ZIP Code
8. Family name		Telephone ( )	
Address (number, street)	City	State	ZIP Code

YES NO

9. Criteria to be met to qualify for SUBACUTE CARE SERVICES:

a. Patient's condition warrants 24-hour access to nursing care by a registered nurse; **and**, ☐ ☐
please summarize care requirements each shift: _____

b. **One** of the following (1), (2), (3):

(1) Patient has a tracheostomy and requires mechanical ventilation at least 50 percent of the day. ☐ ☐

(2) Patient has a tracheostomy and requires suctioning and room air mist or oxygen **and** one of the treatment procedures listed below (check all that apply). ☐ ☐

- ☐ (a) Total Parenteral Nutrition (TPN)
- ☐ (b) Inpatient physical, occupational, and/or speech therapy at least two hours per day, five days per week.
- ☐ (c) Tube feeding (nasogastric or gastrostomy). State frequency/rate: _____
- ☐ (d) Inhalation/respiratory therapy treatments at least 4 times per 24-hour period (not self administered by resident).
- ☐ (e) Continuous or intermittent intravenous (IV) therapy (via peripheral or central line).
  Why is the patient receiving IV therapy? (Include fluid rate and frequency.) _____
- ☐ (f) Wound debridement, packing, and medicated irrigation with/without whirlpool therapy.
  Please explain: _____

(3) Administration of any three of the treatment procedures in b (2) (a) through (f) above. Please check all that apply. ☐ ☐

c. What is the beneficiary's potential for discharge from the subacute care unit to a lower level of care (skilled nursing facility or home)? Please attach a copy of the notes from the most recent discharge planning conference.

d. For **reauthorization** of subacute care services, please provide (a) a detailed summary of acute care hospitalizations for this beneficiary during the previous authorization period; **and** (b) a copy of weekly medical doctor progress notes covering the month prior to TAR submission.

e. Additional comments by the provider (if desired) to support *medical necessity* for the provision of subacute care services (continue on reverse side if necessary/attach appropriate documentation):

10. Authorized signature	11. Date

DHCS 6200 A (07/09)

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INFORMATION FOR AUTHORIZATION/REAUTHORIZATION OF SUBACUTE CARE SERVICES

Effective immediately, providers of subacute care services will submit the attached form (adult or pediatric as per contract) with the Treatment Authorization Request (TAR) to the local Medi-Cal field office when requesting authorization of subacute care services. Unless requested to do so, the provider is requested not to submit any additional documentation with the TAR. If the local Medi-Cal field office requires additional information, the provider will be contacted. Please note that although the Department is not requesting a copy of the Minimum Data Set (MDS) with the TAR, federal regulations require that the provider continue to complete the MDS and place in the resident's charts. To facilitate the completion of this form, please refer to the following:

1. **Name of beneficiary:** Last name, first name, middle name or initial.

2. **DOB:** Please provide complete date, including month, day, and year.

3. **Age:** For residents under 21, please include years and months.

4. **Diagnosis:** Please provide primary medical diagnosis and any applicable secondary diagnosis.

5. **Medi-Cal Identification Number:** Please provide Medi-Cal Identification Number.

Please note: All of the above (1-5) should be the same as on the face of the TAR.

6. **Current level of care:** State at what level of care the resident is currently residing (home, acute, skilled nursing facility, subacute); include the **date of admission** to the present level of care.

7. **Name and location of current provider of above level of care:** Refer to number 6 above.

8. **Family name, address, and telephone number:** Please provide information of family members that can be notified if needed.

9. **Criteria to be met to qualify for SUBACUTE CARE SERVICES:** per Title 22, Sections 51124.5, 51124.6, 51215.5, 51215.6, 51215.8, 51511.5, and 51511.6.

a–b. (4): Answer YES or NO as appropriate and supply requested information. Please be complete but brief.

c. **Potential for discharge:** Briefly state the resident's eventual ability to be discharged. If this is the initial admission to the subacute facility, an educated guess may be all that is possible until further assessment is completed. Please state that. Please attach a copy of the notes from the most recent discharge planning conference regardless of resident's current level of care (may be none if resident is coming from home).

d. **Reauthorizations:** Complete this only if this is a ***reauthorization*** for subacute services at the same facility. The summary of acute hospitalizations covers any time the resident was transferred to an acute facility for *any* length of time for *any* reason (elective admissions included).

e. **Additional comments:** This is an option for the provider. If it is felt that the resident's condition may be borderline in meeting subacute criteria, please provide additional supporting documentation that may assist the field office in authorizing the services requested.

10. **Authorized signature:** Anyone who is authorized to sign for the facility may sign here. The Department recommends that the form be completed by and signed by the resident's physician or case manager if possible.

11. **Date:** All authorization forms must be dated at the time of the signature.

DEPARTMENT OF HEALTH CARE SERVICES
1501 Capitol Ave
P. O. BOX 997419
SACRAMENTO, CA 95899-7419
(916) 552-9110

INFORMATION FOR AUTHORIZATION/REAUTHORIZATION OF SUBACUTE CARE SERVICES—*PEDIATRIC SUBACUTE PROGRAM*

❒ Initial ❒ Reauthorization ❒ Transfer

Information may be in a narrative form or **readable** copies of records.

1. Name of beneficiary		2. Birthdate	3. Age
4.Primary Diagnosis (and any secondary diagnoses pertinent to the level of care)			
5. Medi-Cal Identification Number	6. Current level of care	Date of admission	
7. Name of current provider of above level of care			
Address (number, street)	City	State	ZIP Code
8. Family name		Telephone ( )	
Address (number, street)	City	State	ZIP Code

	YES	NO
9. Criteria to be met to qualify for PEDIATRIC SUBACUTE CARE SERVICES:		
a. Patient's condition warrants 24-hour access to nursing care by a registered nurse and is under 21 years of age; and	❒	❒
b. One of the following (1), (2), (3), (4), or (5):		
(1) Patient has a tracheostomy and requires mechanical ventilation at least six hours per day.	❒	❒
(2) Patient has a tracheostomy and requires suctioning at least every six hours and room air mist or oxygen; **and**	❒	❒
one of the treatment procedures listed below (check all that apply).		
❒ (a) Continuous or intermittent intravenous (IV) therapy (via peripheral or central line).		
Why is the patient receiving IV therapy? (Include fluid rate and frequency.) _____		
_____		
❒ (b) Peritoneal dialysis treatments requiring at least 4 exchanges every 24 hours.		
❒ (c) Tube feeding (nasogastric or gastrostomy). State frequency/rate: _____		
❒ (d) Other daily medical technologies required continuously which, in the opinion of the attending physician and the Medi-Cal consultant, require the services of a professional nurse.		
Please summarize care requirements each shift: _____		
_____		
❒ (e) Dependence on biphasic positive airway pressure at least six hours a day, including assessment or intervention every three hours, where the patient lacks either the cognitive or physical ability to protect their airway.		
(3) Dependence on total parenteral nutrition (TPN) or other intravenous nutritional support; **and** one of the treatment procedures listed above in (2) (a) through (e); including (f) below (check all that apply).	❒	❒
❒ (f) Intermittent suctioning (nontracheostomy) at least every eight hours, **and** room air mist or oxygen.		
(4) Dependence on skilled nursing care in the administration of any three of the treatment procedures in a (2) (a) through (e), including (3) (f) listed above. Please check all that apply.	❒	❒
(5) Dependence on biphasic positive airway pressure or continuous positive airway pressure at least six hours a day, including assessment or intervention every three hours and lacking either cognitive or physical ability of the patient to protect his or her airway and dependence on one of the five treatment procedures specified in a (2) (a) through (e), including (3) (f) above.	❒	❒

b. What is the beneficiary's potential for discharge from the subacute care unit to a lower level of care (skilled nursing facility or home)? Please attach a copy of the notes from the most recent discharge planning conference.

_____

c. For **reauthorization** of subacute care services, please provide (a) a detailed summary of acute care hospitalizations for this beneficiary during the previous authorization period; **and** (b) a copy of weekly medical doctor progress notes covering the month prior to TAR submission.

d. Additional comments by the provider (if desired) to support *medical necessity* for the provision of subacute care services (continue on reverse side if necessary/attach appropriate documentation):

_____

10. Authorized signature	11. Date

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INFORMATION FOR AUTHORIZATION/REAUTHORIZATION OF SUBACUTE CARE SERVICES—PEDIATRIC SUBACUTE PROGRAM

Effective immediately, providers of subacute care services will submit the attached form (adult or pediatric as per contract) with the Treatment Authorization Request (TAR) to Medi-Cal TAR Processing Center when requesting authorization of subacute care services. Unless requested to do so, the provider is requested not to submit any additional documentation with the TAR. If the Medi-Cal field office requires additional information, the provider will be contacted. Please note that although the Department is not requesting a copy of the Minimum Data Set (MDS) with the TAR, Federal regulations require that the provider continue to complete the MDS and place in the resident's charts.

Please indicate in one of the boxes under the title if this is an initial TAR for subacute care, a reauthorization for subacute care, or the patient is being transferred from another facility or home.

To facilitate the completion of this form, please refer to the following:

1. **Name of beneficiary:** Last name, first name, middle name or initial.

2. **DOB:** Please provide complete date, including month, day, and year.

3. **Age:** For residents under 21, please include years and months.

4. **Diagnosis:** Please provide primary medical diagnosis and any applicable secondary diagnosis.

5. **Medi-Cal Identification number:** Please provide Medi-Cal Identification Number.

Please note: All of the above (1-5) should be the same as on the face of the TAR.

6. **Current level of care:** State at what level of care the resident is currently residing (home, acute, skilled nursing facility, subacute); include the **date of admission** to the present level of care.

7. **Name and location of current provider of above level of care:** Refer to number 6 above.

8. **Family name, address, and telephone number:** Please provide information of family members that can be notified if needed.

9. **Criteria to be met to qualify for SUBACUTE CARE SERVICES:** Welfare & Institutions Code 14132.25; Title 22, Sections 51124.5, 51124.6, 51215.5, 51215.6, 51215.8, 51511.5, and 51511.6.

   a. (1) – (5) : Answer YES or NO as appropriate and supply requested information. Please be complete but brief.

   b. **Potential for discharge:** Briefly state the resident's eventual ability to be discharged. If this is the initial admission to the subacute facility, an educated guess may be all that is possible until further assessment is completed. Please state that. Please attach a copy of the notes from the most recent discharge planning conference regardless of resident's current level of care (may be none if resident is coming from home).

   c. **Reauthorizations:** Complete this only if this is a *reauthorization* for subacute services at the same facility. The summary of acute hospitalizations covers any time the resident was transferred to an acute facility for *any* length of time for *any* reason (elective admissions included).

   d. **Additional comments:** This is an option for the provider. If it is felt that the resident's condition may be borderline in meeting subacute criteria, please provide additional supporting documentation that may assist the field office in authorizing the services requested.

10. **Authorized signature:** Anyone who is authorized to sign for the facility may sign here. The Department recommends that the form be completed by and signed by the resident's physician or case manager if possible.

11. **Date:** All authorization forms must be dated at the time of the signature.

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Long-Term Services & Supports (LTSS)
Long-Term Care (LTC)
Phone: 714-246-8444
Fax: 714-246-8843

CalOptima
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Discharge Disposition Form

Nursing Facility Name			
Member Information	First Name:	Last Name:	
Admission Date:		Discharge/Expired Date:	☐ Expired?
Client Identification Number (CIN):		Date of Birth:	
Address: (Discharge Destination)			Phone Number:
Name of Physician(s):		LTC Authorization Number:	
Discharge Diagnoses	ICD-10 Code:	Description:	

IF EXPIRED, STOP HERE.

Discharge Plan

Most Recent Interdisciplinary Care Team (ICT) Meeting Date:			
Discharge Plan:			
Facility or Family Address Where Discharged:			
Selected Community PCP:	First Name:	Last Name:	
Phone:		NPI/PID from Provider Directory:	
Address:			

Discharge Reason/ Disposition (check all that apply)

- ☐ Discharged to acute hospital/higher level of care
- ☐ Discharged to another SNF/ICF/SA
- ☐ Discharged to residence/home of another
- ☐ Discharged to board and care
- ☐ Discharged to motel
- ☐ Ineligible with CalOptima
- ☐ Left Against Medical Advice (AMA)
- ☐ No longer needs nursing facility services
- ☐ Poses risk to the health or safety of individuals in the nursing facility
- ☐ Other (specify):

Nursing Facility Offered Member Home- and Community-Based Services (HCBS) (check all that apply)

- ☐ 2-1-1 Orange County
- ☐ Aging & Disability Resource Connection
- ☐ AIDS Services Foundation
- ☐ Alzheimer's Association
- ☐ Assisted Living
- ☐ Board and Care Facility
- ☐ Case Management (CM) Program
- ☐ Community-Based Adult Services (CBAS)
- ☐ Community Care Transition (CCT)
- ☐ Dental
- ☐ Food Stamps
- ☐ Genetically Handicapped Person's Program (GHPP)
- ☐ Hemophilia Program
- ☐ Health Insurance Counseling & Advocacy Program (HICAP)
- ☐ Hospice
- ☐ Independent Living System
- ☐ In-Home Operations
- ☐ In-Home Supportive Services (IHSS)
- ☐ Legal Aid Society
- ☐ Meals on Wheels/Food Resource
- ☐ Multipurpose Senior Services Program (MSSP)
- ☐ Orange County Housing
- ☐ Program of All-Inclusive Care for the Elderly (PACE)
- ☐ Regional Center of Orange County
- ☐ Shelter
- ☐ Transportation
- ☐ Waiver Program
- ☐ Other (specify):

Print Member/Representative Party Name:	Post Discharge Phone No.:
Facility Representative Signature:	Date:

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken June 2, 2022
Regular Meeting of the CalOptima Board of Directors

Consent Calendar
9. Approve Proposed Changes to the CalAIM Community Supports Policy

Contact
Kelly Giardina, MSG, CCM, Executive Director, Clinical Operations, (657) 900-1013

Recommended Action
Approve proposed changes to GG.1355 CalAIM Community Supports policy.

Background
Following the initial January 1, 2022, implementation of Enhanced Care Management (ECM) and Community Supports, CalOptima is updating the CalAIM Community Supports policy to reflect the following non-material changes:

- Extend Community Supports services to all members who meet the eligibility criteria, including dually eligible members.
- Remove specific policy numbers that cross over multiple lines of business as CalOptima Community Supports will follow all appropriate CalOptima policies and procedures.
- Update glossary terms.

Discussion
CalOptima revised GG.1355 CalAIM Community Supports policy to reflect new guidance from DHCS. This policy was previously approved by the Board of Directors on March 3, 2022. The table below outlines the changes to the policy.

Policy Section	Proposed Changes and Rationale
Page 2, Section II, H.	**Add language to ensure all appropriate coverage for community supports:** CalOptima shall provide Community Support Services for all members who meet the eligibility criteria.
Page 3, Section II, R and Page 7, Section III.G.1.e.	**Remove actual policy numbers**: • CalOptima will follow the grievance and appeals procedures in accordance with all appropriate CalOptima policies and procedures. • CalOptima will follow all appropriate cultural and linguistic services policies.
Section IX. Glossary, pages 20-24	**Update the following definitions to include OneCare and OneCare Connect programs:** • Appeals • Centers for Medicare & Medicaid Services (CMS) • Covered Services • Enhanced Care Management (ECM) Provider • Medically Necessary or Medical Necessity

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Policy Section	Proposed Changes and Rationale
	• Provider

These modifications to GG.1355 CalAIM Community Supports policy ensure that CalOptima follows DHCS guidance for Community Supports and all CalOptima regulatory, contractual, and operational guidelines.

Fiscal Impact

The recommended action to modify CalOptima Policy GG.1355 is operational in nature and has no additional fiscal impact beyond what was incorporated in the proposed CalOptima Fiscal Year 2022-23 Operating Budget.

Rationale for Recommendation

The recommended actions will ensure CalOptima is compliant with contractual and regulatory guidance provided by its regulators (e.g., Department of Health Care Services and Centers for Medicare & Medicaid Services). The updated policy will supersede the prior versions.

Concurrence

Troy R. Szabo, Outside General Counsel, Kennaday Leavitt

Attachments

1. CalOptima Policy GG.1355 Community Supports
2. DHCS Contract Template Provisions
3. DHCS Community Supports Policy Guide (April 2022)
4. California Advancing & Innovating Medi-Cal Proposal
5. 2022-B Final Draft for Community Supports Contract Language

Board Actions

Board Meeting Dates	Action	Not to Exceed Amount
December 20, 2021	CalOptima Board Action previously approved Medical Affairs policies: GG.1353, GG.1354, GG.1355, GG.1356	N/A
June 3, 2021	CalOptima Board Action Approving CalOptima's California Advancing and Innovating Medi-Cal (CalAIM) Model of Care Approach	

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Board Meeting Dates	Action	Not to Exceed Amount
August 5, 2021	CalOptima Board Action Authorizing a Contract with and Funding of a Consultant to Perform Readiness Assessment Activities Related to the California and Innovating Medi-Cal (CalAIM) Initiative	$200,000
October 7, 2021	CalOptima Board Action 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 Addition of Covered Aid Codes	N/A

/s/ Michael Hunn *05/27/2022*
Authorized Signature **Date**

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Policy:	GG.1355
Title:	**Community Supports**
Department:	Medical Management
Section:	Case Management
CEO Approval:	*/s/*
Effective Date:	01/01/2022
Revised Date:	TBD
Applicable to:	☒ Medi-Cal ~~☐~~☒ OneCare ~~☐~~☒ OneCare Connect ☐ PACE ☐ Administrative

I. PURPOSE

This Policy describes the eligibility criteria for CalOptima Community Supports and identifies the requirements for the referral, authorization, and provision of CalOptima Community Supports under the California Advancing and Innovating Medi-Cal (CalAIM) initiative.

II. POLICY

A. Community Supports are medically appropriate, cost-effective alternatives provided as a substitute to services covered under the California Medicaid State Plan and are delivered by a different Provider or in a different setting than those described in the State Plan. These services shall not reduce or jeopardize Member access to State Plan services.

B. Community Supports can only be covered if the State determines they are medically appropriate and cost-effective alternatives and are identified and authorized in CalOptima's Medi-Cal Contract with the Department of Health Care Services (DHCS).

C. A Member's participation in CalOptima Community Supports is optional; CalOptima shall not require a Member to use CalOptima Community Supports.

D. CalOptima shall ensure the underlying State Plan Covered Services are made available to the Member, if Medically Necessary for the Member, or if the Member declines CalOptima Community Supports.

E. CalOptima shall provide public notice of any limitations on Community Supports when an alternative approach involving narrowing eligible populations, including specifying such limitations in the Member Handbook/Evidence of Coverage and website, in addition to receiving written approval from DHCS.

~~E.~~F. To the extent a Member is receiving care or case management, CalOptima Community Supports should be integrated with care or case management, including Enhanced Care Management (ECM) when appropriate.

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~~F.~~G. CalOptima may delegate CalOptima Community Supports to Kaiser Foundation Health Plan (Kaiser), in accordance with the CalOptima Contract for Health Care Services and the Delegation Agreement.

H. CalOptima shall provide Community Support Services for Members who meet the eligibility criteria as defined in Attachment B of this Policy.

~~G.~~I. Effective no sooner than January 1, 2022, CalOptima shall offer four (4) selected DHCS-approved CalOptima Community Supports, listed below and further defined in Attachment A of this Policy.

1. Housing Transition Navigation Services;
2. Housing Deposits;
3. Housing Tenancy and Sustaining Services; and
4. Recuperative Care (Medical Respite).

J. In the event that CalOptima ~~may offer additional~~ expands Community Supports ~~from the~~, the following services listed below may be considered and are further defined in Attachment A of this Policy.

1. Short-Term Post-Hospitalization Housing;
2. Medically-Tailored meals;
3. Sobering Centers;
4. Personal Care/Homemaker Services; and
5. Day Habilitation Program
6. Respite Services;
7. Nursing Facility Transition/Diversion to Assisted Living Facilities (Elderly and Adult Residential Facilities);
8. Community Transition Services/Nursing Facility Transition to a Home;
9. Environmental Accessibility Adaptions (Modifications); and
10. Asthma Remediation.

~~H.~~K. CalOptima will notify DHCS ~~approved list every~~ six (6) months ~~upon notice and~~prior to implementation of any additional community support offering and include submission of an updated CalAIM Model of Care to DHCS.

~~I.~~L. CalOptima shall provide CalOptima Community Supports training and technical assistance to Community Supports Providers, through in-person sessions, webinars, and/or telephone calls, as necessary and in accordance with CalOptima Policy EE.1103Δ: Provider Education and Training and Section III.C. of this Policy.

~~J.~~M. A Community Supports Provider shall not receive payment from CalOptima for the provision of any CalOptima Community Supports not authorized by CalOptima or a Health Network.

~~K.~~N. To be eligible for participation in CalOptima Community Supports, a Member must meet the DHCS-specific requirements for the CalOptima Community Supports under consideration, as described in Attachment B of this Policy.

O. CalOptima or a Health Network shall accept referrals for CalOptima Community Supports from Providers, other community-based entities, Members and/or family members.

P. CalOptima or the Health Network shall use systems and processes capable of tracking CalOptima Community Supports referrals, access to CalOptima Community Supports, and Grievances and Appeals.

1. CalOptima or the Health Network shall track CalOptima Community Supports referrals and will support Community Supports Provider access to systems and processes allowing them to track and manage referral and Member information.

Q. CalOptima shall regularly monitor and provide oversight of Community Supports Providers to ensure compliance with regulatory, contractual, and business requirements as described in Section III.M. of this Policy.

R. A Community Supports Provider or Member, as applicable, shall be entitled to Grievance and Appeals procedures in accordance with CalOptima Policies ~~GG.1510: Appeal Process, HH.1101: CalOptima Provider Complaint, and HH.1102: Member Grievance.~~.

S. CalOptima Community Supports are subject to the State Fair Hearings process, in accordance with CalOptima Policy HH.1108: State Hearing Process and Procedures.

III. PROCEDURE

A. Informing Members and Providers

1. CalOptima shall inform Members and Providers about current and newly added CalOptima-offered Community Supports and the referral process, including how to submit the CalOptima Community Supports request through:

a. Member communication such as the Member Handbook, CalOptima website, Member Orientation meetings, and communication with CalOptima representatives (e.g., Customer Service staff, case managers); and

b. Provider communication including but not limited to the CalOptima website (www.caloptima.org), CalOptima Provider Manual, CalOptima Policies and Procedures, CalOptima Community Announcement, other educational materials, as well as through community events and other regularly scheduled CalOptima stakeholder forums.

2. CalOptima may discontinue a specific CalOptima Community Supports annually, with notice to DHCS, at the end of the calendar year, except in cases where the CalOptima Community Supports is terminated due to Member health, safety, or welfare concerns.

a. CalOptima shall ensure CalOptima Community Supports that were authorized for a Member prior to the discontinuation of that specific CalOptima Community Supports are

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not disrupted by a change in CalOptima Community Supports offerings, either by completing the authorized services or by seamlessly transitioning the Member into other Medically Necessary services or programs that meet their needs.

b. CalOptima shall publicize the service end date and provide at least ninety (90) calendar days' notice to Members. Notice to Members affected by a decision to discontinue a specific CalOptima Community Supports shall include:

i. The change and timing of discontinuation; and

ii. The procedures that will be used to ensure completion of the authorized CalOptima Community Supports or a transition into other Medically Necessary services;

c. CalOptima shall implement a plan for continuity of care for Members receiving the discontinued CalOptima Community Supports.

B. Provider Medi-Cal Enrollment and Credentialing or CalOptima's Vetting Process

1. If a State level enrollment pathway exists for the Community Supports Provider, CalOptima shall verify that the Community Supports Provider is enrolled in Medi-Cal, pursuant to relevant DHCS All Plan Letters (APLs), including APL 19-004: Provider Credentialing/Recredentialing and Screening/Enrollment. CalOptima shall also credential the Community Supports Provider in accordance with CalOptima Policies GG.1650Δ: Credentialing and Recredentialing of Practitioners and GG.1651Δ: Assessment and Re-Assessment of Organizational Providers, as applicable.

2. If no Medi-Cal/Medicaid enrollment pathway exists, CalOptima shall verify the qualifications of the Provider or provider organization to ensure they meet the standards and capabilities to be a Community Supports Provider in accordance with CalOptima Policies GG.1619: Delegation Oversight and HH.2021Δ: Exclusion and Preclusion Monitoring. CalOptima shall also consider the following factors as part of CalOptima's process for vetting the qualifications and experience of Community Supports Providers:

a. Ability to receive referrals from CalOptima and Health Networks for the authorized CalOptima Community Supports service;

b. Sufficient experience to provide services similar to the specific CalOptima Community Supports they are contracted to provide within the service area;

c. Ability to submit claims or invoices for CalOptima Community Supports using standardized protocols;

d. Business licensing that meets industry standards;

e. Capability to comply with all reporting and oversight requirements;

f. History of fraud, waste, and/or abuse;

g. Recent history of criminal activity, including a history of criminal activities that endanger Members and/or their families; and

h. History of liability claims against the Community Supports Provider.

C. Provider Training

1. In addition to network Provider training requirements described in CalOptima's Medi-Cal Contract with DHCS, CalOptima will provide the CalOptima Community Supports training described below to Community Supports Providers, including through in-person sessions, webinars, and/or calls, as necessary:

   a. CalOptima Community Supports program overview, Community Supports Provider role, community resources and referrals, as well as operational and topic-specific trainings.

   b. Special populations, Social Determinants of Health, trauma-informed care, health literacy, data-sharing and reporting requirements will also be covered.

D. Identifying Members and Receiving Requests for CalOptima Community Supports

1. CalOptima and the Health Networks shall identify Members who will benefit from one or more CalOptima Community Supports by:

   a. Working with ECM Providers to identify Members receiving ECM who could benefit from CalOptima Community Supports;

   b. Proactively identifying Members who may benefit from the CalOptima Community Supports through review of available data indicating a Member meets specific eligibility criteria, as described in Attachment B of this Policy;

   c. Accepting CalOptima Community Supports requests from Providers and other community-based entities; and

   d. Accepting CalOptima Community Supports requests from a Member, family member, guardian, caregiver, and/or authorized support person.

2. CalOptima shall refer Members to a Community Supports Provider within two (2) business days of issuing authorization for the service.

3. CalOptima shall provide Medically Necessary Covered Services regardless of whether the Member has been offered a Community Support, is currently receiving a Community Support, or has received a Community Support in the past.

~~3.~~4. If a Community Supports Provider capacity is limited, CalOptima or a Health Network shall prioritize the initiation of CalOptima Community Supports to Members who:

   a. Meet all CalOptima Community Supports criteria; and

   b. Demonstrate a high level of commitment to participating in services.

E. Authorization of CalOptima Community Supports is required prior to the initiation of services.

1. CalOptima shall ensure timely processing of expedited and routine CalOptima Community Supports authorization requests in accordance with CalOptima Policies GG.1500: Authorization Instructions for CalOptima Direct and CalOptima Community Network Providers and GG.1508: Authorization and Processing of Referrals.

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a. An authorization request for CalOptima Community Supports may be expedited when a specific, time-limited indication for the service requested exists and is a critical component of appropriate delivery of the CalOptima Community Supports.

i. Recuperative Care Providers may issue a presumptive authorization for Recuperative Care services to a CalOptima or Health Network Member who meets the established criteria defined in Section III.I.4.b. of this Policy, Attachment B of this Policy, and when delay of an authorization would be harmful to the Member.

2. For Members transitioning from other Medi-Cal Managed Care Plans (MCPs) previously identified and receiving Community Supports, CalOptima shall:

a. Authorize the Member for Community Supports upon:

i. A direct request from the Member, the Member's family, or authorized representative to include an attestation from the Member.

ii. Review of Encounter data demonstrating utilization of available Community Supports in previous ninety (90) days.

b. Outreach to the Member, the Member's previous MCP, and/or the Community Supports provider, as appropriate to mitigate gaps in care.

i. Members will be reassessed based on the following discontinuation criteria:

1) Member states they no longer wish to receive the service;

2) Provider is unable to reach Member after multiple attempts;

3) Member no longer requires the service or has completed service goals; or

4) Member is unresponsive or unwilling to engage with the Community Supports provider. This can include instances when a Member's behavior or environment is unsafe for the Community Supports Provider.

c. CalOptima shall not authorize Community Supports for a Member who transitions from another MCP when the Community Support service is only available once in a Member's lifetime and/or if CalOptima does not provide the Community Support service which the Member had received from the Member's prior MCP.

~~2.~~3. CalOptima shall notify the requestor of CalOptima's decision regarding CalOptima Community Supports service authorization in accordance with CalOptima Policy GG.1507: Notification Requirements for Covered Services Requiring Prior Authorization.

~~3.~~4. CalOptima shall monitor and evaluate CalOptima Community Supports authorizations to ensure they are equitable and non-discriminatory in accordance with Section III.M. of this Policy.

F. Sharing Information with Community Supports Providers

1. As part of the referral process to Community Supports Providers and consistent with federal, State, and, if applicable, local privacy and confidentiality laws, CalOptima shall ensure a Community Supports Provider has access to:

    a. Demographic and administrative information confirming the Member's eligibility and authorization for the requested service;

    b. Appropriate administrative, clinical, and social service information the Community Supports Provider may need to effectively provide the requested service; and

    c. Billing information necessary to enable the Community Supports Provider to submit claims or invoices to CalOptima.

2. CalOptima shall provide the following data elements to Community Supports Providers in a manner and format that is practical to each Community Supports Provider:

    a. Member assignment files, including but may not be limited to:

        i. Encounter and claims data;

        ii. Physical, behavioral, administrative and Social Determinants of Health data; and

        iii. Report of Community Supports Provider performance and quality metrics, as requested.

G. Community Supports Provider Responsibilities Upon Authorization

1. Community Supports Providers shall:

    a. Accept and act upon referrals for authorized CalOptima Community Supports, unless the Community Supports Provider is at pre-determined capacity.

    b. Conduct outreach to the referred Member for authorized CalOptima Community Supports as soon as possible, within twenty-four (24) hours of assignment, if possible.

        i. As part of service initiation, secure, document, and preserve evidence of Member agreement to receive CalOptima Community Supports before providing such services.

    c. Be responsive to incoming calls or other outreach from Members; maintain a phone line that is staffed or able to record voicemail twenty-four (24) hours a day, seven (7) days per week.

    d. Coordinate with other Providers in the Member's care team, including ECM Providers, other Community Supports Providers and CalOptima or the Health Network, as applicable.

    e. Comply with cultural competency and linguistic requirements in accordance with federal, State, and local laws, the Community Supports Provider's contract with CalOptima, and CalOptima ~~Policy DD.2002:~~ Cultural and Linguistic Services~~.~~ Policies.

    f. Comply with applicable federal and State civil rights laws and shall not discriminate on the basis of any characteristic protected by federal and State nondiscrimination laws and in accordance with the Community Supports Provider's contract with CalOptima, and CalOptima Policy HH.1104: Complaints of Discrimination.

g. Coordinate with other entities to ensure the Member has access to appropriate supports, including, but not limited to Orange County Public Health, Orange County Behavioral Health Services and Social Services.

h. Support transition planning into other programs or services that meet the Member's needs when a CalOptima Community Support is discontinued for any reason.

i. Utilize best practices for Members experiencing homelessness and who have complex health, disability, and/or behavioral health conditions.

2. When federal law requires authorization for data sharing, Community Supports Providers shall obtain and document such authorization from each assigned Member, including sharing protected health information (PHI), and confirm it has obtained such authorization to CalOptima.

3. Community Supports Providers are encouraged to identify additional CalOptima Community Supports that may benefit a Member and send any additional request(s) for CalOptima Community Supports to CalOptima or the Member's Health Network, as applicable, for authorization.

H. Billing for Community Supports

1. For CalOptima and Health Network Members, except for Members enrolled in a Health Maintenance Organization (HMO) responsible for CalOptima Community Supports, a Community Supports Provider shall submit claims to CalOptima for CalOptima Community Supports services provided.

a. The claims shall be based on specifications from the DHCS-defined code sets and national standards.

b. If the Community Supports Provider is unable to submit claims using such specifications, an invoice shall be submitted, with DHCS-defined minimum necessary data elements that support conversion of the invoice to a DHCS-defined specification and code set for submission to DHCS, including, but not limited to:

i. Member;

ii. CalOptima Community Supports services rendered; and

iii. Community Supports Provider.

2. A Community Supports Provider shall submit CalOptima Community Supports claims or invoices for a Member assigned to a Health Maintenance Organization (HMO) responsible for CalOptima Community Supports to the HMO for processing.

I. Community Supports Provider Qualifications and Service Transition Criteria for existing and future CalOptima Covered Services: CalOptima Community Supports will be provided to Members by contracted Community Supports Providers in accordance with the following requirements~~:~~ based on CalOptima's current and future Board of Directors and DHCS-approved offerings:

1. Housing Transition Navigation Services

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a. Minimum provider qualifications include:

i. Understanding of federal, State, and local transitional and permanent supporting housing programs and their requirements;

ii. Strong relationships with local housing authorities;

iii. Demonstrated local experience in the provision of Housing Transition Navigation Services, including housing-related services and supports; and

iv. Successful completion of CalOptima's pre-contractual review in accordance with CalOptima Policy GG.1619: Delegation Oversight and HH.2021Δ: Exclusion and Preclusion Monitoring.

b. Housing Transition Navigation Services, as described in Attachment A of this Policy, will be provided to a Member meeting the criteria as provided in Attachment B to this Policy by the Community Supports Provider when authorized by CalOptima or a Health Network until such time as the Member:

i. Is successfully placed in permanent housing, and transitioned to Housing Tenancy and Sustaining Services, as appropriate;

ii. Refuses Housing Transition Navigation Services;

iii. Loses funding and/or a housing voucher, where no resolution of the loss exists;

iv. Is no longer physically, cognitively, or emotionally able to reside in independent, supported housing; or

v. Is no longer eligible with CalOptima or a Health Network.

c. A Community Supports Provider shall provide Housing Transition Navigation Services at an appropriate frequency for the needs of the Member, considering the specific barriers that exist for that Member and shall ensure seamless service to Members entering Housing Transition Navigation Services.

2. Housing Deposits

a. Minimum provider qualifications include:

i. Understanding of federal, State, and local transitional and permanent supporting housing programs and their requirements;

ii. Strong relationships with local housing authorities;

iii. Demonstrated or verifiable experience in providing these unique services; and

iv. Successful completion of CalOptima's pre-contractual review in accordance with CalOptima Policy GG.1619: Delegation Oversight and HH.2021Δ: Exclusion and Preclusion Monitoring.

b. Housing Deposits, as described in Attachment A of this Policy, will be provided to a Member meeting the criteria as provided in Attachment B to this Policy by the Community Supports Provider when authorized by CalOptima or a Health Network until the Member:

i. Refuses Housing Transition Navigation Services (at a minimum, tenant screening, housing assessment and individualized housing support);

ii. Is no longer physically, cognitively or emotionally stable to reside in independent, supported housing; or

iii. Loses eligibility with CalOptima or a Health Network.

3. Housing Tenancy and Sustaining Services

a. Minimum provider qualifications include:

i. Understanding of federal, State, and local transitional and permanent supporting housing programs and requirements;

ii. Demonstrated or verifiable experience in providing housing-related services and supports; and

iii. Successful completion of CalOptima's pre-contractual review in accordance with CalOptima Policies GG.1619: Delegation Oversight and HH.2021Δ: Exclusion and Preclusion Monitoring.

b. Housing Tenancy and Sustaining Services, as described in Attachment A of this Policy, are provided to a Member meeting the criteria as provided in Attachment B to this Policy by a Community Supports Provider when authorized by CalOptima or a Health Network until:

i. The Member's housing support plan determines they are no longer needed;

ii. The Member refuses Housing Tenancy and Sustaining Services;

iii. Loss of funding and/or housing voucher, where no resolution of the loss exists;

iv. The Member is no longer physically, cognitively or emotionally able to reside in independent, supported housing; or

v. The Member is no longer eligible with CalOptima or a Health Network.

4. Recuperative Care

a. Minimum provider qualifications include:

i. Demonstrated or verifiable experience and expertise in providing Recuperative Care;

ii. Services are provided in compliance with the National Standards for Recuperative Care Programs; and

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iii. Successful completion of CalOptima's pre-contractual review in accordance with CalOptima Policy GG.1619: Delegation Oversight and HH.2021Δ: Exclusion and Preclusion Monitoring.

b. Recuperative Care, as described in Attachment A of this Policy, is provided to a Member meeting the criteria as provided in Attachment B to this Policy by a Community Supports Provider when authorized by CalOptima or a Health Network until:

i. Services are no longer required for the Member, and a discharge plan has been established;

ii. The Member has received ninety (90) continuous days of Recuperative Care;

iii. The Member refuses Recuperative Care; or

iv. The Member is no longer eligible with CalOptima or a Health Network.

c. ~~Excluding Members assigned to Kaiser,~~ CalOptima ~~contracted Recuperative Care Providers may presumptively authorize~~will assess the need for presumptive eligibility and continuously evaluate and ensure these services ~~to~~ meet urgent Member needs who may be harmed by a delay in authorization (*e.g.*, hospital discharge for a Member eligible for Recuperative Care whose discharge plan is pending authorization). Presumptive authorization will be valid for no longer than fourteen (14) days total from date of admission into the Recuperative Care facility.

~~i. Presumptive authorization will be valid for no longer than two (2) business days after admission into the Recuperative Care facility.~~

~~ii.~~i. Formal authorization from CalOptima or a Health Network must be obtained for the Recuperative Care stay.

1) The CalOptima Recuperative Care Provider is responsible for immediate submission of a request for Recuperative Care to CalOptima or a Health Network, including for those days presumptively authorized by the Recuperative Care Provider, the authorization request shall include:

a) The request form and medical information including, but not limited to: discharge instructions, discharge summary, referral(s) for home health or durable medical equipment (DME), as appropriate, post-discharge medications and post discharge follow-up appointment provider, date and time.

d. A Recuperative Care Provider shall submit Recuperative Care authorization for Members assigned to Kaiser Members to Kaiser for determination.

5. Short-Term Post-Hospitalization Housing

a. Minimum provider qualifications include:

i. Demonstrated or verifiable experience and expertise in providing Short-Term post Hospitalization Housing for Members with high medical or behavioral health needs;

ii. Understanding of federal, State, and local transitional and permanent supporting housing programs and their requirements;

iii. Strong relationships with local housing authorities;

iv. Demonstrated or verifiable experience in providing these unique services; and

v. Successful completion of CalOptima's pre-contractual review in accordance with CalOptima Policy GG.1619: Delegation Oversight and HH.2021Δ: Exclusion and Preclusion Monitoring.

b. Short-Term Post-Hospitalization Housing, as described in Attachment A of this Policy, will be provided to a Member meeting the criteria as provided in Attachment B to this Policy by the Community Supports Provider when authorized by CalOptima or a Health Network until:

i. Services are no longer required for the Member, and a discharge plan has been established;

ii. The Member refuses Short-Term Post-Hospitalization Housing;

iii. The Member is no longer physically, cognitively or emotionally able to reside in independent, supported housing; or

iv. The Member is no longer eligible with CalOptima or a Health Network.

c. A Community Supports Provider shall provide Short-Term Post-Hospitalization Services at an appropriate frequency for the needs of the Member and not to exceed a six (6) month duration.

6. Medically-Tailored Meals

a. Minimum provider qualifications include:

i. Demonstrated or verifiable experience and expertise in providing unique services; and

ii. Successful completion of CalOptima's pre-contractual review in accordance with CalOptima Policy GG.1619: Delegation Oversight and HH.2021Δ: Exclusion and Preclusion Monitoring

b. Medically-Tailored Meals, as described in Attachment A of this Policy, will be provided to a Member meeting the criteria as provided in Attachment B to this Policy by the Community Supports Provider when authorized by CalOptima or a Health Network until:

i. Services are no longer medically necessary or required for the Member;

ii. The Member refuses Medically-Tailored Meals Services;

iii. The Member has received medically-supportive food and nutrition services for up to 12 weeks as appropriate; or

iv. The Member is no longer eligible with CalOptima or a Health Network.

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7. Sobering Centers

a. Minimum provider qualifications include:

i. Demonstrated or verifiable experience and expertise in providing unique services for this unique population;

ii. Established working relationships with County behavioral health agency;

iii. Strong relationships with law enforcement, emergency personnel, and community outreach partners to identify and divert individuals to Sobering Centers; and

iv. Successful completion of CalOptima's pre-contractual review in accordance with CalOptima Policy GG.1619: Delegation Oversight and HH.2021Δ: Exclusion and Preclusion Monitoring.

b. Sobering Centers, as described in Attachment A of this Policy, will be provided to a Member meeting the criteria as provided in Attachment B to this Policy by the Community Supports Provider when authorized by CalOptima or a Health Network until:

i. Services are no longer necessary or required for the Member;

ii. The duration of services received by the Member approaches the limit (less than twenty-four (24) hours); or

iii. The Member is no longer eligible with CalOptima or a Health Network.

8. Personal Care/Homemaker Services

a. Minimum provider qualifications include:

i. Demonstrated or verifiable experience and expertise in providing unique services for this unique population; and

ii. Successful completion of CalOptima's pre-contractual review in accordance with CalOptima Policy GG.1619: Delegation Oversight and HH.2021Δ: Exclusion and Preclusion Monitoring.

b. Personal Care/Homemaker Services, as described in Attachment A of this Policy, will be provided to a Member meeting the criteria as provided in Attachment B to this Policy by the Community Supports Provider when authorized by CalOptima or a Health Network until:

i. Services are no longer necessary for the Member;

ii. The Member refuses Personal Care/Homemaker Services; or

iii. The Member is no longer eligible with CalOptima or a Health Network.

9. Day Habilitation Program

a. Minimum provider qualifications include:

i. Demonstrated or verifiable experience and expertise in providing unique services;

ii. Services are provided in compliance with the National Standards for Adult Day Service Programs; and

iii. Successful completion of CalOptima's pre-contractual review in accordance with CalOptima Policy GG.1619: Delegation Oversight and HH.2021Δ: Exclusion and Preclusion Monitoring.

b. Day Habilitation Program, as described in Attachment A of this Policy, will be provided to a Member meeting the criteria as provided in Attachment B to this Policy by the Community Supports Provider when authorized by CalOptima or a Health Network until:

i. Services are no longer necessary for the Member;

ii. The Member refuses Day Habilitation Program Services; or

iii. The Member is no longer eligible with CalOptima or a Health Network.

10. Respite Services

a. Minimum provider qualifications include:

i. Demonstrated or verifiable experience and expertise in providing unique services; and

ii. Successful completion of CalOptima's pre-contractual review in accordance with CalOptima Policy GG.1619: Delegation Oversight and HH.2021Δ: Exclusion and Preclusion Monitoring.

b. Respite Services, as described in Attachment A of this Policy, will be provided to a Member meeting the criteria as provided in Attachment B to this Policy by the Community Supports Provider when authorized by CalOptima or a Health Network until:

i. Services are no longer required for the Member;

ii. The Member has reached the three hundred thirty-six (336) hour annual limit; or

iii. The Member is no longer eligible with CalOptima or a Health Network.

11. Nursing Facility Transition for Elderly and Adult Residential Facilities

a. Minimum provider qualifications include:

i. Demonstrated or verifiable experience and expertise in providing Nursing Facility services; and

ii. Successful completion of CalOptima's pre-contractual review in accordance with CalOptima Policy GG.1619: Delegation Oversight and HH.2021Δ: Exclusion and Preclusion Monitoring.

b. Nursing Facility Transition for Elderly and Adult Residential Facilities, as described in Attachment A of this Policy, will be provided to a Member meeting the criteria as provided

in Attachment B to this Policy by the Community Supports Provider when authorized by CalOptima or a Health Network until:

i. Services are no longer required for the Member;

ii. The Member refuses Nursing Facility Transition for Elderly and Adult Residential Facilities Services; or

iii. The Member is no longer eligible with CalOptima or a Health Network.

12. Community Transition Services/Nursing Facility Transition to Home

a. Minimum provider qualifications include:

i. Demonstrated or verifiable experience and expertise in providing Community Transition Services/Nursing Facility Transition to Home services; and

ii. Successful completion of CalOptima's pre-contractual review in accordance with CalOptima Policy GG.1619: Delegation Oversight and HH.2021Δ: Exclusion and Preclusion Monitoring

b. Community Transition Services/ Nursing Facility Transition to Home, as described in Attachment A of this Policy, will be provided to a Member meeting the criteria as provided in Attachment B to this Policy by the Community Supports Provider when authorized by CalOptima or a Health Network until:

i. Services are no longer required for the Member;

ii. The Member refuses Community Transition Services/ Nursing Facility Transition to Home Services;

iii. The Member has reached the total lifetime maximum of $7,500 and does not have an approved exception; or

iv. The Member is no longer eligible with CalOptima or a Health Network.

13. Environmental Accessibility Adaptations

a. Minimum provider qualifications include:

i. Demonstrated or verifiable experience and expertise in providing Environmental Accessibility Adaptations

ii. Services are provided in compliance with applicable State and local building codes; and

iii. Successful completion of CalOptima's pre-contractual review in accordance with CalOptima Policy GG.1619: Delegation Oversight and HH.2021Δ: Exclusion and Preclusion Monitoring.

b. Environmental Accessibility Adaptations, as described in Attachment A of this Policy, will be provided to a Member meeting the criteria as provided in Attachment B to this Policy by

the Community Supports Provider when authorized by CalOptima or a Health Network until:

i. Services are no longer required for the Member;

ii. The Member refuses Environmental Accessibility Adaptations

iii. The Member has reached the total lifetime maximum of $7,500 and does not have an approved exception; or

iv. The Member is no longer eligible with CalOptima or a Health Network.

14. Asthma Remediation

a. Minimum provider qualifications include:

i. Demonstrated or verifiable experience and expertise in providing Asthma Remediation services;

ii. Services are provided in compliance with applicable State and local building codes; and

iii. Successful completion of CalOptima's pre-contractual review in accordance with CalOptima Policy GG.1619: Delegation Oversight and HH.2021Δ: Exclusion and Preclusion Monitoring.

c. Asthma Remediation, as described in Attachment A of this Policy, will be provided to a Member meeting the criteria as provided in Attachment B to this Policy by the Community Supports Provider when authorized by CalOptima or a Health Network until:

i. Services are no longer required for the Member;

ii. The Member refuses Asthma Remediation services;

iii. The Member has reached the total lifetime maximum of $7,500 and does not have an approved exception; or

iv. The Member is no longer eligible with CalOptima or a Health Network.

J. CalOptima or a Health Network shall track referrals to a Community Supports Provider to verify that authorized services have been initiated for the Member.

K. CalOptima or a Health Network will receive regular updates from the Community Supports Provider about the Member's progress toward goals, changes in status or barriers and other significant information affecting CalOptima Community Supports for the Member.

1. A Health Network shall provide data to CalOptima about the ongoing monitoring of appropriate and timely delivery of CalOptima Community Supports to their Members in a manner and format defined by CalOptima and in accordance with CalOptima Policy HH.2003: Health Network and Delegated Entity Reporting.

L. CalOptima shall ensure timely and accurate processing of claims for CalOptima Community Supports in accordance with applicable statutory, regulatory, and contractual requirements, as well

as DHCS guidance and CalOptima Policy FF.2001: Claims Processing for Covered Services for which CalOptima is Financially Responsible.

M. Oversight of CalOptima Community Supports

1. CalOptima shall perform oversight of Community Supports Providers and hold Community Supports Providers accountable for all regulatory and contractual requirements, in accordance with CalOptima Policy GG.1619: Delegation Oversight.

    a. CalOptima shall hold Community Supports Providers responsible for the same reporting requirements as those that CalOptima must report to DHCS.

    b. CalOptima will not impose upon the Community Supports Providers mandatory reporting requirements that are different from or in addition to those required for encounter and supplemental reporting.

2. CalOptima may subcontract with other entities to administer CalOptima Community Supports, and must comply with all of the following:

    a. CalOptima will maintain and be responsible for compliance oversight of all contract provisions and covered services, regardless of the number of subcontracting layers.

        i. Subcontractor agreements will mirror the DHCS ECM and CalOptima Community Supports contract template requirements and the ECM and Community Supports Provider Standard Terms and Conditions.

    b. CalOptima shall retain responsibility for development and maintenance of DHCS-approved policies and procedures to ensure that subcontractors meet required responsibilities and functions.

    c. CalOptima shall be responsible for evaluating prospective subcontractor's ability to perform services.

    d. CalOptima is responsible for ensuring that subcontractor's Community Supports Provider capacity is sufficient to serve eligible Members.

    e. CalOptima will report to the DHCS the names of all subcontractors by type and service(s) provided and identify Orange County as the county in which Members are served.

        i. CalOptima will make all subcontractor agreements available to DHCS upon request. Such agreements must contain the minimum required information specified by DHCS, including method and amount of compensation.

3. On a quarterly basis, CalOptima shall review CalOptima Community Supports authorizations to ensure equitable and non-discriminatory approval determinations.

    a. CalOptima will evaluate the ethnic and racial characteristics of the population for whom CalOptima Community Supports is requested against the same characteristics of the population that was authorized for CalOptima Community Supports and provide feedback on the assessment. If CalOptima identifies an inequitable effect, CalOptima will refer the issue to the Audit and Oversight Department for continued action, in accordance with CalOptima Policy GG.1619: Delegation Oversight.

b. CalOptima shall monitor healthcare service utilization and outcomes of member populations receiving CalOptima Community Supports as follows:

i. On a monthly basis, CalOptima shall monitor the housing status and program participation for each Member receiving housing-related CalOptima Community Supports.

ii. On a semi-annual basis, CalOptima shall monitor emergency room visits and hospitalizations for Members receiving Recuperative Care and analyze utilization prior to and after initiation of services.

N. CalOptima shall submit the following data and reports in a manner, format and frequency as defined by DHCS:

1. Encounter data, when possible, must include data necessary for DHCS to stratify services by age, sex, race, ethnicity, and language spoken to inform health equity initiatives and efforts to mitigate health disparities undertaken by the DHCS, including services generated under subcontracting arrangements~~; and~~.

2. Data will be provided to:

a. Evaluate the utilization and effectiveness of a Community Support;

b. Monitor health outcomes and quality metrics at the local and aggregate levels through timely and accurate Encounter Data and supplemental reporting on health outcomes and equity of care. When possible, metrics must be stratified by age, sex, race, ethnicity, and language spoken; and

c. Monitor Member appeals and grievances associated with Community Supports.

~~2.~~3. Supplemental reports, on a schedule and in a format as specified by DHCS.

IV. ATTACHMENT(S)

A. Community Supports Components
B. Community Supports Eligibility (Population Subset)
~~C. CalAIM Community Supports Referral Form~~

V. REFERENCE(S)

A. Department of Health Care Services (DHCS) California Advancing and Innovating Medi-Cal (CalAIM) Proposal
B. Department of Health Care Services (DHCS) Managed Care ~~Plan~~ CalAIM Enhanced Care Management (ECM) and Community Supports (ILOS) Contract Template Provisions
C. CalAIM ECM and ~~ILOS~~Community Supports Model of Care Template
D. Medi-Cal ~~In Lieu of Services (ILOS)~~Community Supports Policy Guide (~~September 2021~~April 2022)
E. CalOptima Contract for Health Care Services
F. CalOptima Policy CMC.4002: Cultural and Linguistic Services
G. CalOptima Policy CMC.9002: Member Grievance Process
H. CalOptima Policy CMC.9003: Standard Appeal

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I. CalOptima Policy CMC.9004: Expedited Appeal
J. CalOptima Policy DD.2002: Cultural and Linguistic Services
~~F.~~K. CalOptima Policy MA.4002: Cultural and Linguistic Services
~~G.~~L. CalOptima Policy EE.1103Δ: Provider Education and Training
~~H.~~M. CalOptima Policy EE.1141Δ: CalOptima Provider Contracts
~~I.~~N. CalOptima Policy FF.2001: Claims Processing for Covered Services which CalOptima is Financially Responsible
~~J.~~O. CalOptima Policy GG.1353: Enhanced Care Management (ECM) Service Delivery
~~K.~~P. CalOptima Policy GG.1356: Enhanced Care Management (ECM) Administration
~~L.~~Q. CalOptima Policy GG.1500 Authorization Instructions for CalOptima Direct and CalOptima Community Network Providers
~~M.~~R. CalOptima Policy GG.1507: Notification Requirements for Covered Services Requiring Prior Authorization.
~~N.~~S. CalOptima Policy GG.1508 Authorization and Processing of Referrals
~~O.~~T. CalOptima Policy GG.1650Δ: Credentialing and Recredentialing of Practitioners and
~~P.~~U. CalOptima Policy GG.1651Δ: Assessment and Re-Assessment of Organizational Providers
~~Q.~~V. CalOptima Policy HH.1101: CalOptima Provider Complaint
~~R.~~W. CalOptima Policy HH.1102: Member Grievance
~~S.~~X. CalOptima Policy HH.1104: Complaints of Discrimination
~~T.~~Y. CalOptima Policy HH.2003: Health Network and Delegated Entity Reporting
~~U.~~Z. CalOptima Policy HH.2021Δ: Exclusion and Preclusion Monitoring
AA. CalOptima Policy MA.9002: Member Grievance Process
BB. CalOptima Policy MA.9003: Standard Pre-Service Appeal
CC. CalOptima Policy MA.9004: Expedited Pre-Service Appeal
DD. CalOptima Policy MA.9006: Provider Complaint Process
~~V.~~EE. Department of Health Care Services (DHCS) All Plan Letter (APL) 19-004: Provider Credentialing/Recredentialing and Screening/Enrollment

VI. REGULATORY AGENCY APPROVAL(S)

~~None to Date~~

Date	Regulatory Agency	Response
11/30/2021	Department of Health Care Services (DHCS)	Approved as Submitted
TBD	Department of Health Care Services (DHCS)	

VII. BOARD ACTION(S)

Date	Meeting
12/20/2021	Special Meeting of the CalOptima Board of Directors
03/03/2022	Regular Meeting of the CalOptima Board of Directors
TBD	Regular Meeting of the CalOptima Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	01/01/2022	GG.1355	Community Supports	Medi-Cal
Revised	TBD	GG.1355	Community Supports	Medi-Cal

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IX. GLOSSARY

Term	Definition
Appeal	Medi-Cal: A review by CalOptima of an adverse benefit determination, which includes one of the following actions: 1. A denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for Medical Necessity, appropriateness, setting, or effectiveness of a Covered Service; 2. A reduction, suspension, or termination of a previously authorized service; 3. A denial, in whole or in part, of payment for a service; 4. Failure to provide services in a timely manner; or 5. Failure to act within the timeframes provided in 42 CFR 438.408(b). OneCare: Any of the procedures that deal with the review of an adverse initial determination made by CalOptima on health care services or benefits under Part C or D the Member believes he or she is entitled to receive, including a delay in providing, arranging for, or approving the health care services or drug coverage (when a delay would adversely affect the health of the Member), or on any amounts the Member must pay for a service or drug as defined in 42 CFR §422.566(b) and §423.566(b). These procedures include reconsideration or redetermination, a reconsideration by an independent review entity (IRE), adjudication by an Administrative Law Judge (ALJ) or attorney adjudicator, review by the Medicare Appeals Council (MAC), and judicial review. OneCare Connect: In general, a Member's actions, both internal and external to CalOptima requesting review of CalOptima's denial, reduction or termination of benefits or services, from CalOptima. Appeals relating to Medi-Cal covered benefits and services shall proceed pursuant to the laws and regulations governing Medi-Cal Appeals. Appeals relating to Medicare covered benefits and services shall proceed pursuant to the laws and regulations governing Medicare Appeals. A Medi-Cal based Appeal is defined as review by CalOptima of an Adverse Benefit Determination.
California Medicaid State Plan	A comprehensive description of California's State Medicaid Program, based upon the requirements of Title XIX of the Social Security Act, that serves as a contractual agreement between the State of California and the federal Centers for Medicare and Medicaid Services.
CalOptima Community Supports	Community Supports that CalOptima has received approval from the Department of Health Care Services (DHCS) to provide.
Centers for Medicare & Medicaid Services (CMS)	The federal agency under the United States Department of Health and Human Services responsible for administering the Medicare and Medicaid programs.

Term	Definition
Community Supports	Pursuant to 42 CFR § 438.3(e)(2), Community Supports are services or settings that are offered in place of services or settings covered under the California Medicaid State Plan and are a medically appropriate, cost-effective alternative to a State Plan Covered Service. Authorized Community Supports offered are included in development of CalOptima's capitation rate and count toward the medical expense component of CalOptima's Medical Loss Ratio (MLR) in accordance with 42 CFR § 438.8 (e)(2) Community Supports are optional for both CalOptima and the Member and must be approved by DHCS.
Community Supports Provider	A CalOptima-contracted Provider of the DHCS-approved CalOptima Community Supports. Providers are entities with experience and expertise providing one (1) or more of the CalOptima Community Supports approved by the DHCS.
Covered Services	Medi-Cal: Those services provided in the Fee-For-Service Medi-Cal program (as set forth in Title 22, CCR, Division 3, Subdivision 1, Chapter 3, beginning with Section 51301), the Child Health and Disability Prevention program (as set forth in Title 17, CCR, Division 1, Chapter 4, Subchapter 13, Article 4, beginning with section 6842), and the California Children's Services (as set forth in Title 22, CCR, Division 2, subdivision 7, and Welfare and Institutions Code, Division 9, Part 3, Chapter 7, Article 2.985, beginning with section 14094.4) under the Whole-Child Model program, to the extent those services are included as Covered Services under CalOptima's Medi-Cal Contract with DHCS and are Medically Necessary, along with chiropractic services (as defined in Section 51308 of Title 22, CCR), podiatry services (as defined in Section 51310 of Title 22, CCR), speech pathology services and audiology services (as defined in Section 51309 of Title 22, CCR), and Enhanced Care Management and CalOptima Community Supports (as provided under the California Advancing and Innovating Medi-Cal initiative) for Members meeting eligibility criteria, or other services as authorized by the CalOptima Board of Directors, which shall be covered for Members notwithstanding whether such benefits are provided under the Fee-For-Service Medi-Cal program. OneCare: Those medical services, equipment, or supplies that CalOptima is obligated to provide to Members under the Centers of Medicare & Medicaid Services (CMS) Contract. OneCare Connect: Those medical services, equipment, or supplies that CalOptima is obligated to provide to Members under the Three-Way Contract with the Department of Health Care Services (DHCS) and Centers for Medicare & Medicaid Services (CMS).
Department of Health Care Services (DHCS)	The single State Department responsible for administration of the Medi-Cal program, California Children Services (CCS), Genetically Handicapped Persons Program (GHPP), Child Health and Disabilities Prevention (CHDP), and other health related programs
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.

Term	Definition
ECM Member	A Member that is authorized for, continuously participating in, and receiving Enhanced Care Management, and assigned to a Health Network or CalOptima Direct.
ECM Provider	~~Providers~~A Provider within the community that ~~have~~has a contractual relationship with CalOptima~~, or CalOptima acting directly,~~ (such as a delegated Health Network) to provide ECM services to Members authorized to receive ECM. ECM Providers have experience and expertise providing intensive, in-person care management services to individuals in one or more of the Populations of Focus for ECM.
Encounter	Any unit of Covered Services provided to a member by a Health Network regardless of reimbursement methodology.
Grievance	An oral or written expression of dissatisfaction about any matter other than an action that is an adverse benefit determination, as identified within the definition of an Appeal, and may include, but is not limited to: the quality of care or services provided, interpersonal relationships with a Provider or CalOptima's employee, failure to respect a Member's rights regardless of whether remedial action is requested, and the right to dispute an extension of time proposed by CalOptima to make an authorization decision.
Health Network	A Physician Hospital Consortium (PHC), physician group under a shared risk contract, or health care service plan, such as a Health Maintenance Organization (HMO) that contracts with CalOptima to provide Covered Services to Members assigned to that Health Network.

Term	Definition
Medically Necessary or Medical Necessity	Medi-Cal: Reasonable and necessary Covered Services to protect life, to prevent significant illness or significant disability, or alleviate severe pain through the diagnosis or treatment of disease, illness, or injury, as required under W&I Code 14059.5(a) and Title 22 CCR Section 51303(a). Medically Necessary services shall include Covered Services necessary to achieve age-appropriate growth and development, and attain, maintain, or regain functional capacity. For Members under 21 years of age, a service is Medically Necessary if it meets the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) standard of medical necessity set forth in Section 1396d(r)(5) of Title 42 of the United States Code, as required by W&I Code 14059.5(b) and W&I Code Section 14132(v). Without limitation, Medically Necessary services for Members under 21 years of age include Covered Services necessary to achieve or maintain age-appropriate growth and development, attain, regain or maintain functional capacity, or improve, support or maintain the Member's current health condition. CalOptima shall determine Medical Necessity on a case-by-case basis, taking into account the individual needs of the child. OneCare: The services, supplies, or drugs that are needed for the prevention, diagnosis, or treatment of your medical condition and meet accepted standards of medical practice. OneCare Connect: Services must be provided in a way that provides all protections to the Member provided by Medicare and Medi-Cal. Per Medicare, services must be reasonable and necessary Covered Services for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member, or otherwise medically necessary under 42 U.S.C. § 1395y. In accordance with Title XIX law and related regulations, and per Medi-Cal, Medical Necessity means reasonable and necessary services to protect life, to prevent significant illness or significant disability, or to alleviate severe pain through the diagnosis or treatment of disease, illness, or injury under WIC Section 14059.5.
Member	A Medi-Cal eligible beneficiary as determined by the County of Orange Social Services Agency, the California Department of Health Care Services (DHCS) Medi-Cal Program, or the United States Social Security Administration, who is enrolled in the CalOptima program.

Term	Definition
Provider	Medi-Cal: A physician, nurse, nurse mid-wife, nurse practitioner, medical technician, physician assistant, hospital, laboratory, ancillary provider, or other person or institution that furnishes Covered Services. OneCare: Any Medicare provider (e.g., hospital, skilled nursing facility, home health agency, outpatient physical therapy, comprehensive outpatient rehabilitation facility, end-stage renal disease facility, hospice, physician, non-physician provider, laboratory, supplier, etc.) providing Covered Services under Medicare Part B. Any organization, institution, or individual that provides Covered Services to Medicare members. Physicians, ambulatory surgical centers, and outpatient clinics are some of the providers of Covered Services under Medicare Part B. OneCare Connect: A physician, pharmacist, nurse, nurse mid-wife, nurse practitioner, medical technician, physician assistant, hospital, laboratory, health maintenance organization, Health Network, physician group, or other person or institution who furnishes Covered Services.
Recuperative Care	Short-term residential care for individuals who do not require hospitalization but need to recover from a physical or behavioral health injury or illness and whose condition would be exacerbated by an unstable living environment.
Social Determinants of Health	The conditions in the environments where 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. Social Determinants of Health can be grouped into 5 domains: economic stability, education access and quality, health care access and quality, neighborhood and built environment, and social and community context. Social Determinants of Health have a major impact on people's health, well-being, and quality of life. Examples of SDOH include: safe housing, transportation, and neighborhoods, racism, discrimination, and violence, education, job opportunities, and income, access to nutritious foods and physical activity opportunities, polluted air and water, and language and literacy skills.

Policy:	GG.1355
Title:	**Community Supports**
Department:	Medical Management
Section:	Case Management
CEO Approval:	*/s/*
Effective Date:	01/01/2022
Revised Date:	TBD
Applicable to:	☒ Medi-Cal ☒ OneCare ☒ OneCare Connect ☐ PACE ☐ Administrative

I. PURPOSE

This Policy describes the eligibility criteria for CalOptima Community Supports and identifies the requirements for the referral, authorization, and provision of CalOptima Community Supports under the California Advancing and Innovating Medi-Cal (CalAIM) initiative.

II. POLICY

A. Community Supports are medically appropriate, cost-effective alternatives provided as a substitute to services covered under the California Medicaid State Plan and are delivered by a different Provider or in a different setting than those described in the State Plan. These services shall not reduce or jeopardize Member access to State Plan services.

B. Community Supports can only be covered if the State determines they are medically appropriate and cost-effective alternatives and are identified and authorized in CalOptima's Medi-Cal Contract with the Department of Health Care Services (DHCS).

C. A Member's participation in CalOptima Community Supports is optional; CalOptima shall not require a Member to use CalOptima Community Supports.

D. CalOptima shall ensure the underlying State Plan Covered Services are made available to the Member, if Medically Necessary for the Member, or if the Member declines CalOptima Community Supports.

E. CalOptima shall provide public notice of any limitations on Community Supports when an alternative approach involving narrowing eligible populations, including specifying such limitations in the Member Handbook/Evidence of Coverage and website, in addition to receiving written approval from DHCS.

F. To the extent a Member is receiving care or case management, CalOptima Community Supports should be integrated with care or case management, including Enhanced Care Management (ECM) when appropriate.

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G. CalOptima may delegate CalOptima Community Supports to Kaiser Foundation Health Plan (Kaiser), in accordance with the CalOptima Contract for Health Care Services and the Delegation Agreement.

H. CalOptima shall provide Community Support Services for Members who meet the eligibility criteria as defined in Attachment B of this Policy.

I. Effective no sooner than January 1, 2022, CalOptima shall offer four (4) selected DHCS-approved CalOptima Community Supports, listed below and further defined in Attachment A of this Policy.

1. Housing Transition Navigation Services;

2. Housing Deposits;

3. Housing Tenancy and Sustaining Services; and

4. Recuperative Care (Medical Respite).

J. In the event that CalOptima expands Community Supports, the following services listed below may be considered and are further defined in Attachment A of this Policy.

1. Short-Term Post-Hospitalization Housing;

2. Medically-Tailored meals;

3. Sobering Centers;

4. Personal Care/Homemaker Services; and

5. Day Habilitation Program

6. Respite Services;

7. Nursing Facility Transition/Diversion to Assisted Living Facilities (Elderly and Adult Residential Facilities);

8. Community Transition Services/Nursing Facility Transition to a Home;

9. Environmental Accessibility Adaptions (Modifications); and

10. Asthma Remediation.

K. CalOptima will notify DHCS six (6) months prior to implementation of any additional community support offering and include submission of an updated CalAIM Model of Care to DHCS.

L. CalOptima shall provide CalOptima Community Supports training and technical assistance to Community Supports Providers, through in-person sessions, webinars, and/or telephone calls, as necessary and in accordance with CalOptima Policy EE.1103Δ: Provider Education and Training and Section III.C. of this Policy.

M. A Community Supports Provider shall not receive payment from CalOptima for the provision of any CalOptima Community Supports not authorized by CalOptima or a Health Network.

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N. To be eligible for participation in CalOptima Community Supports, a Member must meet the DHCS-specific requirements for the CalOptima Community Supports under consideration, as described in Attachment B of this Policy.

O. CalOptima or a Health Network shall accept referrals for CalOptima Community Supports from Providers, other community-based entities, Members and/or family members.

P. CalOptima or the Health Network shall use systems and processes capable of tracking CalOptima Community Supports referrals, access to CalOptima Community Supports, and Grievances and Appeals.

1. CalOptima or the Health Network shall track CalOptima Community Supports referrals and will support Community Supports Provider access to systems and processes allowing them to track and manage referral and Member information.

Q. CalOptima shall regularly monitor and provide oversight of Community Supports Providers to ensure compliance with regulatory, contractual, and business requirements as described in Section III.M. of this Policy.

R. A Community Supports Provider or Member, as applicable, shall be entitled to Grievance and Appeals procedures in accordance with CalOptima Policies.

S. CalOptima Community Supports are subject to the State Fair Hearings process, in accordance with CalOptima Policy HH.1108: State Hearing Process and Procedures.

III. PROCEDURE

A. Informing Members and Providers

1. CalOptima shall inform Members and Providers about current and newly added CalOptima-offered Community Supports and the referral process, including how to submit the CalOptima Community Supports request through:

a. Member communication such as the Member Handbook, CalOptima website, Member Orientation meetings, and communication with CalOptima representatives (e.g., Customer Service staff, case managers); and

b. Provider communication including but not limited to the CalOptima website (www.caloptima.org), CalOptima Provider Manual, CalOptima Policies and Procedures, CalOptima Community Announcement, other educational materials, as well as through community events and other regularly scheduled CalOptima stakeholder forums.

2. CalOptima may discontinue a specific CalOptima Community Supports annually, with notice to DHCS, at the end of the calendar year, except in cases where the CalOptima Community Supports is terminated due to Member health, safety, or welfare concerns.

a. CalOptima shall ensure CalOptima Community Supports that were authorized for a Member prior to the discontinuation of that specific CalOptima Community Supports are not disrupted by a change in CalOptima Community Supports offerings, either by completing the authorized services or by seamlessly transitioning the Member into other Medically Necessary services or programs that meet their needs.

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b. CalOptima shall publicize the service end date and provide at least ninety (90) calendar days' notice to Members. Notice to Members affected by a decision to discontinue a specific CalOptima Community Supports shall include:

i. The change and timing of discontinuation; and

ii. The procedures that will be used to ensure completion of the authorized CalOptima Community Supports or a transition into other Medically Necessary services.

c. CalOptima shall implement a plan for continuity of care for Members receiving the discontinued CalOptima Community Supports.

B. Provider Medi-Cal Enrollment and Credentialing or CalOptima's Vetting Process

1. If a State level enrollment pathway exists for the Community Supports Provider, CalOptima shall verify that the Community Supports Provider is enrolled in Medi-Cal, pursuant to relevant DHCS All Plan Letters (APLs), including APL 19-004: Provider Credentialing/Recredentialing and Screening/Enrollment. CalOptima shall also credential the Community Supports Provider in accordance with CalOptima Policies GG.1650Δ: Credentialing and Recredentialing of Practitioners and GG.1651Δ: Assessment and Re-Assessment of Organizational Providers, as applicable.

2. If no Medi-Cal/Medicaid enrollment pathway exists, CalOptima shall verify the qualifications of the Provider or provider organization to ensure they meet the standards and capabilities to be a Community Supports Provider in accordance with CalOptima Policies GG.1619: Delegation Oversight and HH.2021Δ: Exclusion and Preclusion Monitoring. CalOptima shall also consider the following factors as part of CalOptima's process for vetting the qualifications and experience of Community Supports Providers:

a. Ability to receive referrals from CalOptima and Health Networks for the authorized CalOptima Community Supports service;

b. Sufficient experience to provide services similar to the specific CalOptima Community Supports they are contracted to provide within the service area;

c. Ability to submit claims or invoices for CalOptima Community Supports using standardized protocols;

d. Business licensing that meets industry standards;

e. Capability to comply with all reporting and oversight requirements;

f. History of fraud, waste, and/or abuse;

g. Recent history of criminal activity, including a history of criminal activities that endanger Members and/or their families; and

h. History of liability claims against the Community Supports Provider.

C. Provider Training

1. In addition to network Provider training requirements described in CalOptima's Medi-Cal Contract with DHCS, CalOptima will provide the CalOptima Community Supports training described below to Community Supports Providers, including through in-person sessions, webinars, and/or calls, as necessary:

    a. CalOptima Community Supports program overview, Community Supports Provider role, community resources and referrals, as well as operational and topic-specific trainings.

    b. Special populations, Social Determinants of Health, trauma-informed care, health literacy, data-sharing and reporting requirements will also be covered.

D. Identifying Members and Receiving Requests for CalOptima Community Supports

1. CalOptima and the Health Networks shall identify Members who will benefit from one or more CalOptima Community Supports by:

    a. Working with ECM Providers to identify Members receiving ECM who could benefit from CalOptima Community Supports;

    b. Proactively identifying Members who may benefit from the CalOptima Community Supports through review of available data indicating a Member meets specific eligibility criteria, as described in Attachment B of this Policy;

    c. Accepting CalOptima Community Supports requests from Providers and other community-based entities; and

    d. Accepting CalOptima Community Supports requests from a Member, family member, guardian, caregiver, and/or authorized support person.

2. CalOptima shall refer Members to a Community Supports Provider within two (2) business days of issuing authorization for the service.

3. CalOptima shall provide Medically Necessary Covered Services regardless of whether the Member has been offered a Community Support, is currently receiving a Community Support, or has received a Community Support in the past.

4. If a Community Supports Provider capacity is limited, CalOptima or a Health Network shall prioritize the initiation of CalOptima Community Supports to Members who:

    a. Meet all CalOptima Community Supports criteria; and

    b. Demonstrate a high level of commitment to participating in services.

E. Authorization of CalOptima Community Supports is required prior to the initiation of services.

1. CalOptima shall ensure timely processing of expedited and routine CalOptima Community Supports authorization requests in accordance with CalOptima Policies GG.1500: Authorization Instructions for CalOptima Direct and CalOptima Community Network Providers and GG.1508: Authorization and Processing of Referrals.

a. An authorization request for CalOptima Community Supports may be expedited when a specific, time-limited indication for the service requested exists and is a critical component of appropriate delivery of the CalOptima Community Supports.

i. Recuperative Care Providers may issue a presumptive authorization for Recuperative Care services to a CalOptima or Health Network Member who meets the established criteria defined in Section III.I.4.b. of this Policy, Attachment B of this Policy, and when delay of an authorization would be harmful to the Member.

2. For Members transitioning from other Medi-Cal Managed Care Plans (MCPs) previously identified and receiving Community Supports, CalOptima shall:

a. Authorize the Member for Community Supports upon:

i. A direct request from the Member, the Member's family, or authorized representative to include an attestation from the Member.

ii. Review of Encounter data demonstrating utilization of available Community Supports in previous ninety (90) days.

b. Outreach to the Member, the Member's previous MCP, and/or the Community Supports provider, as appropriate to mitigate gaps in care.

i. Members will be reassessed based on the following discontinuation criteria:

1) Member states they no longer wish to receive the service;

2) Provider is unable to reach Member after multiple attempts;

3) Member no longer requires the service or has completed service goals; or

4) Member is unresponsive or unwilling to engage with the Community Supports provider. This can include instances when a Member's behavior or environment is unsafe for the Community Supports Provider.

c. CalOptima shall not authorize Community Supports for a Member who transitions from another MCP when the Community Support service is only available once in a Member's lifetime and/or if CalOptima does not provide the Community Support service which the Member had received from the Member's prior MCP.

3. CalOptima shall notify the requestor of CalOptima's decision regarding CalOptima Community Supports service authorization in accordance with CalOptima Policy GG.1507: Notification Requirements for Covered Services Requiring Prior Authorization.

4. CalOptima shall monitor and evaluate CalOptima Community Supports authorizations to ensure they are equitable and non-discriminatory in accordance with Section III.M. of this Policy.

F. Sharing Information with Community Supports Providers

1. As part of the referral process to Community Supports Providers and consistent with federal, State, and, if applicable, local privacy and confidentiality laws, CalOptima shall ensure a Community Supports Provider has access to:

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a. Demographic and administrative information confirming the Member's eligibility and authorization for the requested service;

b. Appropriate administrative, clinical, and social service information the Community Supports Provider may need to effectively provide the requested service; and

c. Billing information necessary to enable the Community Supports Provider to submit claims or invoices to CalOptima.

2. CalOptima shall provide the following data elements to Community Supports Providers in a manner and format that is practical to each Community Supports Provider:

a. Member assignment files, including but may not be limited to:

i. Encounter and claims data;

ii. Physical, behavioral, administrative and Social Determinants of Health data; and

iii. Report of Community Supports Provider performance and quality metrics, as requested.

G. Community Supports Provider Responsibilities Upon Authorization

1. Community Supports Providers shall:

a. Accept and act upon referrals for authorized CalOptima Community Supports, unless the Community Supports Provider is at pre-determined capacity.

b. Conduct outreach to the referred Member for authorized CalOptima Community Supports as soon as possible, within twenty-four (24) hours of assignment, if possible.

i. As part of service initiation, secure, document, and preserve evidence of Member agreement to receive CalOptima Community Supports before providing such services.

c. Be responsive to incoming calls or other outreach from Members; maintain a phone line that is staffed or able to record voicemail twenty-four (24) hours a day, seven (7) days per week.

d. Coordinate with other Providers in the Member's care team, including ECM Providers, other Community Supports Providers and CalOptima or the Health Network, as applicable.

e. Comply with cultural competency and linguistic requirements in accordance with federal, State, and local laws, the Community Supports Provider's contract with CalOptima, and CalOptima Cultural and Linguistic Services Policies.

f. Comply with applicable federal and State civil rights laws and shall not discriminate on the basis of any characteristic protected by federal and State nondiscrimination laws and in accordance with the Community Supports Provider's contract with CalOptima, and CalOptima Policy HH.1104: Complaints of Discrimination.

g. Coordinate with other entities to ensure the Member has access to appropriate supports, including, but not limited to Orange County Public Health, Orange County Behavioral Health Services and Social Services.

h. Support transition planning into other programs or services that meet the Member's needs when a CalOptima Community Support is discontinued for any reason.

i. Utilize best practices for Members experiencing homelessness and who have complex health, disability, and/or behavioral health conditions.

2. When federal law requires authorization for data sharing, Community Supports Providers shall obtain and document such authorization from each assigned Member, including sharing protected health information (PHI), and confirm it has obtained such authorization to CalOptima.

3. Community Supports Providers are encouraged to identify additional CalOptima Community Supports that may benefit a Member and send any additional request(s) for CalOptima Community Supports to CalOptima or the Member's Health Network, as applicable, for authorization.

H. Billing for Community Supports

1. For CalOptima and Health Network Members, except for Members enrolled in a Health Maintenance Organization (HMO) responsible for CalOptima Community Supports, a Community Supports Provider shall submit claims to CalOptima for CalOptima Community Supports services provided.

a. The claims shall be based on specifications from the DHCS-defined code sets and national standards.

b. If the Community Supports Provider is unable to submit claims using such specifications, an invoice shall be submitted, with DHCS-defined minimum necessary data elements that support conversion of the invoice to a DHCS-defined specification and code set for submission to DHCS, including, but not limited to:

i. Member;

ii. CalOptima Community Supports services rendered; and

iii. Community Supports Provider.

2. A Community Supports Provider shall submit CalOptima Community Supports claims or invoices for a Member assigned to a Health Maintenance Organization (HMO) responsible for CalOptima Community Supports to the HMO for processing.

I. Community Supports Provider Qualifications and Service Transition Criteria for existing and future CalOptima Covered Services: CalOptima Community Supports will be provided to Members by contracted Community Supports Providers in accordance with the following requirements based on CalOptima's current and future Board of Directors and DHCS-approved offerings:

1. Housing Transition Navigation Services

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a. Minimum provider qualifications include:

i. Understanding of federal, State, and local transitional and permanent supporting housing programs and their requirements;

ii. Strong relationships with local housing authorities;

iii. Demonstrated local experience in the provision of Housing Transition Navigation Services, including housing-related services and supports; and

iv. Successful completion of CalOptima's pre-contractual review in accordance with CalOptima Policy GG.1619: Delegation Oversight and HH.2021Δ: Exclusion and Preclusion Monitoring.

b. Housing Transition Navigation Services, as described in Attachment A of this Policy, will be provided to a Member meeting the criteria as provided in Attachment B to this Policy by the Community Supports Provider when authorized by CalOptima or a Health Network until such time as the Member:

i. Is successfully placed in permanent housing, and transitioned to Housing Tenancy and Sustaining Services, as appropriate;

ii. Refuses Housing Transition Navigation Services;

iii. Loses funding and/or a housing voucher, where no resolution of the loss exists;

iv. Is no longer physically, cognitively, or emotionally able to reside in independent, supported housing; or

v. Is no longer eligible with CalOptima or a Health Network.

c. A Community Supports Provider shall provide Housing Transition Navigation Services at an appropriate frequency for the needs of the Member, considering the specific barriers that exist for that Member and shall ensure seamless service to Members entering Housing Transition Navigation Services.

2. Housing Deposits

a. Minimum provider qualifications include:

i. Understanding of federal, State, and local transitional and permanent supporting housing programs and their requirements;

ii. Strong relationships with local housing authorities;

iii. Demonstrated or verifiable experience in providing these unique services; and

iv. Successful completion of CalOptima's pre-contractual review in accordance with CalOptima Policy GG.1619: Delegation Oversight and HH.2021Δ: Exclusion and Preclusion Monitoring.

b. Housing Deposits, as described in Attachment A of this Policy, will be provided to a Member meeting the criteria as provided in Attachment B to this Policy by the Community Supports Provider when authorized by CalOptima or a Health Network until the Member:

i. Refuses Housing Transition Navigation Services (at a minimum, tenant screening, housing assessment and individualized housing support);

ii. Is no longer physically, cognitively, or emotionally stable to reside in independent, supported housing; or

iii. Loses eligibility with CalOptima or a Health Network.

3. Housing Tenancy and Sustaining Services

a. Minimum provider qualifications include:

i. Understanding of federal, State, and local transitional and permanent supporting housing programs and requirements;

ii. Demonstrated or verifiable experience in providing housing-related services and supports; and

iii. Successful completion of CalOptima's pre-contractual review in accordance with CalOptima Policies GG.1619: Delegation Oversight and HH.2021Δ: Exclusion and Preclusion Monitoring.

b. Housing Tenancy and Sustaining Services, as described in Attachment A of this Policy, are provided to a Member meeting the criteria as provided in Attachment B to this Policy by a Community Supports Provider when authorized by CalOptima or a Health Network until:

i. The Member's housing support plan determines they are no longer needed;

ii. The Member refuses Housing Tenancy and Sustaining Services;

iii. Loss of funding and/or housing voucher, where no resolution of the loss exists;

iv. The Member is no longer physically, cognitively, or emotionally able to reside in independent, supported housing; or

v. The Member is no longer eligible with CalOptima or a Health Network.

4. Recuperative Care

a. Minimum provider qualifications include:

i. Demonstrated or verifiable experience and expertise in providing Recuperative Care;

ii. Services are provided in compliance with the National Standards for Recuperative Care Programs; and

iii. Successful completion of CalOptima's pre-contractual review in accordance with CalOptima Policy GG.1619: Delegation Oversight and HH.2021Δ: Exclusion and Preclusion Monitoring.

b. Recuperative Care, as described in Attachment A of this Policy, is provided to a Member meeting the criteria as provided in Attachment B to this Policy by a Community Supports Provider when authorized by CalOptima or a Health Network until:

i. Services are no longer required for the Member, and a discharge plan has been established;

ii. The Member has received ninety (90) continuous days of Recuperative Care;

iii. The Member refuses Recuperative Care; or

iv. The Member is no longer eligible with CalOptima or a Health Network.

c. CalOptima will assess the need for presumptive eligibility and continuously evaluate and ensure these services meet urgent Member needs who may be harmed by a delay in authorization (*e.g.*, hospital discharge for a Member eligible for Recuperative Care whose discharge plan is pending authorization). Presumptive authorization will be valid for no longer than fourteen (14) days total from date of admission into the Recuperative Care facility.

i. Formal authorization from CalOptima or a Health Network must be obtained for the Recuperative Care stay.

1) The CalOptima Recuperative Care Provider is responsible for immediate submission of a request for Recuperative Care to CalOptima or a Health Network, including for those days presumptively authorized by the Recuperative Care Provider, the authorization request shall include:

a) The request form and medical information including, but not limited to: discharge instructions, discharge summary, referral(s) for home health or durable medical equipment (DME), as appropriate, post-discharge medications and post discharge follow-up appointment provider, date, and time.

d. A Recuperative Care Provider shall submit Recuperative Care authorization for Members assigned to Kaiser Members to Kaiser for determination.

5. Short-Term Post-Hospitalization Housing

a. Minimum provider qualifications include:

i. Demonstrated or verifiable experience and expertise in providing Short-Term post Hospitalization Housing for Members with high medical or behavioral health needs;

ii. Understanding of federal, State, and local transitional and permanent supporting housing programs and their requirements;

iii. Strong relationships with local housing authorities;

iv. Demonstrated or verifiable experience in providing these unique services; and

v. Successful completion of CalOptima's pre-contractual review in accordance with CalOptima Policy GG.1619: Delegation Oversight and HH.2021Δ: Exclusion and Preclusion Monitoring.

b. Short-Term Post-Hospitalization Housing, as described in Attachment A of this Policy, will be provided to a Member meeting the criteria as provided in Attachment B to this Policy by the Community Supports Provider when authorized by CalOptima or a Health Network until:

i. Services are no longer required for the Member, and a discharge plan has been established;

ii. The Member refuses Short-Term Post-Hospitalization Housing;

iii. The Member is no longer physically, cognitively, or emotionally able to reside in independent, supported housing; or

iv. The Member is no longer eligible with CalOptima or a Health Network.

c. A Community Supports Provider shall provide Short-Term Post-Hospitalization Services at an appropriate frequency for the needs of the Member and not to exceed a six (6) month duration.

6. Medically-Tailored Meals

a. Minimum provider qualifications include:

i. Demonstrated or verifiable experience and expertise in providing unique services; and

ii. Successful completion of CalOptima's pre-contractual review in accordance with CalOptima Policy GG.1619: Delegation Oversight and HH.2021Δ: Exclusion and Preclusion Monitoring

b. Medically-Tailored Meals, as described in Attachment A of this Policy, will be provided to a Member meeting the criteria as provided in Attachment B to this Policy by the Community Supports Provider when authorized by CalOptima or a Health Network until:

i. Services are no longer medically necessary or required for the Member;

ii. The Member refuses Medically-Tailored Meals Services;

iii. The Member has received medically-supportive food and nutrition services for up to 12 weeks as appropriate; or

iv. The Member is no longer eligible with CalOptima or a Health Network.

7. Sobering Centers

a. Minimum provider qualifications include:

i. Demonstrated or verifiable experience and expertise in providing unique services for this unique population;

ii. Established working relationships with County behavioral health agency;

iii. Strong relationships with law enforcement, emergency personnel, and community outreach partners to identify and divert individuals to Sobering Centers; and

iv. Successful completion of CalOptima's pre-contractual review in accordance with CalOptima Policy GG.1619: Delegation Oversight and HH.2021Δ: Exclusion and Preclusion Monitoring.

b. Sobering Centers, as described in Attachment A of this Policy, will be provided to a Member meeting the criteria as provided in Attachment B to this Policy by the Community Supports Provider when authorized by CalOptima or a Health Network until:

i. Services are no longer necessary or required for the Member;

ii. The duration of services received by the Member approaches the limit (less than twenty-four (24) hours); or

iii. The Member is no longer eligible with CalOptima or a Health Network.

8. Personal Care/Homemaker Services

a. Minimum provider qualifications include:

i. Demonstrated or verifiable experience and expertise in providing unique services for this unique population; and

ii. Successful completion of CalOptima's pre-contractual review in accordance with CalOptima Policy GG.1619: Delegation Oversight and HH.2021Δ: Exclusion and Preclusion Monitoring.

b. Personal Care/Homemaker Services, as described in Attachment A of this Policy, will be provided to a Member meeting the criteria as provided in Attachment B to this Policy by the Community Supports Provider when authorized by CalOptima or a Health Network until:

i. Services are no longer necessary for the Member;

ii. The Member refuses Personal Care/Homemaker Services; or

iii. The Member is no longer eligible with CalOptima or a Health Network.

9. Day Habilitation Program

a. Minimum provider qualifications include:

i. Demonstrated or verifiable experience and expertise in providing unique services;

ii. Services are provided in compliance with the National Standards for Adult Day Service Programs; and

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iii. Successful completion of CalOptima's pre-contractual review in accordance with CalOptima Policy GG.1619: Delegation Oversight and HH.2021Δ: Exclusion and Preclusion Monitoring.

b. Day Habilitation Program, as described in Attachment A of this Policy, will be provided to a Member meeting the criteria as provided in Attachment B to this Policy by the Community Supports Provider when authorized by CalOptima or a Health Network until:

i. Services are no longer necessary for the Member;

ii. The Member refuses Day Habilitation Program Services; or

iii. The Member is no longer eligible with CalOptima or a Health Network.

10. Respite Services

a. Minimum provider qualifications include:

i. Demonstrated or verifiable experience and expertise in providing unique services; and

ii. Successful completion of CalOptima's pre-contractual review in accordance with CalOptima Policy GG.1619: Delegation Oversight and HH.2021Δ: Exclusion and Preclusion Monitoring.

b. Respite Services, as described in Attachment A of this Policy, will be provided to a Member meeting the criteria as provided in Attachment B to this Policy by the Community Supports Provider when authorized by CalOptima or a Health Network until:

i. Services are no longer required for the Member;

ii. The Member has reached the three hundred thirty-six (336) hour annual limit; or

iii. The Member is no longer eligible with CalOptima or a Health Network.

11. Nursing Facility Transition for Elderly and Adult Residential Facilities

a. Minimum provider qualifications include:

i. Demonstrated or verifiable experience and expertise in providing Nursing Facility services; and

ii. Successful completion of CalOptima's pre-contractual review in accordance with CalOptima Policy GG.1619: Delegation Oversight and HH.2021Δ: Exclusion and Preclusion Monitoring.

b. Nursing Facility Transition for Elderly and Adult Residential Facilities, as described in Attachment A of this Policy, will be provided to a Member meeting the criteria as provided in Attachment B to this Policy by the Community Supports Provider when authorized by CalOptima or a Health Network until:

i. Services are no longer required for the Member;

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ii. The Member refuses Nursing Facility Transition for Elderly and Adult Residential Facilities Services; or

iii. The Member is no longer eligible with CalOptima or a Health Network.

12. Community Transition Services/Nursing Facility Transition to Home

a. Minimum provider qualifications include:

i. Demonstrated or verifiable experience and expertise in providing Community Transition Services/Nursing Facility Transition to Home services; and

ii. Successful completion of CalOptima's pre-contractual review in accordance with CalOptima Policy GG.1619: Delegation Oversight and HH.2021Δ: Exclusion and Preclusion Monitoring

b. Community Transition Services/ Nursing Facility Transition to Home, as described in Attachment A of this Policy, will be provided to a Member meeting the criteria as provided in Attachment B to this Policy by the Community Supports Provider when authorized by CalOptima or a Health Network until:

i. Services are no longer required for the Member;

ii. The Member refuses Community Transition Services/ Nursing Facility Transition to Home Services;

iii. The Member has reached the total lifetime maximum of $7,500 and does not have an approved exception; or

iv. The Member is no longer eligible with CalOptima or a Health Network.

13. Environmental Accessibility Adaptations

a. Minimum provider qualifications include:

i. Demonstrated or verifiable experience and expertise in providing Environmental Accessibility Adaptations

ii. Services are provided in compliance with applicable State and local building codes; and

iii. Successful completion of CalOptima's pre-contractual review in accordance with CalOptima Policy GG.1619: Delegation Oversight and HH.2021Δ: Exclusion and Preclusion Monitoring.

b. Environmental Accessibility Adaptations, as described in Attachment A of this Policy, will be provided to a Member meeting the criteria as provided in Attachment B to this Policy by the Community Supports Provider when authorized by CalOptima or a Health Network until:

i. Services are no longer required for the Member;

ii. The Member refuses Environmental Accessibility Adaptations

iii. The Member has reached the total lifetime maximum of $7,500 and does not have an approved exception; or

iv. The Member is no longer eligible with CalOptima or a Health Network.

14. Asthma Remediation

a. Minimum provider qualifications include:

i. Demonstrated or verifiable experience and expertise in providing Asthma Remediation services;

ii. Services are provided in compliance with applicable State and local building codes; and

iii. Successful completion of CalOptima's pre-contractual review in accordance with CalOptima Policy GG.1619: Delegation Oversight and HH.2021Δ: Exclusion and Preclusion Monitoring.

c. Asthma Remediation, as described in Attachment A of this Policy, will be provided to a Member meeting the criteria as provided in Attachment B to this Policy by the Community Supports Provider when authorized by CalOptima or a Health Network until:

i. Services are no longer required for the Member;

ii. The Member refuses Asthma Remediation services;

iii. The Member has reached the total lifetime maximum of $7,500 and does not have an approved exception; or

iv. The Member is no longer eligible with CalOptima or a Health Network.

J. CalOptima or a Health Network shall track referrals to a Community Supports Provider to verify that authorized services have been initiated for the Member.

K. CalOptima or a Health Network will receive regular updates from the Community Supports Provider about the Member's progress toward goals, changes in status or barriers and other significant information affecting CalOptima Community Supports for the Member.

1. A Health Network shall provide data to CalOptima about the ongoing monitoring of appropriate and timely delivery of CalOptima Community Supports to their Members in a manner and format defined by CalOptima and in accordance with CalOptima Policy HH.2003: Health Network and Delegated Entity Reporting.

L. CalOptima shall ensure timely and accurate processing of claims for CalOptima Community Supports in accordance with applicable statutory, regulatory, and contractual requirements, as well as DHCS guidance and CalOptima Policy FF.2001: Claims Processing for Covered Services for which CalOptima is Financially Responsible.

M. Oversight of CalOptima Community Supports

1. CalOptima shall perform oversight of Community Supports Providers and hold Community Supports Providers accountable for all regulatory and contractual requirements, in accordance with CalOptima Policy GG.1619: Delegation Oversight.

    a. CalOptima shall hold Community Supports Providers responsible for the same reporting requirements as those that CalOptima must report to DHCS.

    b. CalOptima will not impose upon the Community Supports Providers mandatory reporting requirements that are different from or in addition to those required for encounter and supplemental reporting.

2. CalOptima may subcontract with other entities to administer CalOptima Community Supports, and must comply with all of the following:

    a. CalOptima will maintain and be responsible for compliance oversight of all contract provisions and covered services, regardless of the number of subcontracting layers.

        i. Subcontractor agreements will mirror the DHCS ECM and CalOptima Community Supports contract template requirements and the ECM and Community Supports Provider Standard Terms and Conditions.

    b. CalOptima shall retain responsibility for development and maintenance of DHCS-approved policies and procedures to ensure that subcontractors meet required responsibilities and functions.

    c. CalOptima shall be responsible for evaluating prospective subcontractor's ability to perform services.

    d. CalOptima is responsible for ensuring that subcontractor's Community Supports Provider capacity is sufficient to serve eligible Members.

    e. CalOptima will report to the DHCS the names of all subcontractors by type and service(s) provided and identify Orange County as the county in which Members are served.

        i. CalOptima will make all subcontractor agreements available to DHCS upon request. Such agreements must contain the minimum required information specified by DHCS, including method and amount of compensation.

3. On a quarterly basis, CalOptima shall review CalOptima Community Supports authorizations to ensure equitable and non-discriminatory approval determinations.

    a. CalOptima will evaluate the ethnic and racial characteristics of the population for whom CalOptima Community Supports is requested against the same characteristics of the population that was authorized for CalOptima Community Supports and provide feedback on the assessment. If CalOptima identifies an inequitable effect, CalOptima will refer the issue to the Audit and Oversight Department for continued action, in accordance with CalOptima Policy GG.1619: Delegation Oversight.

    b. CalOptima shall monitor healthcare service utilization and outcomes of member populations receiving CalOptima Community Supports as follows:

i. On a monthly basis, CalOptima shall monitor the housing status and program participation for each Member receiving housing-related CalOptima Community Supports.

ii. On a semi-annual basis, CalOptima shall monitor emergency room visits and hospitalizations for Members receiving Recuperative Care and analyze utilization prior to and after initiation of services.

N. CalOptima shall submit the following data and reports in a manner, format and frequency as defined by DHCS:

1. Encounter data, when possible, must include data necessary for DHCS to stratify services by age, sex, race, ethnicity, and language spoken to inform health equity initiatives and efforts to mitigate health disparities undertaken by the DHCS, including services generated under subcontracting arrangements.

2. Data will be provided to:

a. Evaluate the utilization and effectiveness of a Community Support;

b. Monitor health outcomes and quality metrics at the local and aggregate levels through timely and accurate Encounter Data and supplemental reporting on health outcomes and equity of care. When possible, metrics must be stratified by age, sex, race, ethnicity, and language spoken; and

c. Monitor Member appeals and grievances associated with Community Supports.

3. Supplemental reports, on a schedule and in a format as specified by DHCS.

IV. ATTACHMENT(S)

A. Community Supports Components
B. Community Supports Eligibility (Population Subset)

V. REFERENCE(S)

A. Department of Health Care Services (DHCS) California Advancing and Innovating Medi-Cal (CalAIM) Proposal
B. Department of Health Care Services (DHCS) Managed Care CalAIM Enhanced Care Management (ECM) and Community Supports (ILOS) Contract Template Provisions
C. CalAIM ECM and Community Supports Model of Care Template
D. Medi-Cal Community Supports Policy Guide (April 2022)
E. CalOptima Contract for Health Care Services
F. CalOptima Policy CMC.4002: Cultural and Linguistic Services
G. CalOptima Policy CMC.9002: Member Grievance Process
H. CalOptima Policy CMC.9003: Standard Appeal
I. CalOptima Policy CMC.9004: Expedited Appeal
J. CalOptima Policy DD.2002: Cultural and Linguistic Services
K. CalOptima Policy MA.4002: Cultural and Linguistic Services
L. CalOptima Policy EE.1103Δ: Provider Education and Training
M. CalOptima Policy EE.1141Δ: CalOptima Provider Contracts

N. CalOptima Policy FF.2001: Claims Processing for Covered Services which CalOptima is Financially Responsible
O. CalOptima Policy GG.1353: Enhanced Care Management (ECM) Service Delivery
P. CalOptima Policy GG.1356: Enhanced Care Management (ECM) Administration
Q. CalOptima Policy GG.1500 Authorization Instructions for CalOptima Direct and CalOptima Community Network Providers
R. CalOptima Policy GG.1507: Notification Requirements for Covered Services Requiring Prior Authorization.
S. CalOptima Policy GG.1508 Authorization and Processing of Referrals
T. CalOptima Policy GG.1650Δ: Credentialing and Recredentialing of Practitioners and
U. CalOptima Policy GG.1651Δ: Assessment and Re-Assessment of Organizational Providers
V. CalOptima Policy HH.1101: CalOptima Provider Complaint
W. CalOptima Policy HH.1102: Member Grievance
X. CalOptima Policy HH.1104: Complaints of Discrimination
Y. CalOptima Policy HH.2003: Health Network and Delegated Entity Reporting
Z. CalOptima Policy HH.2021Δ: Exclusion and Preclusion Monitoring
AA. CalOptima Policy MA.9002: Member Grievance Process
BB. CalOptima Policy MA.9003: Standard Pre-Service Appeal
CC. CalOptima Policy MA.9004: Expedited Pre-Service Appeal
DD. CalOptima Policy MA.9006: Provider Complaint Process
EE. Department of Health Care Services (DHCS) All Plan Letter (APL) 19-004: Provider Credentialing/Recredentialing and Screening/Enrollment

VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency	Response
11/30/2021	Department of Health Care Services (DHCS)	Approved as Submitted
TBD	Department of Health Care Services (DHCS)	

VII. BOARD ACTION(S)

Date	Meeting
12/20/2021	Special Meeting of the CalOptima Board of Directors
03/03/2022	Regular Meeting of the CalOptima Board of Directors
TBD	Regular Meeting of the CalOptima Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	01/01/2022	GG.1355	Community Supports	Medi-Cal
Revised	TBD	GG.1355	Community Supports	Medi-Cal

IX. GLOSSARY

Term	Definition
Appeal	Medi-Cal: A review by CalOptima of an adverse benefit determination, which includes one of the following actions: 1. A denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for Medical Necessity, appropriateness, setting, or effectiveness of a Covered Service; 2. A reduction, suspension, or termination of a previously authorized service; 3. A denial, in whole or in part, of payment for a service; 4. Failure to provide services in a timely manner; or 5. Failure to act within the timeframes provided in 42 CFR 438.408(b). OneCare: Any of the procedures that deal with the review of an adverse initial determination made by CalOptima on health care services or benefits under Part C or D the Member believes he or she is entitled to receive, including a delay in providing, arranging for, or approving the health care services or drug coverage (when a delay would adversely affect the health of the Member), or on any amounts the Member must pay for a service or drug as defined in 42 CFR §422.566(b) and §423.566(b). These procedures include reconsideration or redetermination, a reconsideration by an independent review entity (IRE), adjudication by an Administrative Law Judge (ALJ) or attorney adjudicator, review by the Medicare Appeals Council (MAC), and judicial review. OneCare Connect: In general, a Member's actions, both internal and external to CalOptima requesting review of CalOptima's denial, reduction or termination of benefits or services, from CalOptima. Appeals relating to Medi-Cal covered benefits and services shall proceed pursuant to the laws and regulations governing Medi-Cal Appeals. Appeals relating to Medicare covered benefits and services shall proceed pursuant to the laws and regulations governing Medicare Appeals. A Medi-Cal based Appeal is defined as review by CalOptima of an Adverse Benefit Determination.
California Medicaid State Plan	A comprehensive description of California's State Medicaid Program, based upon the requirements of Title XIX of the Social Security Act, that serves as a contractual agreement between the State of California and the federal Centers for Medicare and Medicaid Services.
CalOptima Community Supports	Community Supports that CalOptima has received approval from the Department of Health Care Services (DHCS) to provide.
Centers for Medicare & Medicaid Services (CMS)	The federal agency under the United States Department of Health and Human Services responsible for administering the Medicare and Medicaid programs.

Term	Definition
Community Supports	Pursuant to 42 CFR § 438.3(e)(2), Community Supports are services or settings that are offered in place of services or settings covered under the California Medicaid State Plan and are a medically appropriate, cost-effective alternative to a State Plan Covered Service. Authorized Community Supports offered are included in development of CalOptima's capitation rate and count toward the medical expense component of CalOptima's Medical Loss Ratio (MLR) in accordance with 42 CFR § 438.8 (e)(2) Community Supports are optional for both CalOptima and the Member and must be approved by DHCS.
Community Supports Provider	A CalOptima-contracted Provider of the DHCS-approved CalOptima Community Supports. Providers are entities with experience and expertise providing one (1) or more of the CalOptima Community Supports approved by the DHCS.
Covered Services	Medi-Cal: Those services provided in the Fee-For-Service Medi-Cal program (as set forth in Title 22, CCR, Division 3, Subdivision 1, Chapter 3, beginning with Section 51301), the Child Health and Disability Prevention program (as set forth in Title 17, CCR, Division 1, Chapter 4, Subchapter 13, Article 4, beginning with section 6842), and the California Children's Services (as set forth in Title 22, CCR, Division 2, subdivision 7, and Welfare and Institutions Code, Division 9, Part 3, Chapter 7, Article 2.985, beginning with section 14094.4) under the Whole-Child Model program, to the extent those services are included as Covered Services under CalOptima's Medi-Cal Contract with DHCS and are Medically Necessary, along with chiropractic services (as defined in Section 51308 of Title 22, CCR), podiatry services (as defined in Section 51310 of Title 22, CCR), speech pathology services and audiology services (as defined in Section 51309 of Title 22, CCR), and Enhanced Care Management and CalOptima Community Supports (as provided under the California Advancing and Innovating Medi-Cal initiative) for Members meeting eligibility criteria, or other services as authorized by the CalOptima Board of Directors, which shall be covered for Members notwithstanding whether such benefits are provided under the Fee-For-Service Medi-Cal program. OneCare: Those medical services, equipment, or supplies that CalOptima is obligated to provide to Members under the Centers of Medicare & Medicaid Services (CMS) Contract. OneCare Connect: Those medical services, equipment, or supplies that CalOptima is obligated to provide to Members under the Three-Way Contract with the Department of Health Care Services (DHCS) and Centers for Medicare & Medicaid Services (CMS).
Department of Health Care Services (DHCS)	The single State Department responsible for administration of the Medi-Cal program, California Children Services (CCS), Genetically Handicapped Persons Program (GHPP), Child Health and Disabilities Prevention (CHDP), and other health related programs
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.

Term	Definition
ECM Member	A Member that is authorized for, continuously participating in, and receiving Enhanced Care Management, and assigned to a Health Network or CalOptima Direct.
ECM Provider	A Provider within the community that has a contractual relationship with CalOptima (such as a delegated Health Network) to provide ECM services to Members authorized to receive ECM. ECM Providers have experience and expertise providing intensive, in-person care management services to individuals in one or more of the Populations of Focus for ECM.
Encounter	Any unit of Covered Services provided to a member by a Health Network regardless of reimbursement methodology.
Grievance	An oral or written expression of dissatisfaction about any matter other than an action that is an adverse benefit determination, as identified within the definition of an Appeal, and may include, but is not limited to: the quality of care or services provided, interpersonal relationships with a Provider or CalOptima's employee, failure to respect a Member's rights regardless of whether remedial action is requested, and the right to dispute an extension of time proposed by CalOptima to make an authorization decision.
Health Network	A Physician Hospital Consortium (PHC), physician group under a shared risk contract, or health care service plan, such as a Health Maintenance Organization (HMO) that contracts with CalOptima to provide Covered Services to Members assigned to that Health Network.

Term	Definition
Medically Necessary or Medical Necessity	Medi-Cal: Reasonable and necessary Covered Services to protect life, to prevent significant illness or significant disability, or alleviate severe pain through the diagnosis or treatment of disease, illness, or injury, as required under W&I Code 14059.5(a) and Title 22 CCR Section 51303(a). Medically Necessary services shall include Covered Services necessary to achieve age-appropriate growth and development, and attain, maintain, or regain functional capacity. For Members under 21 years of age, a service is Medically Necessary if it meets the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) standard of medical necessity set forth in Section 1396d(r)(5) of Title 42 of the United States Code, as required by W&I Code 14059.5(b) and W&I Code Section 14132(v). Without limitation, Medically Necessary services for Members under 21 years of age include Covered Services necessary to achieve or maintain age-appropriate growth and development, attain, regain or maintain functional capacity, or improve, support or maintain the Member's current health condition. CalOptima shall determine Medical Necessity on a case-by-case basis, taking into account the individual needs of the child. OneCare: The services, supplies, or drugs that are needed for the prevention, diagnosis, or treatment of your medical condition and meet accepted standards of medical practice. OneCare Connect: Services must be provided in a way that provides all protections to the Member provided by Medicare and Medi-Cal. Per Medicare, services must be reasonable and necessary Covered Services for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member, or otherwise medically necessary under 42 U.S.C. § 1395y. In accordance with Title XIX law and related regulations, and per Medi-Cal, Medical Necessity means reasonable and necessary services to protect life, to prevent significant illness or significant disability, or to alleviate severe pain through the diagnosis or treatment of disease, illness, or injury under WIC Section 14059.5.
Member	A Medi-Cal eligible beneficiary as determined by the County of Orange Social Services Agency, the California Department of Health Care Services (DHCS) Medi-Cal Program, or the United States Social Security Administration, who is enrolled in the CalOptima program.

Term	Definition
Provider	Medi-Cal: A physician, nurse, nurse mid-wife, nurse practitioner, medical technician, physician assistant, hospital, laboratory, ancillary provider, or other person or institution that furnishes Covered Services. OneCare: Any Medicare provider (e.g., hospital, skilled nursing facility, home health agency, outpatient physical therapy, comprehensive outpatient rehabilitation facility, end-stage renal disease facility, hospice, physician, non-physician provider, laboratory, supplier, etc.) providing Covered Services under Medicare Part B. Any organization, institution, or individual that provides Covered Services to Medicare members. Physicians, ambulatory surgical centers, and outpatient clinics are some of the providers of Covered Services under Medicare Part B. OneCare Connect: A physician, pharmacist, nurse, nurse mid-wife, nurse practitioner, medical technician, physician assistant, hospital, laboratory, health maintenance organization, Health Network, physician group, or other person or institution who furnishes Covered Services.
Recuperative Care	Short-term residential care for individuals who do not require hospitalization but need to recover from a physical or behavioral health injury or illness and whose condition would be exacerbated by an unstable living environment.
Social Determinants of Health	The conditions in the environments where 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. Social Determinants of Health can be grouped into 5 domains: economic stability, education access and quality, health care access and quality, neighborhood and built environment, and social and community context. Social Determinants of Health have a major impact on people's health, well-being, and quality of life. Examples of SDOH include: safe housing, transportation, and neighborhoods, racism, discrimination, and violence, education, job opportunities, and income, access to nutritious foods and physical activity opportunities, polluted air and water, and language and literacy skills.

I. Housing Transition Navigation Services

A. Service Description: Housing Transition Navigation Services assist Members with obtaining housing and include the following components:

1. Conducting a tenant screening and housing assessment that identifies the Member's preferences and barriers related to successful tenancy. The assessment may include collecting information on the Member's housing needs and on potential housing transition barriers, as well as identification of housing retention barriers.

2. Development of an individualized housing support plan, that:

   a. Is based upon the housing assessment;

   b. Addresses identified barriers;

   c. Includes measurable short- and long-term goals for each issue;

      i. Establishes the Member's approach to meeting the goal; and

      ii. Identifies other providers or services required to meet the goal, whether reimbursed by Medi-Cal or not.

3. Searching for housing and presenting options to the Member.

4. Assisting in securing housing as documented in the individualized housing support plan.

5. Completion of housing applications.

6. Securing required documentation:

   a. Social Security card;

   b. Birth certificate; and

   c. Prior rental history.

7. Assisting with benefits advocacy as documented in the individualized housing support plan, such as, but not limited to:

   a. Assisting in obtaining and submitting necessary documentation for SSI eligibility, as appropriate; and

   b. Supporting SSI application process, as appropriate.

8. Identifying and securing available resources to subsidize rent (such as U.S. Department of Housing and Urban Development's Housing Choice Voucher Program (Section 8), or State

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and local assistance programs) and matching available rental subsidy resources to Members, as documented in the individualized housing support plan.

a. Identifying and securing resources to cover expenses identified in the individualized housing support plan, such as, but not limited to:

i. Security deposit;

ii. Moving costs;

iii. Adaptive aids;

iv. Environmental modifications; and

v. Other one-time expenses.

9. Assisting with requests for reasonable accommodation, if necessary, as documented in the individualized housing support plan.

10. Educating and engaging with landlords.

a. Ensuring that the living environment is safe and ready for move-in;

b. Communicating and advocating on behalf of the Member with landlords; and

c. Assisting with arranging for and supporting the details of the move.

11. 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.

12. 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, as documented in the individualized housing support plan.

13. Identifying and coordinating environmental modifications to install necessary accommodations for accessibility (see Environmental Accessibility Adaptation Community Supports), as documented in the individualized housing support plan.

B. Restrictions/Limitations:

1. Housing Transition/ Navigation Services must be identified as reasonable and necessary in the Member's individualized housing support plan. Service duration can be as long as necessary.

~~2.~~ Community Supports shall supplement and not supplant services received by the Members ~~may not be receiving duplicative support from~~through other State ~~or~~, local ~~tax~~, or federally ~~-~~ funded programs, ~~which shall be considered first, before using Medi-Cal funding~~in accordance with the CalAIM Special Terms and Conditions and federal and DHCS guidance.

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II. Housing Deposits

A. Service Description: 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 or payment of rental costs, including, but not limited to:

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 and last month's rent as required by landlord for occupancy.

5. Services necessary for the Member'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 a Member's health and safety in the home such as hospital beds, Hoyer lifts, air filters, and specialized cleaning or pest control supplies etc., that are necessary to ensure access and safety for the Member upon move-in to the home.

B. Restrictions/Limitations

1. Housing Deposits are available once in an individual's lifetime.

   a. Housing Deposits can only be approved ***one additional*** time with documentation as to what has changed to demonstrate that a second Housing Deposit would be more successful on the second attempt.

   b. A good faith effort must be made by CalOptima or the Health Network to determine whether a Member has previously received services.

2. The individualized housing support plan must identify the Housing Deposit as reasonable and necessary, and that the Member is otherwise unable to meet this expense.

3. A Member must also be receiving Housing Transition Navigation Services (at a minimum, the associated tenant screening, housing assessment, and individualized housing support plan) in conjunction with this service.

4. Community Supports shall supplement and not supplant services received by the Members ~~may not be receiving duplicative support from~~through other State, local, or federally--funded programs, ~~which shall be considered first, before using Medi-Cal funding.~~in accordance with the CalAIM Special Terms and Conditions and federal and DHCS guidance.

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III. Housing Tenancy and Sustaining Services

A. Service Description: Housing Tenancy and Sustaining Services provide tenancy and sustaining services, with a goal of maintaining safe and stable tenancy once housing is secured. Services include the following, based on an individualized assessment of needs and documented in the individualized housing support plan:

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 roles, rights, and responsibilities of the tenant and landlord.

3. Coaching on developing and maintaining key relationships with landlords/property managers to foster 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 the risk of eviction or other adverse action.

    a. Includes development of a repayment plan and/or identifying funding in the case where a Member owes back rent or payment for damage to a 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:

    a. Assisting in obtaining and submitting necessary documentation for SSI eligibility, as appropriate; and

    b. Supporting SSI application process, as appropriate.

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 addressing 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).

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13. Providing independent living and life skills including assistance with and training on budgeting, including financial literacy and connection to community resources.

B. Restrictions/Limitations:

1. Housing Tenancy and Sustaining Services are available from the initiation of services through the time when the Member's housing support plan determines they are no longer needed. They are available for a single duration in a Member's lifetime.

a. Housing Tenancy and Sustaining Services can be approved one additional time with documentation as to what conditions have changed to demonstrate why providing these services would be more successful on the second attempt.

b. CalOptima or a Health Network, as appliable, shall make a good faith effort to review information available to them to determine whether the Member has previously received services.

c. Service duration can be as long as necessary.

2. Housing Tenancy and Support Services must be identified as reasonable and necessary in the Member's individualized housing support plan and are available only when the Member is unable to successfully maintain longer-term housing without such assistance.

3. Community Supports shall supplement and not supplant services received by the Members ~~may not be receiving duplicative support from~~through other State, local, or federally-~~-~~funded programs, ~~which shall be considered first, before using Medi-Cal funding~~in accordance with the CalAIM Special Terms and Conditions and federal and DHCS guidance.

IV. Recuperative Care (Medical Respite)

A. Service Description: Recuperative Care is short-term residential care for individuals who do not require hospitalization but need to recover from a physical or behavioral health injury or illness and whose condition would be exacerbated by an unstable living environment. Recuperative Care will be provided for a duration not to exceed 90 continuous days in duration and will include, at a minimum:

1. Interim housing with a bed and meals.

2. Ongoing monitoring of a Member's ongoing medical or behavioral health condition, such as, but not limited to:

a. Vital signs;

b. Assessments;

c. Wound care; and

d. Medication monitoring.

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3. Based on individual needs, the service may also include:

   a. Limited or short-term assistance with Instrumental Activities of Daily Living (IADLs) and/or Activities of Daily Living (ADLs);

   b. Coordination of transportation to post-discharge appointments;

   c. Connection to any other ongoing services a Member may require, including mental health and substance use disorder services;

   d. Support in accessing benefits and housing; and

   e. Gaining stability with case management relationships and programs.

B. Restrictions/Limitations:

1. Recuperative Care is an allowable Community Supports if it:

   a. Is necessary to achieve or maintain medical stability and prevent hospital admission or readmission, which may require behavioral health interventions;

   b. Is not more than 90 days in continuous duration; and

   c. Does not include funding for building modification or building rehabilitation.

2. Community Supports shall supplement and not supplant services received by the Members ~~may not be receiving duplicative support from~~ through other State, local, or federally-~~-~~funded programs, ~~which shall~~ in accordance with the CalAIM Special Terms and Conditions and federal and DHCS guidance.

V. Short-Term Post-Hospitalization Housing

A. Service Description: Short-Term Post-Hospitalization provides temporary housing for Members to continue their medical/psychiatric/substance use disorder recovery immediately after exiting an inpatient hospital or facility, and provide ongoing supports necessary for recuperation and recovery that may include, but not limited to:

1. Assistance with gaining/regaining ability to perform activities of daily living.

2. Receiving necessary medical/psychiatric/substance use disorder care.

3. Receiving case management services.

4. Assistance with accessing other housing supports such as Housing Transition Navigation.

5. 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.

B. Restrictions/Limitations

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1. Short-Term Post-Hospitalization services are available once in an individual's lifetime and not to exceed a duration of six (6) months.

   a. A good faith effort must be made by CalOptima or the Health Network to determine whether a Member has previously received services.

2. Community Supports shall supplement and not supplant services received by the Members through other State, local, or federally-funded programs, in accordance with the CalAIM Special Terms and Conditions and federal and DHCS guidance.

VI. Medically Tailored Meals/Medically-Supportive Food

A. Service Description: Medically Tailored Meals/Medically-Supportive Food provides meals that help Members achieve their nutrition goals at critical times to regain and maintain their health and provide services that may include, but not limited to:

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 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/or side effects to ensure the best possible nutrition-related health outcomes.

4. Medically-supportive food and nutrition services, including medically tailored groceries, healthy food vouchers, and food pharmacies.

5. Behavioral, cooking, and/or nutrition education is included when paired with direct food assistance as enumerated above.

B. Restrictions/Limitations

1. Medically-tailored meals are:

   a. Provided up to two (2) meals per day; and/or

   b. Medically-supportive food and nutrition services provided for up to 12 weeks or longer if medically necessary.

2. Meals that are eligible for or reimbursed by alternate programs are not eligible.

3. Meals are not covered to respond solely to food insecurities.

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4. Community Supports shall supplement and not supplant services received by the Members through other State, local, or federally-funded programs, in accordance with the CalAIM Special Terms and Conditions and federal and DHCS guidance.

VII. Sobering Centers

A. Service Description: Sobering Centers provides an alternative destination for Members, primarily those who are homeless or those with unstable living situations, with a safe, supportive environment to become sober. Services may include, but not limited to:

1. Medical Services

    a. Medical triage;

    b. Lab testing;

    c. Treatment for nausea; and

    d. Wound and dressing changes;

2. Personal and Hygiene Care Services

    a. Temporary bed;

    b. Rehydration and food service; and

    c. Shower and laundry facilities;

3. Substance use education and counseling.

4. Navigation and warm hand-offs for additional substance use services.

5. Direct coordination with the county behavioral health agency and warm hand-offs for additional behavioral health services.

6. Screening and linkage to ongoing supportive services such as follow-up mental health and substance use disorder treatment and housing options, as appropriate.

7. Establishing strong partnership with law enforcement, emergency personnel, and outreach teams to identify and divert individuals to Sobering Centers.

8. Identifying Members with emergent physical health conditions and arrange transport to a hospital or appropriate source of medical care.

9. Utilizing best practices for Members 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.

10. Other necessary health care services and homeless care support services as appropriate.

B. Restrictions/Limitations

1. Sobering Center service is covered for a duration of less than twenty-four (24) hours.

2. Community Supports shall supplement and not supplant services received by the Members through other State, local, or federally-funded programs, in accordance with the CalAIM Special Terms and Conditions and federal and DHCS guidance.

VIII. Personal Care and Homemaker Services

A. Service Description: Personal Care and Homemaker Services provide Members who need assistance with Activities of Daily Living (ADLs) and/or Instrumental Activities of Daily Living (IADLs) the ability to remain in their home/residence. Services may include but not limited to:

1. ADLs such as bathing, dressing, toileting, ambulation, or feeding. Personal Care Services can also include assistance with such as meal preparation, grocery shopping, and money management.

2. IADLs such as cleaning, meal preparation, grocery shopping, and money management.

B. Restrictions/Limitations

1. Personal Care and Homemaker Services cannot be ~~considered first, before using~~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.

2. 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 the Personal Care and Homemaker Services Community Support during this reassessment waiting period.

3. Community Supports shall supplement and not supplant services received by the Members through other State, local, or federally-funded programs, in accordance with the CalAIM Special Terms and Conditions and federal and DHCS guidance.

IX. Day Habilitation

A. Service Description: Day Habilitation Programs provide assistance to Members in acquiring, retaining, and improving self-help, socialization, and adaptive skills necessary to reside successfully in the person's natural environment. Services are provided in a Member's home or an out-of-home, non- facility setting with an unlicensed caregiver with the necessary training and supervision.

1. Day Habilitation Program services include, but are not limited to, training on:

a. The use of public transportation;

b. Personal skills development in conflict resolution;

c. Community participation;

d. Developing and maintaining interpersonal relationships;

e. Daily living skills (cooking, cleaning, shopping, money management); and

f. Community resource awareness such as police, fire, or local services to support independence in the community.

2. Other program services may include assistance with, but not limited to, the following:

a. Selecting and moving into a home;

b. Locating and choosing suitable housemates;

c. Locating household furnishings;

d. Settling disputes with landlords;

e. Managing personal financial affairs;

f. Recruiting, screening, hiring, training, supervising, and dismissing personal attendants;

g. Dealing with and responding appropriately to governmental agencies and personnel;

h. Asserting civil and statutory rights through self-advocacy;

i. Building and maintaining interpersonal relationships, including a circle of support;

j. Coordination with Medi-Cal managed care plan to link Member to any Community Supports and/or enhanced care management services for which the Member may be eligible;

k. Referral to non-Community Supports housing resources if Member does not meet Housing Transition/Navigation Serv ices Community Support eligibility criteria;

l. Assistance with income and benefits advocacy including General assistance/General Relief and SSI if Member is not receiving these services through Community Supports or Enhanced Care Management; and/or

m. Coordination with Medi-Cal managed care plan to link Member to health care, mental health services, and substance use disorder services based on the individual needs of the Member for Members who are not receiving this linkage through Community Supports or enhanced care management.

B. Restrictions/Limitations

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1. Community Supports shall supplement and not supplant services received by the Members through other State, local, or federally-funded programs, in accordance with the CalAIM Special Terms and Conditions and federal and DHCS guidance.

X. Respite Services

A. Service Description: Respite services are provided to caregivers of Members who require intermittent temporary supervision. These services are provided on a short-term basis because of the absence or need for relief of the caregiver who normally care for and/or supervise the Member 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 that may include, but not limited to:

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 Member'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.

4. Services are provided in:

   a. Private residence;

   b. Residential facility approved by the State, such as, Congregate Living Health Facilities (CLHFs); or

   c. Providers contracted by county behavioral health.

B. Restrictions/Limitations

1. In the home setting, these services, in combination with any direct care services the Member is receiving, may not exceed twenty-four (24) hours per day of care.

2. Service limit is up to three hundred thirty-six (336) hours per calendar year. The service is inclusive of all in-home and in-facility services. Exceptions to the three hundred thirty-six (336) hour per calendar year limit can be made, with CalOptima or Health Network authorization, when the caregiver experiences an episode, including medical treatment and hospitalization that leaves a Member without their caregiver. Respite support provided during these episodes can be excluded from the three hundred thirty-six (336)-hour annual limit.

3. Respite service is only to avoid placements for which the CalOptima or a Health Network would be responsible.

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4. Community Supports shall supplement and not supplant services received by the Members through other State, local, or federally-funded programs, in accordance with the CalAIM Special Terms and Conditions and federal and DHCS guidance.

XI. Nursing Facility Transition/Diversion to Assisted Living Facilities (Residential Care)

A. Service Description: Nursing Facility Transition/Diversion to Assisted Living Facilities (Residential Care) helps Members who would like to transition back into a home-like, community setting and/or to avoid institutionalization when possible. Members 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. These services may include, but not limited to:

1. Wrap-around Services:

   a. Assistance with ADLs and IADLs such as bathing, dressing, toileting, ambulation, or feeding. Personal Care Services can also include assistance with such as meal preparation, grocery shopping, and money management as needed;

   b. IIADLs such as cleaning, meal preparation, grocery shopping, and money management as needed;

   c. Companion services;

   d. Medication oversight;

   e. Therapeutic social and recreational programming provided in a home-like environment; and

   f. Includes twenty-four (24)-hour direct care staff on-site to meet scheduled unpredictable needs in a way that promotes maximum dignity and independence, and to provide supervision, safety, and security.

2. Allowable expenses are those necessary to enable a person to establish a community facility residence (except room and board), including, but not limited to:

   a. Assessing the Member's housing needs and presenting options;

   b. Assessing the service needs of the Member to determine if the Member needs enhanced onsite services at the Residential Care Facilities for the Elderly (RCFE) and Adult Residential Facilities (ARF) so the Member can be safely and stably housed in an RCFE/ARF;

   c. 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);

   d. Communicating with facility administration and coordinating the move;

   e. Establishing procedures and contacts to retain facility housing; and

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f. Coordinating with the Medi-Cal managed care plan to ensure that the needs of Members who need enhanced services to be safely and stably housed in RCFE/ARF settings have Community Supports and/or Enhanced Care Management services that provide the necessary enhanced services.

i. Managed care plans ~~my~~may also fund RCFE/ARF operations directly to provide these enhanced services.

B. Restrictions/Limitations

1. Members are directly responsible for paying their own living expenses.

2. Community Supports shall supplement and not supplant services received by the Members through other State, local, or federally-funded programs, in accordance with the CalAIM Special Terms and Conditions and federal and DHCS guidance.

XII. Community Transition Services/Nursing Facility Transition to a Home

A. Service Description: Community Transition Services/Nursing Facility Transition to a Home Services provide assistance to Members to live in the community and avoid further institutionalization. Members are transitioning from a licensed facility to a living arrangement in a private residence are directly responsible for his or her own living expenses. Services may include, but not limited to:

1. Allowable expenses necessary to enable a person to establish a basic household that do not constitute room and board and include:

a. Assessing the Member's housing needs and presenting options;

b. 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);

c. Communicating with landlord (if applicable) and coordinating the move;

d. Establishing procedures and contacts to retain housing;

e. 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; and

f. Identifying the need for and coordinating funding for environmental modifications to install necessary accommodations for accessibility.

B. Restrictions/Limitations

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1. 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.

2. Community Transition Services are payable up to a total lifetime maximum amount of $7,500.00. The only exception to the $7,500.00 total maximum is if the Member 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.

3. Community Transition Services must be necessary to ensure the health, welfare, and safety of the Member, and without which the Member would be unable to move to the private residence and would then require continued or re- institutionalization.

4. Community Supports shall supplement and not supplant services received by the Members through other State, local, or federally-funded programs, in accordance with the CalAIM Special Terms and Conditions and federal and DHCS guidance.

XIII. Environmental Accessibility Adaptations (Home Modifications)

A. Service Description: 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 Member would require institutionalization. These services may include, but not limited to:

1. In-home modifications such as:

   a. Ramps and grab-bars to assist Members in accessing the home;

   b. Doorway widening for Members who require a wheelchair;

   c. Stair lifts;

   d. Making a bathroom and shower wheelchair accessible (e.g., constructing a roll-in shower);

   e. Installation of specialized electric and plumbing systems that are necessary to accommodate the medical equipment and supplies of the Member; and

   f. Installation and testing of a Personal Emergency Response System (PERS) for Members who are alone for significant parts of the day without a caregiver and who otherwise require routine supervision (including monthly service costs, as needed).

B. Restrictions/Limitations

1. 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.

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2. EAAs must be conducted in accordance with applicable State and local building codes.

3. EAAs are payable up to a total lifetime maximum of $7,500. The only exceptions to the $7,500 total maximum are if the Member's place of residence changes or if the Member's condition has changed so significantly that additional modifications are necessary to ensure the health, welfare, and safety of the Member, or are necessary to enable the Member to function with greater independence in the home and avoid institutionalization or hospitalization.

4. EAAs may include finishing (e.g., drywall and painting) to return the home to a habitable condition, but do not include aesthetic embellishments.

5. Community Supports shall supplement and not supplant services received by the Members through other State, local, or federally-funded programs, in accordance with the CalAIM Special Terms and Conditions and federal and DHCS guidance.

XIV. Asthma Remediation

A. Service Description: 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. Services may include, but not limited to:

1. Providing information to Members 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:

   a. Identification of environmental triggers commonly found in and around the home, including allergens and irritants.

2. Purchasing materials such as:

   a. Allergen-impermeable mattress and pillow dustcovers;

   b. High-efficiency particulate air (HEPA) filtered vacuums;

   c. Asthma friendly cleaning products;

   d. De-humidifiers; and

   e. Air filters;

3. Health-related minor home repairs such as:

   a. Pest management or patching holes and cracks through which pests can enter;

   b. Minor mold removal and remediation services;

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c. Ventilation improvements;

d. Integrated Pest Management (IPM) services; and

e. Other moisture-controlling interventions;

4. Other interventions identified to be medically appropriate and cost effective.

B. Restrictions/Limitations

1. If another State Plan service such as Durable Medical Equipment, is available and would accomplish the same goals of preventing asthma emergencies or hospitalizations.

2. Asthma remediations must be conducted in accordance with applicable State and local building codes.

3. Asthma remediations are payable up to a total lifetime maximum of $7,500. The only exception to the $7,500 total maximum is if the Member's condition has changed so significantly that additional modifications are necessary to ensure the health, welfare, and safety of the Member, or are necessary to enable the Member to function with greater independence in the home and avoid institutionalization or hospitalization.

4. Asthma Remediation modifications are limited to those that are of direct medical or remedial benefit to the Member 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.

~~1.~~5. Community Supports shall supplement and not supplant services received by the Members through other State, local, or federally-funded programs, in accordance with the CalAIM Special Terms and Conditions and federal and DHCS guidance.

V. References

A. Department of Health Care Services Medi-Cal ~~In Lieu of Services (ILOS)~~Community Supports Policy Guide (~~September~~December 2021), Section III. ~~In Lieu of Services~~Community Supports – Service Definitions includes comprehensive service descriptions and restrictions/limitations of Housing Transition Navigation Services, Housing Deposits, Housing Tenancy and Sustaining Services, and Recuperative Care (Medical Respite) in the Description/Overview and Restrictions/Limitations sections.

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I. Housing Transition Navigation Services

A. Service Description: Housing Transition Navigation Services assist Members with obtaining housing and include the following components:

1. Conducting a tenant screening and housing assessment that identifies the Member's preferences and barriers related to successful tenancy. The assessment may include collecting information on the Member's housing needs and on potential housing transition barriers, as well as identification of housing retention barriers.

2. Development of an individualized housing support plan, that:

   a. Is based upon the housing assessment;

   b. Addresses identified barriers;

   c. Includes measurable short- and long-term goals for each issue;

      i. Establishes the Member's approach to meeting the goal; and

      ii. Identifies other providers or services required to meet the goal, whether reimbursed by Medi-Cal or not.

3. Searching for housing and presenting options to the Member.

4. Assisting in securing housing as documented in the individualized housing support plan.

5. Completion of housing applications.

6. Securing required documentation:

   a. Social Security card;

   b. Birth certificate; and

   c. Prior rental history.

7. Assisting with benefits advocacy as documented in the individualized housing support plan, such as, but not limited to:

   a. Assisting in obtaining and submitting necessary documentation for SSI eligibility, as appropriate; and

   b. Supporting SSI application process, as appropriate.

8. Identifying and securing available resources to subsidize rent (such as U.S. Department of Housing and Urban Development's Housing Choice Voucher Program (Section 8), or State and local assistance programs) and matching available rental subsidy resources to Members, as documented in the individualized housing support plan.

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a. Identifying and securing resources to cover expenses identified in the individualized housing support plan, such as, but not limited to:

i. Security deposit;

ii. Moving costs;

iii. Adaptive aids;

iv. Environmental modifications; and

v. Other one-time expenses.

9. Assisting with requests for reasonable accommodation, if necessary, as documented in the individualized housing support plan.

10. Educating and engaging with landlords.

a. Ensuring that the living environment is safe and ready for move-in;

b. Communicating and advocating on behalf of the Member with landlords; and

c. Assisting with arranging for and supporting the details of the move.

11. 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.

12. 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, as documented in the individualized housing support plan.

13. Identifying and coordinating environmental modifications to install necessary accommodations for accessibility (see Environmental Accessibility Adaptation Community Supports), as documented in the individualized housing support plan.

B. Restrictions/Limitations:

1. Housing Transition/ Navigation Services must be identified as reasonable and necessary in the Member's individualized housing support plan. Service duration can be as long as necessary.

2. Community Supports shall supplement and not supplant services received by the Members through other State, local, or federally-funded programs, in accordance with the CalAIM Special Terms and Conditions and federal and DHCS guidance.

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II. Housing Deposits

A. Service Description: 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 or payment of rental costs, including, but not limited to:

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 and last month's rent as required by landlord for occupancy.

5. Services necessary for the Member'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 a Member's health and safety in the home such as hospital beds, Hoyer lifts, air filters, and specialized cleaning or pest control supplies etc., that are necessary to ensure access and safety for the Member upon move-in to the home.

B. Restrictions/Limitations

1. Housing Deposits are available once in an individual's lifetime.

   a. Housing Deposits can only be approved ***one additional*** time with documentation as to what has changed to demonstrate that a second Housing Deposit would be more successful on the second attempt.

   b. A good faith effort must be made by CalOptima or the Health Network to determine whether a Member has previously received services.

2. The individualized housing support plan must identify the Housing Deposit as reasonable and necessary, and that the Member is otherwise unable to meet this expense.

3. A Member must also be receiving Housing Transition Navigation Services (at a minimum, the associated tenant screening, housing assessment, and individualized housing support plan) in conjunction with this service.

4. Community Supports shall supplement and not supplant services received by the Members through other State, local, or federally-funded programs, in accordance with the CalAIM Special Terms and Conditions and federal and DHCS guidance.

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III. Housing Tenancy and Sustaining Services

A. Service Description: Housing Tenancy and Sustaining Services provide tenancy and sustaining services, with a goal of maintaining safe and stable tenancy once housing is secured. Services include the following, based on an individualized assessment of needs and documented in the individualized housing support plan:

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 roles, rights, and responsibilities of the tenant and landlord.

3. Coaching on developing and maintaining key relationships with landlords/property managers to foster 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 the risk of eviction or other adverse action.

    a. Includes development of a repayment plan and/or identifying funding in the case where a Member owes back rent or payment for damage to a 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:

    a. Assisting in obtaining and submitting necessary documentation for SSI eligibility, as appropriate; and

    b. Supporting SSI application process, as appropriate.

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 addressing 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).

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13. Providing independent living and life skills including assistance with and training on budgeting, including financial literacy and connection to community resources.

B. Restrictions/Limitations:

1. Housing Tenancy and Sustaining Services are available from the initiation of services through the time when the Member's housing support plan determines they are no longer needed. They are available for a single duration in a Member's lifetime.

a. Housing Tenancy and Sustaining Services can be approved one additional time with documentation as to what conditions have changed to demonstrate why providing these services would be more successful on the second attempt.

b. CalOptima or a Health Network, as appliable, shall make a good faith effort to review information available to them to determine whether the Member has previously received services.

c. Service duration can be as long as necessary.

2. Housing Tenancy and Support Services must be identified as reasonable and necessary in the Member's individualized housing support plan and are available only when the Member is unable to successfully maintain longer-term housing without such assistance.

3. Community Supports shall supplement and not supplant services received by the Members through other State, local, or federally-funded programs, in accordance with the CalAIM Special Terms and Conditions and federal and DHCS guidance.

IV. Recuperative Care (Medical Respite)

A. Service Description: Recuperative Care is short-term residential care for individuals who do not require hospitalization but need to recover from a physical or behavioral health injury or illness and whose condition would be exacerbated by an unstable living environment. Recuperative Care will be provided for a duration not to exceed 90 continuous days in duration and will include, at a minimum:

1. Interim housing with a bed and meals.

2. Ongoing monitoring of a Member's ongoing medical or behavioral health condition, such as, but not limited to:

a. Vital signs;

b. Assessments;

c. Wound care; and

d. Medication monitoring.

3. Based on individual needs, the service may also include:

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a. Limited or short-term assistance with Instrumental Activities of Daily Living (IADLs) and/or Activities of Daily Living (ADLs);

b. Coordination of transportation to post-discharge appointments;

c. Connection to any other ongoing services a Member may require, including mental health and substance use disorder services;

d. Support in accessing benefits and housing; and

e. Gaining stability with case management relationships and programs.

B. Restrictions/Limitations:

1. Recuperative Care is an allowable Community Supports if it:

a. Is necessary to achieve or maintain medical stability and prevent hospital admission or readmission, which may require behavioral health interventions;

b. Is not more than 90 days in continuous duration; and

c. Does not include funding for building modification or building rehabilitation.

2. Community Supports shall supplement and not supplant services received by the Members through other State, local, or federally-funded programs, in accordance with the CalAIM Special Terms and Conditions and federal and DHCS guidance.

V. Short-Term Post-Hospitalization Housing

A. Service Description: Short-Term Post-Hospitalization provides temporary housing for Members to continue their medical/psychiatric/substance use disorder recovery immediately after exiting an inpatient hospital or facility, and provide ongoing supports necessary for recuperation and recovery that may include, but not limited to:

1. Assistance with gaining/regaining ability to perform activities of daily living.

2. Receiving necessary medical/psychiatric/substance use disorder care.

3. Receiving case management services.

4. Assistance with accessing other housing supports such as Housing Transition Navigation.

5. 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.

B. Restrictions/Limitations

1. Short-Term Post-Hospitalization services are available once in an individual's lifetime and not to exceed a duration of six (6) months.

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a. A good faith effort must be made by CalOptima or the Health Network to determine whether a Member has previously received services.

2. Community Supports shall supplement and not supplant services received by the Members through other State, local, or federally-funded programs, in accordance with the CalAIM Special Terms and Conditions and federal and DHCS guidance.

VI. Medically Tailored Meals/Medically-Supportive Food

A. Service Description: Medically Tailored Meals/Medically-Supportive Food provides meals that help Members achieve their nutrition goals at critical times to regain and maintain their health and provide services that may include, but not limited to:

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 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/or side effects to ensure the best possible nutrition-related health outcomes.

4. Medically-supportive food and nutrition services, including medically tailored groceries, healthy food vouchers, and food pharmacies.

5. Behavioral, cooking, and/or nutrition education is included when paired with direct food assistance as enumerated above.

B. Restrictions/Limitations

1. Medically-tailored meals are:

a. Provided up to two (2) meals per day; and/or

b. Medically-supportive food and nutrition services provided for up to 12 weeks or longer if medically necessary.

2. Meals that are eligible for or reimbursed by alternate programs are not eligible.

3. Meals are not covered to respond solely to food insecurities.

4. Community Supports shall supplement and not supplant services received by the Members through other State, local, or federally-funded programs, in accordance with the CalAIM Special Terms and Conditions and federal and DHCS guidance.

VII. Sobering Centers

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A. Service Description: Sobering Centers provides an alternative destination for Members, primarily those who are homeless or those with unstable living situations, with a safe, supportive environment to become sober. Services may include, but not limited to:

1. Medical Services
    a. Medical triage;
    b. Lab testing;
    c. Treatment for nausea; and
    d. Wound and dressing changes;
2. Personal and Hygiene Care Services
    a. Temporary bed;
    b. Rehydration and food service; and
    c. Shower and laundry facilities;
3. Substance use education and counseling.
4. Navigation and warm hand-offs for additional substance use services.
5. Direct coordination with the county behavioral health agency and warm hand-offs for additional behavioral health services.
6. Screening and linkage to ongoing supportive services such as follow-up mental health and substance use disorder treatment and housing options, as appropriate.
7. Establishing strong partnership with law enforcement, emergency personnel, and outreach teams to identify and divert individuals to Sobering Centers.
8. Identifying Members with emergent physical health conditions and arrange transport to a hospital or appropriate source of medical care.
9. Utilizing best practices for Members 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.
10. Other necessary health care services and homeless care support services as appropriate.

B. Restrictions/Limitations

1. Sobering Center service is covered for a duration of less than twenty-four (24) hours.

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2. Community Supports shall supplement and not supplant services received by the Members through other State, local, or federally-funded programs, in accordance with the CalAIM Special Terms and Conditions and federal and DHCS guidance.

VIII. Personal Care and Homemaker Services

A. Service Description: Personal Care and Homemaker Services provide Members who need assistance with Activities of Daily Living (ADLs) and/or Instrumental Activities of Daily Living (IADLs) the ability to remain in their home/residence. Services may include but not limited to:

1. ADLs such as bathing, dressing, toileting, ambulation, or feeding. Personal Care Services can also include assistance with such as meal preparation, grocery shopping, and money management.

2. IADLs such as cleaning, meal preparation, grocery shopping, and money management.

B. Restrictions/Limitations

1. Personal Care and Homemaker Services 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.

2. 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 the Personal Care and Homemaker Services Community Support during this reassessment waiting period.

3. Community Supports shall supplement and not supplant services received by the Members through other State, local, or federally-funded programs, in accordance with the CalAIM Special Terms and Conditions and federal and DHCS guidance.

IX. Day Habilitation

A. Service Description: Day Habilitation Programs provide assistance to Members in acquiring, retaining, and improving self-help, socialization, and adaptive skills necessary to reside successfully in the person's natural environment. Services are provided in a Member's home or an out-of-home, non- facility setting with an unlicensed caregiver with the necessary training and supervision.

1. Day Habilitation Program services include, but are not limited to, training on:

   a. The use of public transportation;

   b. Personal skills development in conflict resolution;

   c. Community participation;

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d. Developing and maintaining interpersonal relationships;

e. Daily living skills (cooking, cleaning, shopping, money management); and

f. Community resource awareness such as police, fire, or local services to support independence in the community.

2. Other program services may include assistance with, but not limited to, the following:

a. Selecting and moving into a home;

b. Locating and choosing suitable housemates;

c. Locating household furnishings;

d. Settling disputes with landlords;

e. Managing personal financial affairs;

f. Recruiting, screening, hiring, training, supervising, and dismissing personal attendants;

g. Dealing with and responding appropriately to governmental agencies and personnel;

h. Asserting civil and statutory rights through self-advocacy;

i. Building and maintaining interpersonal relationships, including a circle of support;

j. Coordination with Medi-Cal managed care plan to link Member to any Community Supports and/or enhanced care management services for which the Member may be eligible;

k. Referral to non-Community Supports housing resources if Member does not meet Housing Transition/Navigation Serv ices Community Support eligibility criteria;

l. Assistance with income and benefits advocacy including General assistance/General Relief and SSI if Member is not receiving these services through Community Supports or Enhanced Care Management; and/or

m. Coordination with Medi-Cal managed care plan to link Member to health care, mental health services, and substance use disorder services based on the individual needs of the Member for Members who are not receiving this linkage through Community Supports or enhanced care management.

B. Restrictions/Limitations

1. Community Supports shall supplement and not supplant services received by the Members through other State, local, or federally-funded programs, in accordance with the CalAIM Special Terms and Conditions and federal and DHCS guidance.

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X. Respite Services

A. Service Description: Respite services are provided to caregivers of Members who require intermittent temporary supervision. These services are provided on a short-term basis because of the absence or need for relief of the caregiver who normally care for and/or supervise the Member 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 that may include, but not limited to:

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 Member'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.

4. Services are provided in:

   a. Private residence;

   b. Residential facility approved by the State, such as, Congregate Living Health Facilities (CLHFs); or

   c. Providers contracted by county behavioral health.

B. Restrictions/Limitations

1. In the home setting, these services, in combination with any direct care services the Member is receiving, may not exceed twenty-four (24) hours per day of care.

2. Service limit is up to three hundred thirty-six (336) hours per calendar year. The service is inclusive of all in-home and in-facility services. Exceptions to the three hundred thirty-six (336) hour per calendar year limit can be made, with CalOptima or Health Network authorization, when the caregiver experiences an episode, including medical treatment and hospitalization that leaves a Member without their caregiver. Respite support provided during these episodes can be excluded from the three hundred thirty-six (336)-hour annual limit.

3. Respite service is only to avoid placements for which the CalOptima or a Health Network would be responsible.

4. Community Supports shall supplement and not supplant services received by the Members through other State, local, or federally-funded programs, in accordance with the CalAIM Special Terms and Conditions and federal and DHCS guidance.

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XI. Nursing Facility Transition/Diversion to Assisted Living Facilities (Residential Care)

A. Service Description: Nursing Facility Transition/Diversion to Assisted Living Facilities (Residential Care) helps Members who would like to transition back into a home-like, community setting and/or to avoid institutionalization when possible. Members 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. These services may include, but not limited to:

1. Wrap-around Services:

   a. Assistance with ADLs and IADLs such as bathing, dressing, toileting, ambulation, or feeding. Personal Care Services can also include assistance with such as meal preparation, grocery shopping, and money management as needed;

   b. IIADLs such as cleaning, meal preparation, grocery shopping, and money management as needed;

   c. Companion services;

   d. Medication oversight;

   e. Therapeutic social and recreational programming provided in a home-like environment; and

   f. Includes twenty-four (24)-hour direct care staff on-site to meet scheduled unpredictable needs in a way that promotes maximum dignity and independence, and to provide supervision, safety, and security.

2. Allowable expenses are those necessary to enable a person to establish a community facility residence (except room and board), including, but not limited to:

   a. Assessing the Member's housing needs and presenting options;

   b. Assessing the service needs of the Member to determine if the Member needs enhanced onsite services at the Residential Care Facilities for the Elderly (RCFE) and Adult Residential Facilities (ARF) so the Member can be safely and stably housed in an RCFE/ARF;

   c. 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);

   d. Communicating with facility administration and coordinating the move;

   e. Establishing procedures and contacts to retain facility housing; and

   f. Coordinating with the Medi-Cal managed care plan to ensure that the needs of Members who need enhanced services to be safely and stably housed in RCFE/ARF

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settings have Community Supports and/or Enhanced Care Management services that provide the necessary enhanced services.

i. Managed care plans may also fund RCFE/ARF operations directly to provide these enhanced services.

B. Restrictions/Limitations

1. Members are directly responsible for paying their own living expenses.

2. Community Supports shall supplement and not supplant services received by the Members through other State, local, or federally-funded programs, in accordance with the CalAIM Special Terms and Conditions and federal and DHCS guidance.

XII. Community Transition Services/Nursing Facility Transition to a Home

A. Service Description: Community Transition Services/Nursing Facility Transition to a Home Services provide assistance to Members to live in the community and avoid further institutionalization. Members are transitioning from a licensed facility to a living arrangement in a private residence are directly responsible for his or her own living expenses. Services may include, but not limited to:

1. Allowable expenses necessary to enable a person to establish a basic household that do not constitute room and board and include:

a. Assessing the Member's housing needs and presenting options;

b. 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);

c. Communicating with landlord (if applicable) and coordinating the move;

d. Establishing procedures and contacts to retain housing;

e. 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; and

f. Identifying the need for and coordinating funding for environmental modifications to install necessary accommodations for accessibility.

B. Restrictions/Limitations

1. 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.

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2. Community Transition Services are payable up to a total lifetime maximum amount of $7,500.00. The only exception to the $7,500.00 total maximum is if the Member 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.

3. Community Transition Services must be necessary to ensure the health, welfare, and safety of the Member, and without which the Member would be unable to move to the private residence and would then require continued or re- institutionalization.

4. Community Supports shall supplement and not supplant services received by the Members through other State, local, or federally-funded programs, in accordance with the CalAIM Special Terms and Conditions and federal and DHCS guidance.

XIII. Environmental Accessibility Adaptations (Home Modifications)

A. Service Description: 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 Member would require institutionalization. These services may include, but not limited to:

1. In-home modifications such as:

   a. Ramps and grab-bars to assist Members in accessing the home;

   b. Doorway widening for Members who require a wheelchair;

   c. Stair lifts;

   d. Making a bathroom and shower wheelchair accessible (e.g., constructing a roll-in shower);

   e. Installation of specialized electric and plumbing systems that are necessary to accommodate the medical equipment and supplies of the Member; and

   f. Installation and testing of a Personal Emergency Response System (PERS) for Members who are alone for significant parts of the day without a caregiver and who otherwise require routine supervision (including monthly service costs, as needed).

B. Restrictions/Limitations

1. 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.

2. EAAs must be conducted in accordance with applicable State and local building codes.

3. EAAs are payable up to a total lifetime maximum of $7,500. The only exceptions to the $7,500 total maximum are if the Member's place of residence changes or if the Member's

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condition has changed so significantly that additional modifications are necessary to ensure the health, welfare, and safety of the Member, or are necessary to enable the Member to function with greater independence in the home and avoid institutionalization or hospitalization.

4. EAAs may include finishing (e.g., drywall and painting) to return the home to a habitable condition, but do not include aesthetic embellishments.

5. Community Supports shall supplement and not supplant services received by the Members through other State, local, or federally-funded programs, in accordance with the CalAIM Special Terms and Conditions and federal and DHCS guidance.

XIV. Asthma Remediation

A. Service Description: 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. Services may include, but not limited to:

1. Providing information to Members 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:

   a. Identification of environmental triggers commonly found in and around the home, including allergens and irritants.

2. Purchasing materials such as:

   a. Allergen-impermeable mattress and pillow dustcovers;

   b. High-efficiency particulate air (HEPA) filtered vacuums;

   c. Asthma friendly cleaning products;

   d. De-humidifiers; and

   e. Air filters;

3. Health-related minor home repairs such as:

   a. Pest management or patching holes and cracks through which pests can enter;

   b. Minor mold removal and remediation services;

   c. Ventilation improvements;

   d. Integrated Pest Management (IPM) services; and

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e. Other moisture-controlling interventions;

4. Other interventions identified to be medically appropriate and cost effective.

B. Restrictions/Limitations

1. If another State Plan service such as Durable Medical Equipment, is available and would accomplish the same goals of preventing asthma emergencies or hospitalizations.

2. Asthma remediations must be conducted in accordance with applicable State and local building codes.

3. Asthma remediations are payable up to a total lifetime maximum of $7,500. The only exception to the $7,500 total maximum is if the Member's condition has changed so significantly that additional modifications are necessary to ensure the health, welfare, and safety of the Member, or are necessary to enable the Member to function with greater independence in the home and avoid institutionalization or hospitalization.

4. Asthma Remediation modifications are limited to those that are of direct medical or remedial benefit to the Member 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.

5. Community Supports shall supplement and not supplant services received by the Members through other State, local, or federally-funded programs, in accordance with the CalAIM Special Terms and Conditions and federal and DHCS guidance.

V. References

A. Department of Health Care Services Medi-Cal Community Supports Policy Guide (December 2021), Section III. Community Supports – Service Definitions includes comprehensive service descriptions and restrictions/limitations of Housing Transition Navigation Services, Housing Deposits, Housing Tenancy and Sustaining Services, and Recuperative Care (Medical Respite) in the Description/Overview and Restrictions/Limitations sections.

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I. Eligibility for Housing Transition Navigation Services

A. Members who are prioritized for a permanent supportive housing unit or rental subsidy resource through the local homeless Coordinated Entry System or similar system; or

B. Members who meet the Housing and Urban Development (HUD) definition of homeless as defined in 24 CFR § 91.5 (including those exiting institutions but not including any limits on the number of days in the institution) and meet one of the following criteria:

1. Are receiving Enhanced Care Management; and/or

2. Have one or more serious chronic conditions; and/or

3. Have a serious mental illness; and/or

4. Are at risk of institutionalization or requiring residential services because of a substance use disorder; or

C. Members who meet the HUD definition of at risk of homelessness (as defined in 24 CFR § 91.5).

1. Members 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 one of the following:

a. Have one or more serious chronic conditions;

b. Have a serious mental illness;

c. Are at risk of institutionalization or overdose or are requiring residential services because of a substance use disorder;

d. Have a serious emotional disturbance (children and adolescents);

e. Are receiving Enhanced Care Management; or

f. 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 are children or adolescents with serious emotional disturbance and/or who have been victims of trafficking or domestic violence.

II. Eligibility for Housing Deposits

A. Any Member who received Housing Transition/Navigation Services Community Supports; and

B. Members who are prioritized for a permanent supportive housing unit or rental subsidy resource through the local homeless Coordinated Entry System or similar system; or

C. Members who meet the Housing and Urban Development (HUD) definition of homeless as defined in 24 CFR section 91.5 (including those exiting institutions but not including any limits on the number of days in the institution) and meet one of the following criteria:

1. Are receiving Enhanced Care Management; and/or

2. Have one or more serious chronic conditions; and/or

3. Have a serious mental illness; and/or

4. Are at risk of institutionalization or requiring residential services because of a substance use disorder.

III. Eligibility for Housing Tenancy and Sustaining Services

A. Any Member who received Housing Transition/Navigation Services Community Supports; or

B. Members who are prioritized for a permanent supportive housing unit or rental subsidy resource through the local homeless Coordinated Entry System or similar system; or

C. Members who meet the Housing and Urban Development (HUD) definition of homeless as defined in 24 CFR section 91.5 (including those exiting institutions but not including any limits on the number of days in the institution) and meet one of the following criteria:

1. Are receiving Enhanced Care Management; and/or

2. Have one or more serious chronic conditions; and/or

3. Have a serious mental illness; and/or

4. Are at risk of institutionalization or requiring residential services because of a substance use disorder; or

D. Members who meet the Housing and Urban Development (HUD) definition of at risk of homelessness (as defined in 24 CFR § 91.5).

1. Members who are determined to be at risk of experiencing homelessness are eligible to receive Housing Tenancy and Sustaining Services if they have significant barriers to housing stability and meet one of the following:

a. Have one or more serious chronic conditions;

b. Have a serious mental illness;

c. Are at risk of institutionalization or overdose or are requiring residential services because of a substance use disorder;

d. Have a serious emotional disturbance (children and adolescents);

e. Are receiving Enhanced Care Management; or

f. 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 are children or adolescents with serious emotional disturbance and/or who have been victims of trafficking or domestic violence.

IV. Eligibility for Recuperative Care (Medical Respite)

A. Members who are at risk of hospitalization or are post-hospitalization, and

1. Live alone with no formal supports; or

2. Face housing insecurity, or

3. Have housing that would jeopardize their health and safety without modification.

V. Eligibility for Short-Term Hospitalization Housing

A. Members who are exiting recuperative care; or

B. Members exiting an inpatient hospital stay (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, or nursing facility with a medical and or behavioral health need; and

C. Members who meet the Housing and Urban Development (HUD) definition of homeless as defined in 24 CFR § 91.5 (including those exiting institutions but not including any limits on the number of days in the institution) and meet one of the following criteria:

1. Are receiving Enhanced Care Management; and/or

2. Have one or more serious chronic conditions; and/or

3. Have a serious mental illness; and/or

4. Are at risk of institutionalization or requiring residential services because of a substance use disorder; or

D. Members who meet the Housing and Urban Development (HUD) definition of at risk of homelessness (as defined in 24 CFR § 91.5).

1. An individual or family who:

a. Has an annual income below thirty percent (30%) of median family income for the area, as determined by HUD;

b. 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; and

c. Meets one of the following conditions:

i. Has moved because of economic reasons two or more times during the sixty (60) days immediately preceding the application for homelessness prevention assistance;

ii. Is living in the home of another because of economic hardship;

iii. Has been notified in writing that their right to occupy their current housing or living situation will be terminated within twenty-one (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 organization 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 (2) 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 (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 guardians of that child or youth if living with her or him.

E. Individuals who are determined to be at risk of experiencing homelessness are eligible to receive Short-Term Post-Hospitalization services if they have significant barriers to housing stability and meet at least one of the following:

1. Have one or more serious chronic conditions;

2. Have a Serious Mental Illness;

3. Are at risk of institutionalization or overdose or are requiring residential services because of a substance use disorder o Have a Serious Emotional Disturbance (children and adolescents);

4. Are receiving Enhanced Care Management; or

5. 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 domestic violence.

F. In addition to meeting one of these criteria at a minimum, Members 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.

VI. Eligibility for Medically-Tailored Meals

A. Members 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.

B. Members being discharged from the hospital or a skilled nursing facility or at high risk of hospitalization or nursing facility placement; or

C. Members with extensive care coordination needs.

VII. Eligibility for Sobering Centers

A. Members ~~age~~aged 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

B. Members 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.

VIII. Eligibility for Personal Care/Homemaker services

A. Members at risk for hospitalization, or institutionalization in a nursing facility;

B. Members with functional deficits and no other adequate support system; or

C. Members approved for In-Home Supportive Services.

IX. Eligibility for Day Habilitation Program

A. Members who are experiencing homelessness,

B. Members who exited homelessness and entered housing in the last twenty-four (24) months; and

C. Members at risk of homelessness or institutionalization whose housing stability could be improved through participation in a day habilitation program.

X. Eligibility for Respite Services

A. Members who live in the community and are compromised in their ADLs and are therefore dependent upon a qualified caregiver who provides most of their support; and

B. Members who require caregiver relief to avoid institutional placement; or

C. Members may include children who previously were covered for Respite Services under the:

1. Pediatrics Palliative Care Waiver;

2. Foster care program beneficiaries;

3. California Children's Services;

4. Genetically Handicapped Persons Program (GHPP); or

5. Members with Complex Care Needs.

XI. Eligibility for Nursing Facility Transition for Elderly and Adult Residential Facilities

A. For Nursing Facility Transition:

1. Member has resided 60+ days in a nursing facility;

2. Member is willing to live in an assisted living setting as an alternative to a Nursing Facility; and

3. Member is able to reside safely in an assisted living facility with appropriate and cost-effective supports.

B. For Nursing Facility Diversion:

1. Member is interested in remaining in the community;

2. Member is willing and able to reside safely in an assisted living facility with appropriate and cost-effective supports and services; and

3. Member must be:

a. Currently receiving medically necessary nursing facility Level of Care (LOC) services; and

b. Choosing to transition home and continue to receive medically necessary nursing facility LOC services in lieu of remaining in the nursing facility or Medical Respite setting.

XII. Eligibility for Community Transition Services/Nursing Facility Transition to Home

A. Member must be:

1. Currently receiving medically necessary nursing facility Level of Care (LOC) services and;

2. Choosing to transition home and continue to receive medically necessary nursing facility LOC services in lieu of remaining in the nursing facility or Medical Respite setting.

B. Member has lived 60+ days in a nursing home and/or Medical Respite setting; and

C. Member is interested in moving back to the community; and

D. Member is able to reside safely in the community with appropriate and cost-effective supports and services.

XIII. Eligibility for Environmental Accessibility Adaptions

A. Member is at risk for institutionalization in a nursing facility.

XIV. Eligibility for Asthma Remediation

A. Members with poorly controlled asthma as determined by:

1. An emergency department visit or hospitalization; or

2. Two (2) sick or urgent care visits in the past twelve (12) months; or

3. A score of 19 or lower on the Asthma Control Test, and

4. A licensed health care provider who has documentation that the service will likely avoid asthma-related hospitalizations, emergency department visits, or other high-cost services.

~~V.~~XV. Restrictions/Limitations References

Restrictions and/or limitations for Housing Transition Navigation Services, Housing Deposits, Housing Tenancy and Sustaining Services, and Recuperative Care (Medical Respite~~)~~, Short-Term Hospitalization Housing, Medically-Tailored Meals, Sobering Centers, Personal Care/Homemaker services, Day Habilitation Program, Respite Services, Nursing Facility Transition for Elderly and Adult Residential Facilities, Community Transition Services/Nursing Facility Transition to Home, Environmental Accessibility Adaptions and Asthma Remediation are set forth in Attachment A: Community Supports Components of CalOptima Policy GG.1355: Community Supports.

~~VI.~~XVI. References

A. Department of Health Care Services Medi-Cal ~~In Lieu of Services (ILOS)~~Community Supports Policy Guide (~~September~~December 2021), Section III. ~~In Lieu of Services~~Community Supports – Service Definitions includes comprehensive Member eligibility criteria for Housing Transition Navigation Services, Housing Deposits, Housing Tenancy and Sustaining Services, and Recuperative Care (Medical Respite) in the Eligibility (Population Subset) sections.

VII. Glossary

Term	Definition
Coordinated Entry System	A process which coordinates the assessment and referral of individuals and families seeking housing and includes the use of a comprehensive and standardized assessment tool. In Orange County, it includes the Family Coordinated Entry System and the Individual Coordinated Entry System.
Homeless Management Information Systems (HMIS)	A local information technology system used to collect client-level data and data on the provision of housing and services to homeless individuals and families and persons at risk of homelessness and is compliant with HUD's data collection, management, and reporting standards.
United States Department of Housing and Urban Development (HUD)	The Federal agency responsible for national policy and programs that address national housing needs, improve and develop communities, and enforce fair housing laws.

I. Eligibility for Housing Transition Navigation Services

A. Members who are prioritized for a permanent supportive housing unit or rental subsidy resource through the local homeless Coordinated Entry System or similar system; or

B. Members who meet the Housing and Urban Development (HUD) definition of homeless as defined in 24 CFR § 91.5 (including those exiting institutions but not including any limits on the number of days in the institution) and meet one of the following criteria:

1. Are receiving Enhanced Care Management; and/or

2. Have one or more serious chronic conditions; and/or

3. Have a serious mental illness; and/or

4. Are at risk of institutionalization or requiring residential services because of a substance use disorder; or

C. Members who meet the HUD definition of at risk of homelessness (as defined in 24 CFR § 91.5).

1. Members 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 one of the following:

a. Have one or more serious chronic conditions;

b. Have a serious mental illness;

c. Are at risk of institutionalization or overdose or are requiring residential services because of a substance use disorder;

d. Have a serious emotional disturbance (children and adolescents);

e. Are receiving Enhanced Care Management; or

f. 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 are children or adolescents with serious emotional disturbance and/or who have been victims of trafficking or domestic violence.

II. Eligibility for Housing Deposits

A. Any Member who received Housing Transition/Navigation Services Community Supports; and

B. Members who are prioritized for a permanent supportive housing unit or rental subsidy resource through the local homeless Coordinated Entry System or similar system; or

C. Members who meet the Housing and Urban Development (HUD) definition of homeless as defined in 24 CFR section 91.5 (including those exiting institutions but not including any limits on the number of days in the institution) and meet one of the following criteria:

1. Are receiving Enhanced Care Management; and/or

2. Have one or more serious chronic conditions; and/or

3. Have a serious mental illness; and/or

4. Are at risk of institutionalization or requiring residential services because of a substance use disorder.

III. Eligibility for Housing Tenancy and Sustaining Services

A. Any Member who received Housing Transition/Navigation Services Community Supports; or

B. Members who are prioritized for a permanent supportive housing unit or rental subsidy resource through the local homeless Coordinated Entry System or similar system; or

C. Members who meet the Housing and Urban Development (HUD) definition of homeless as defined in 24 CFR section 91.5 (including those exiting institutions but not including any limits on the number of days in the institution) and meet one of the following criteria:

1. Are receiving Enhanced Care Management; and/or

2. Have one or more serious chronic conditions; and/or

3. Have a serious mental illness; and/or

4. Are at risk of institutionalization or requiring residential services because of a substance use disorder; or

D. Members who meet the Housing and Urban Development (HUD) definition of at risk of homelessness (as defined in 24 CFR § 91.5).

1. Members who are determined to be at risk of experiencing homelessness are eligible to receive Housing Tenancy and Sustaining Services if they have significant barriers to housing stability and meet one of the following:

a. Have one or more serious chronic conditions;

b. Have a serious mental illness;

c. Are at risk of institutionalization or overdose or are requiring residential services because of a substance use disorder;

d. Have a serious emotional disturbance (children and adolescents);

e. Are receiving Enhanced Care Management; or

f. 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 are children or adolescents with serious emotional disturbance and/or who have been victims of trafficking or domestic violence.

IV. Eligibility for Recuperative Care (Medical Respite)

A. Members who are at risk of hospitalization or are post-hospitalization, and

1. Live alone with no formal supports; or

2. Face housing insecurity, or

3. Have housing that would jeopardize their health and safety without modification.

V. Eligibility for Short-Term Hospitalization Housing

A. Members who are exiting recuperative care; or

B. Members exiting an inpatient hospital stay (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, or nursing facility with a medical and or behavioral health need; and

C. Members who meet the Housing and Urban Development (HUD) definition of homeless as defined in 24 CFR § 91.5 (including those exiting institutions but not including any limits on the number of days in the institution) and meet one of the following criteria:

1. Are receiving Enhanced Care Management; and/or

2. Have one or more serious chronic conditions; and/or

3. Have a serious mental illness; and/or

4. Are at risk of institutionalization or requiring residential services because of a substance use disorder; or

D. Members who meet the Housing and Urban Development (HUD) definition of at risk of homelessness (as defined in 24 CFR § 91.5).

1. An individual or family who:

a. Has an annual income below thirty percent (30%) of median family income for the area, as determined by HUD;

b. 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; and

c. Meets one of the following conditions:

i. Has moved because of economic reasons two or more times during the sixty (60) days immediately preceding the application for homelessness prevention assistance;

ii. Is living in the home of another because of economic hardship;

iii. Has been notified in writing that their right to occupy their current housing or living situation will be terminated within twenty-one (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 organization 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 (2) 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 (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 guardians of that child or youth if living with her or him.

E. Individuals who are determined to be at risk of experiencing homelessness are eligible to receive Short-Term Post-Hospitalization services if they have significant barriers to housing stability and meet at least one of the following:

1. Have one or more serious chronic conditions;

2. Have a Serious Mental Illness;

3. Are at risk of institutionalization or overdose or are requiring residential services because of a substance use disorder o Have a Serious Emotional Disturbance (children and adolescents);

4. Are receiving Enhanced Care Management; or

5. 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 domestic violence.

F. In addition to meeting one of these criteria at a minimum, Members 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.

VI. Eligibility for Medically-Tailored Meals

A. Members 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.

B. Members being discharged from the hospital or a skilled nursing facility or at high risk of hospitalization or nursing facility placement; or

C. Members with extensive care coordination needs.

VII. Eligibility for Sobering Centers

A. Members aged 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

B. Members 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.

VIII. Eligibility for Personal Care/Homemaker services

A. Members at risk for hospitalization, or institutionalization in a nursing facility;

B. Members with functional deficits and no other adequate support system; or

C. Members approved for In-Home Supportive Services.

IX. Eligibility for Day Habilitation Program

A. Members who are experiencing homelessness,

B. Members who exited homelessness and entered housing in the last twenty-four (24) months; and

C. Members at risk of homelessness or institutionalization whose housing stability could be improved through participation in a day habilitation program.

X. Eligibility for Respite Services

A. Members who live in the community and are compromised in their ADLs and are therefore dependent upon a qualified caregiver who provides most of their support; and

B. Members who require caregiver relief to avoid institutional placement; or

C. Members may include children who previously were covered for Respite Services under the:

1. Pediatrics Palliative Care Waiver;

2. Foster care program beneficiaries;

3. California Children's Services;

4. Genetically Handicapped Persons Program (GHPP); or

5. Members with Complex Care Needs.

XI. Eligibility for Nursing Facility Transition for Elderly and Adult Residential Facilities

A. For Nursing Facility Transition:

1. Member has resided 60+ days in a nursing facility;

2. Member is willing to live in an assisted living setting as an alternative to a Nursing Facility; and

3. Member is able to reside safely in an assisted living facility with appropriate and cost-effective supports.

B. For Nursing Facility Diversion:

1. Member is interested in remaining in the community;

2. Member is willing and able to reside safely in an assisted living facility with appropriate and cost-effective supports and services; and

3. Member must be:

a. Currently receiving medically necessary nursing facility Level of Care (LOC) services; and

b. Choosing to transition home and continue to receive medically necessary nursing facility LOC services in lieu of remaining in the nursing facility or Medical Respite setting.

XII. Eligibility for Community Transition Services/Nursing Facility Transition to Home

A. Member must be:

1. Currently receiving medically necessary nursing facility Level of Care (LOC) services and;

2. Choosing to transition home and continue to receive medically necessary nursing facility LOC services in lieu of remaining in the nursing facility or Medical Respite setting.

B. Member has lived 60+ days in a nursing home and/or Medical Respite setting; and

C. Member is interested in moving back to the community; and

D. Member is able to reside safely in the community with appropriate and cost-effective supports and services.

XIII. Eligibility for Environmental Accessibility Adaptions

A. Member is at risk for institutionalization in a nursing facility.

XIV. Eligibility for Asthma Remediation

A. Members with poorly controlled asthma as determined by:

1. An emergency department visit or hospitalization; or

2. Two (2) sick or urgent care visits in the past twelve (12) months; or

3. A score of 19 or lower on the Asthma Control Test, and

4. A licensed health care provider who has documentation that the service will likely avoid asthma-related hospitalizations, emergency department visits, or other high-cost services.

XV. Restrictions/Limitations References

Restrictions and/or limitations for Housing Transition Navigation Services, Housing Deposits, Housing Tenancy and Sustaining Services, and Recuperative Care (Medical Respite), Short-Term Hospitalization Housing, Medically-Tailored Meals, Sobering Centers, Personal Care/Homemaker services, Day Habilitation Program, Respite Services, Nursing Facility Transition for Elderly and Adult Residential Facilities, Community Transition Services/Nursing Facility Transition to Home, Environmental Accessibility Adaptions and Asthma Remediation are set forth in Attachment A: Community Supports Components of CalOptima Policy GG.1355: Community Supports.

XVI. References

A. Department of Health Care Services Medi-Cal Community Supports Policy Guide (December 2021), Section III. Community Supports – Service Definitions includes comprehensive Member eligibility criteria for Housing Transition Navigation Services, Housing Deposits, Housing Tenancy and Sustaining Services, and Recuperative Care (Medical Respite) in the Eligibility (Population Subset) sections.

VII. Glossary

Term	Definition
Coordinated Entry System	A process which coordinates the assessment and referral of individuals and families seeking housing and includes the use of a comprehensive and standardized assessment tool. In Orange County, it includes the Family Coordinated Entry System and the Individual Coordinated Entry System.
Homeless Management Information Systems (HMIS)	A local information technology system used to collect client-level data and data on the provision of housing and services to homeless individuals and families and persons at risk of homelessness and is compliant with HUD's data collection, management, and reporting standards.
United States Department of Housing and Urban Development (HUD)	The Federal agency responsible for national policy and programs that address national housing needs, improve, and develop communities, and enforce fair housing laws.

State of California—Health and Human Services Agency

Department of Health Care Services

CalAIM Enhanced Care Management (ECM) and Community Supports (ILOS)

Contract Template Provisions

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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:** community-based entities with experience and expertise providing intensive, in-person care management services to Members in one or more of the Populations of Focus for ECM.

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

4. **Model of Care:** Contractor's framework for providing ECM and Community Supports, including its Policies and Procedures for partnering with ECM and Community Supports Providers.

5. **Population of Focus:** a subset of Medi-Cal Managed Care Health Plan Members that meet eligibility criteria, as defined by DHCS, by which they are eligible to receive the ECM benefit.

ECM Scope of Services

1. Contractor's Responsibility for Administration of ECM

A. Contractor must take a whole-person approach to offering ECM, ensuring that ECM addresses the clinical and non-clinical needs of high-need and high-cost Members in distinct Populations of Focus, as defined in Provision 3, Populations of Focus for ECM of this Attachment, through systematic coordination of services and Comprehensive Case Management. Contractor must ensure ECM is community-based, interdisciplinary, high-touch, and person-centered.

B. Contractor must ensure ECM is available throughout its Service Area.

C. Contractor must ensure ECM is offered primarily through in-person interaction where Members and their family members, guardians, authorized representatives, caregivers, and authorized support persons live, seek care, or prefer to access services in their local community. Contractor must ensure its ECM Providers focus on building relationships with Members, and in-person visits may be supplemented with secure teleconferencing and telehealth, when appropriate and with the Member's consent.

D. In situations where Contractor is performing ECM functions using Contractor's own staff, Contractor must follow the same requirements as a contracted ECM Provider.

E. In counties with operating Health Homes Program (HHP) and Whole Person Care (WPC) pilots, Contractor must enter into Subcontractor Agreements with WPC Lead Entities and HHP Community-Based Care Management Entities (CB-CMEs) for the provision of ECM, as described in Provision 7, Member Identification for ECM of this Attachment.

F. Contractor must follow the appropriate processes to ensure Members who may benefit from ECM receive ECM as defined in this Contract.

G. Contractor must ensure ECM provided to each Member encompasses the ECM core service components described in Provision 12, Core Service Components of ECM of this Attachment.

H. Contractor must ensure a Member receiving ECM is not receiving duplicative services from other sources, including by not limited to county-specific Targeted Case Management (TCM) services administered by Local Governmental Agencies (LGAs).

I. For Members who are dually eligible for Medicare and Medi-Cal and enrolled in a Medicare Advantage Plan, including a Dual-Eligible Special Needs Plan (D-SNP), Contactor must coordinate with the Medicare Advantage Plan for the provision of ECM for those Members.

J. Contractor must develop Member-facing written material about ECM for use across its network of ECM Providers. The written material must be submitted for DHCS review and approval prior to use. This material must include the following:

    1) Explain ECM and how a Member may request it;

    2) Explain that ECM participation is voluntary and can be discontinued at any time;

    3) Explain that the Member must authorize ECM-related data sharing;

    4) Describe the process by which the Member may choose a different ECM Lead Care Manager or ECM Provider; and

    5) 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 Provision 7, Member Identification for ECM of this Attachment.

B. Contractor must provide ECM Members that meet the eligibility criteria for the following Populations of Focus:

1) Members over the age of 21 who are:

a) Experiencing homelessness;

b) High utilizers;

c) Experiencing Serious Mental Illness (SMI) or Substance Use Disorder (SUD);

d) Transitioning from incarceration;

e) At risk for institutionalization who are eligible for Long-Term Care services; and

f) Nursing facility residents transitioning to the community.

2) Children who are:

a) Experiencing homelessness;

b) High utilizers;

c) Experiencing 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 individuals involved in foster care ages 26 and under); and

f) Transitioning from incarceration.

C. Contractor may offer ECM to Members who do not meet Population of Focus criteria in full, but may benefit from ECM.

D. Contractor must follow all DHCS policies and guidance including All Plan Letters (APLs) and ECM Policy Guide that further defines the approach to ECM for each Population of Focus, including the eligibility criteria for each Population of Focus and the phase-in timeline for Populations of Focus.

E. To avoid duplication between existing care management and coordination approaches, Members are excluded from ECM while enrolled in the following programs:

1) 1915(c) waiver programs including:

a) Multipurpose Senior Services Program (MSSP);

b) Assisted Living Waiver (ALW);

c) Home and Community-Based Alternatives (HCBA) Waiver;

d) Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome (HIV/AIDS) Waiver;

e) HCBS Waiver for Individuals with Developmental Disabilities (DD); and

f) Self-Determination Program for Individuals with intellectual and DD.

2) Fully integrated programs for Members dually eligible for Medicare and Medi-Cal including:

a) Cal MediConnect (CMC);

b) Fully Integrated Dual Eligible Special Needs Plans (FIDE-SNPs); and

c) Program for All-Inclusive Care for the Elderly (PACE).

3) Family Mosaic Project

4) California Community Transitions (CCT) Money Follows the Person (MFTP)

5) Basic Case Management (BCM) or Complex Care Management (CCM)

3. ECM Providers

A. Contractor must ensure ECM is provided primarily through in-person interaction in settings that are most appropriate for the Member, such as where the Member lives, seeks care, or prefers to access services in their local community.

B. ECM Providers may include, but are not limited to, the following entities:

1) Counties;

2) County behavioral health Providers;

3) Primary Care Physician (PCP), Specialist, or Physician groups;

4) Federally Qualified Health Centers (FQHCs);

5) Community health centers;

6) Community-based organizations;

7) Hospitals or hospital-based Physician groups or clinics (including public hospitals and district or municipal public hospitals);

8) Rural Health Clinics (RHC) and American Indian Health Service (AIHS) Programs;

9) Local Health Departments (LHDs);

10) Behavioral health entities;

11) Community mental health centers;

12) SUD treatment Providers;

13) Community Health Workers;

14) Organizations serving individuals experiencing homelessness;

15) Organizations serving justice-involved individuals;

16) CCS Providers; and

17) Other qualified Providers or entities that are not listed above, as approved by DHCS.

C. For the Population of Focus for eligible individuals with SMI or SUD and the Population of Focus for eligible individuals with SED, Contractor must prioritize county behavioral health staff or behavioral health Providers to serve in the ECM Provider role, provided they agree and are able to coordinate all services needed by those Populations of Focus, not just their behavioral health services.

D. Contractor must attempt to enter into a Subcontractor Agreement with each AIHS Facility as set forth in 22 CCR sections 55110 through 55180 to provide ECM, when applicable, as described in Exhibit A, Attachment 8, Provision 7, Federally Qualified Health Centers (FQHC), Rural Health Clinics (RHC), and American Indian Health Service Programs, Paragraph C.

E. Contractor must ensure ECM Providers meet the requirements set forth in all applicable APLs including, but not limited to, the requirements regarding the use of a care management documentation system.

F. Care management documentation systems may include certified electronic health record technology, or other documentation tools that can:

1) Document Member goals and goal attainment status;

2) Develop and assign care team tasks;

3) Define and support Member care coordination and care management needs;

4) Gather information from other sources to identify Member needs and support care team coordination and communication; and

5) Support notifications regarding Member health status and transitions in care such as discharges from a hospital or LTC Facility, and housing status.

G. Contractor must also comply with requirements on data exchange pursuant to Provision 13, Data System Requirements and Data Sharing to Support ECM of this Attachment.

H. Contractor must ensure all ECM Providers for whom a State-level enrollment pathway exists enroll in Medi-Cal, pursuant to relevant APLs, including APL 19-004. If APL 19-004 does not apply to an ECM Provider, Contractor must have a process for verifying qualifications and experience of ECM Providers, which must extend to individuals employed by or delivering services on behalf of the ECM Provider. Contractor must ensure that all ECM Providers meet the capabilities and standards required to be an ECM Provider.

I. Contractor must not require eligible ECM Providers to be National Committee for Quality Assurance (NCQA) certified or accredited as a condition of entering into a Subcontractor Agreement.

4. ECM Provider Capacity

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

B. Contractor must ensure sufficient ECM Provider capacity to meet the needs of all ECM Populations of Focus.

C. Contractor must meet DHCS' requirements regarding ECM Provider capacity separately from general Network adequacy; ECM Provider capacity does not alter the general Network adequacy provisions in Exhibit A, Attachment 6, Provider Network.

D. Contractor must report on its ECM Provider capacity to DHCS initially in its ECM MOC Template as referenced in Provision 6, ECM Model of Care (MOC) of this Attachment, and on an ongoing basis pursuant to DHCS reporting requirements in a form and manner specified by DHCS.

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

F. If Contractor is unable to provide sufficient capacity to meet the needs of all ECM Populations of Focus through contracts with community-based ECM Providers, Contractor may submit a written request to DHCS for an exception that authorizes Contractor to use Contractor's own personnel for ECM. Any such request must be submitted in accordance with DHCS guidelines and must meet at least one (1) of the following criteria:

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

    2) There is a justified quality of care concern with one (1) or more of the otherwise qualified ECM Providers;

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

    4) ECM Providers are unwilling to contract;

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

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

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

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

H. Contractor's failure to provide network capacity that meets the needs of all ECM Populations of Focus in a community-based manner may result in imposition of corrective action proceedings, and may result in sanctions pursuant to Exhibit E, Attachment 2, Program Terms and Conditions, Provision 16, Sanctions.

5. Model of Care

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

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

C. Contractor may collaborate with other Medi-Cal Managed Care Health Plans within the same county on the development of its ECM MOC.

D. Contractor must submit its ECM MOC for DHCS review and approval. Contractor must also submit any significant changes to its ECM MOC for DHCS review and approval at least 60 calendar days in advance of any occurrence of changes or updates, in accordance with DHCS policies and guidance, including all applicable APLs. Significant changes may include, but are not limited to, changes to the Health Homes Program (HHP), ECM Contractor's approach to administer or deliver ECM services, approved policies and procedures, and Subcontractor Agreements boilerplates.

6. Identifying Members for ECM

A. Contractor must promote continuity from the HHP and WPC pilots to ECM.

B. Contractor must authorize ECM for Members in HHP and WPC pilot counties, following the DHCS implementation schedule.

C. To ensure continuity between HHP and ECM, Contractor must:

1) 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

2) Ensure that each Member automatically authorized for ECM under this Provision is assessed within six (6) 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 must:

1) 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

2) Ensure each Member automatically authorized under this Provision is assessed within six (6) 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 must enter into a Subcontractor Agreement with each WPC Lead Entity 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 Paragraph F below.

F. Contractor must submit to DHCS for prior approval any requests for exceptions to the Subcontractor Agreement requirement with a WPC Lead Entity or HHP CB-CME as an ECM Provider. Permissible exceptions to the Subcontractor Agreement requirement, include, but are not limited to:

1) There is a justified quality of care concern with the ECM Provider(s);

2) Contractor and ECM Provider(s) are unable to agree on contracted rates;

3) ECM Provider(s) is/are unwilling to contract;

4) ECM Provider(s) is/are unresponsive to multiple attempts to contract;

5) ECM Provider(s) is/are unable to comply with the Medi-Cal enrollment process or vetting by Contractor; or

6) 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.

G. Contractor must proactively identify Members who may benefit from ECM and who meet the eligibility criteria for the ECM Populations of Focus, as described in Provision 3, Populations of Focus for ECM of this Attachment.

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

1) Members' health care utilization;

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

3) Health risks and needs due to social determinants of health; and,

4) Long-term services and supports (LTSS) needs.

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

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

a) Enrollment data;

b) Encounter Data;

c) Utilization/claims data;

d) Pharmacy data;

e) Laboratory data;

f) Screening or assessment data;

g) Clinical information on physical and behavioral health;

h) SMI/SUD data, if available;

i) Risk stratification information for Members under 21 years of age in Contractor's Whole Child Model (WCM) program;

j) Information about Social Determinants of Health, including standardized assessment tools including Protocol for Responding to and Assessing Patients' Assets, Risks and Experiences (PRAPARE) and International Classification of Diseases, Tenth Revision (ICD-10) codes;

k) Results from any available Adverse Childhood Experience (ACE) screening; and

l) Other cross-sector data and information, including housing, social services, foster care, criminal justice history, and other information relevant to the ECM Populations of Focus such as Homeless Management Information System (HMIS), and available data from the education system.

2) Receipt of requests from ECM Providers and other Providers or community-based entities.

a) Contractor must accept requests for ECM on behalf of Members from:

i. ECM Providers;

ii. Other Providers; and

iii. Community-based entities, including those contracted to provide Community Supports, as described in Provision 20, Community Supports Providers of this Attachment.

b) Contractor must directly engage with Network Providers, Subcontractors and county agencies to inform these entities of ECM, the ECM Populations of Focus, and how to request ECM for Members.

c) Contractor must encourage ECM Providers to identify Members who meet the criteria for the ECM Populations of Focus, and must develop a process for receiving and responding to requests from ECM Providers.

3) Requests from Members.

Contractor must have a process for allowing Members to request ECM and for Members' parents, family members, legal guardians, authorized representatives, caregivers, and authorized support persons to request ECM on a Member's behalf. Contractor must provide information to Members regarding the Member initiated ECM request and approval process.

7. Authorizing Members for ECM

A. Contractor must authorize ECM for each eligible Member identified through any of the pathways described in Provision 7, Member Identification for ECM of this Attachment.

B. Contractor must develop policies and procedures that explain how it will authorize ECM for eligible Members in an equitable and non-discriminatory manner.

C. For requests from Providers and other external entities, Members, Member's parent, family member, legal guardian, authorized representative, caregiver, or authorized support person:

1) Contractor must ensure that authorization or a decision to not authorize ECM occurs as soon as possible and in accordance with Exhibit A, Attachment 5, Provision 3, Timeframes for Medical Authorization and APL 21-011;

2) If Contractor does not authorize ECM, Contractor must ensure the Member and the requesting individual or entity who requested ECM on a Member's behalf, as applicable, are informed of the Member's right to an Appeal and the Appeals process by way of the Notice of Action (NOA) as described in Exhibit A, Attachment 13, Provision 8, Denial, Deferral, or

Modification of Prior Authorization Requests, Exhibit A, Attachment 14, Member Grievance and Appeal System, and APL 21-011; and

3) Contractor must follow its standard Grievances and Appeals process outlined in Exhibit A, Attachment 14, Member Grievance and Appeal System and APL 21-011.

D. Contractor must follow requirements for transitioning Members previously served by WPC pilots or HHP contained in Provision 7, Member Identification for ECM of this Attachment.

E. Contractor may collaborate with its ECM Providers to develop a process and identify possible circumstances under which presumptive authorization or preauthorization of ECM may occur, where select ECM Providers may directly authorize ECM for a limited period of time until Contractor authorizes or denies ECM.

F. To inform Members that ECM authorization, Contractor must follow its standard notice process outlined in Exhibit A, Attachment 13, Provision 8, Denial, Deferral, or Modification of Prior Authorization Requests and APL 21-011.

8. Assignment to an ECM Provider

A. Contractor must assign every Member authorized for ECM to an ECM Provider. Contractor may assign Members to Contractor itself only with a DHCS-approved exception to the ECM Provider contracting requirement as described in Provision 5, ECM Provider Capacity of this Attachment.

B. Contractor must develop a process to disseminate information of assigned Members to ECM Providers on a regular basis.

C. Contractor must ensure communication of Member assignment to the designated ECM Provider occurs within ten (10) Working Days of authorization or on an agreed upon schedule.

D. If a Member prefers a specific ECM Provider, Contractor must assign the Member to that Provider, to the extent practicable.

E. If a Member's assigned PCP is a contracted ECM Provider, Contractor must assign the Member to the PCP as the ECM Provider, unless the Member indicates otherwise or Contractor identifies a more appropriate ECM Provider given the Member's individual needs and health conditions.

F. If a Member receives services from a behavioral health Provider for SED, SUD, or SMI and the Member's behavioral health Provider is a contracted ECM Provider, Contractor must assign that Member to that behavioral health Provider as the ECM Provider, unless the Member indicates otherwise or Contractor identifies a more appropriate ECM Provider given the Member's individual needs and health conditions.

G. If a Member is enrolled in CCS and the Member's CCS Case Manager is affiliated with a contracted ECM Provider, Contractor must assign that Member to the CCS Case Manager as the ECM Provider, unless the Member or parent, legal guardian, or authorized representative has indicated otherwise or Contractor identifies a more appropriate ECM Provider given the Member's individual needs and health conditions.

H. Contractor must notify the Member's PCP, if different from the ECM Provider, of the assignment to the ECM Provider assignment, within ten (10) Working Days of the date of assignment.

I. Contractor must document the Member's ECM Lead Care Manager in its system of record.

J. Contractor must permit Members to change ECM Providers at any time. Contractor must implement any Member's request to change their ECM Provider within 30 calendar days to the extent practicable, but no later than within 90 days of receiving the original request.

9. Initiating Delivery of ECM

A. Contractor must not require Member authorization for ECM-related data sharing (whether in writing or otherwise) as a condition of initiating delivery of ECM, unless such authorization is required by federal law.

B. Contractor must develop policies and procedures for its Network of ECM Providers that meet the following requirements, including but not limited to:

1) Where required by law, ECM Providers must obtain Member's authorization to share information with Contractor and all others involved in the Member's care to maximize the benefits of ECM; and

2) ECM Providers must provide Contractor with Member-level records of any obtained authorizations for ECM-related data sharing as required by federal law and to facilitate ongoing data sharing with Contractor.

C. Contractor must ensure that upon the initiation of ECM, each Member receiving ECM has a Lead Care Manager with responsibility for interacting directly with the Member and the Member's family, legal guardians, authorized representatives, caregivers, and other authorized support persons, as appropriate.

The assigned ECM Lead Care Manager is responsible for engaging with a multi-disciplinary care team to identify gaps in Member's care and at a minimum, ensure effective coordination of all primary, behavioral, developmental, oral health, LTSS, Community Supports, and other services to address Social Determinants of Health, regardless of setting.

D. Contractor must ensure accurate and up-to-date Member-level records related to the provision of ECM services are maintained for Members authorized for ECM.

10. Discontinuation of ECM

A. Contractor must ensure Members are able to decline or end ECM upon initial outreach and engagement, or at any other time.

B. Contractor must require the ECM Provider to notify Contractor to discontinue ECM for Members when any of the following circumstances are met:

   1) The Member has met all care plan goals;

   2) The Member is ready to transition to a lower level of care;

   3) The Member no longer wishes to receive ECM or is unresponsive or unwilling to engage; or

   4) The ECM Provider has not been able to connect with the Member after multiple attempts.

C. Contractor must develop processes to determine if the Member is no longer authorized to receive ECM and, if so, to notify 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; Exhibit A, Attachment 14, Member Grievance and Appeal System; and APL 21-011.

D. Contractor must develop processes for transitioning Members from ECM to lower levels of care management to provide coordination of ongoing needs.

E. Contractor must notify the ECM Provider when ECM has been discontinued by Contractor.

F. Contractor must notify the Member of the discontinuation of the ECM benefit and ensure the Member is informed of their right to an Appeal and the Appeals process by way of a NOA process as described in Exhibit A, Attachment 13, Provision 8, Denial, Deferral, or Modification of Prior Authorization Requests, Exhibit A, Attachment 14, Member Grievance and Appeal System, and APL 21-011.

11. Core Service Components of ECM

A. Contractor must ensure all Members receiving ECM benefits receive all of the following seven (7) ECM core service components, as further defined in applicable APLs:

   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.

12. Data System Requirements and Data Sharing to Support ECM

A. Contractor must have an IT infrastructure and data analytic capabilities to support ECM, including the capabilities to:

1) Consume and use claims and Encounter Data, as well as other data types listed in Provision 7, Member Identification for ECM of this Attachment;

2) Assign Members to ECM Providers;

3) Keep records of Members receiving ECM and authorizations necessary for sharing Protected Health Information and Personal Identifying Information between Contractor and ECM and other Providers, among ECM Providers and family member(s) or support person(s), whether obtained by ECM Provider or by Contractor;

4) Securely share data with ECM Providers and other Providers in support of ECM;

5) Receive, process, and send Encounter Data from ECM Providers to DHCS;

6) Receive and process supplemental reports from ECM Providers;

7) Send ECM supplemental reports to DHCS; and

8) Open, track, and manage referrals to Community Supports Providers.

B. In order to support ECM, Contractor must follow DHCS guidance on data sharing and provide the following information to all ECM Providers:

1) Member assignment files, defined as a list of Medi-Cal Members authorized for ECM and assigned to the ECM Provider;

2) Encounter Data and claims data;

3) Physical, behavioral, administrative, and Social Determinants of Health data, such as HMIS data, for all Members assigned to the ECM Provider; and

4) Reports of performance on quality measures and metrics, as requested.

C. Contractor must use defined federal and State standards, specifications, code sets, and terminologies when sharing physical, behavioral, social, and

administrative data with ECM Providers and with DHCS.

13. Oversight of ECM Providers

A. Contractor must perform oversight of ECM Providers, holding them accountable to all ECM requirements contained in this Contract, DHCS policies and guidance, including all applicable APLs, and Contractor's ECM MOC.

   1) Contractor must evaluate the prospective Subcontractor's ability to perform services;

   2) Contractor must ensure the Subcontractor's ECM Provider capacity is sufficient to serve all Populations of Focus;

   3) Contractor must 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, Subcontractor Reports; and

   4) Contractor must 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, Network Provider Agreements and Subcontractor Agreements.

B. Contractor must hold ECM Providers responsible for the same reporting requirements as those Contractor has with DHCS.

   1) Contractor must not impose mandatory reporting requirements that differ from or are additional to those required for Encounter and supplemental reporting; and

   2) Contractor may collaborate with other Medi-Cal Managed Care Health Plans within the same county on oversight of ECM Providers.

C. Contractor must not utilize tools developed or promulgated by NCQA to perform oversight of ECM Providers, unless by mutual consent with the ECM Provider.

D. Contractor must provide ECM training and technical assistance to ECM Providers, including in-person sessions, webinars, or calls, as necessary, in addition to Network Provider training requirements described in Exhibit A, Attachment 7, Provision 5, Network Provider Training.

E. Contractor must ensure the Subcontractor Agreement mirrors the requirements set forth in this Contract and in accordance with all applicable APLs, as applicable to Subcontractor.

   Contractor may collaborate with its Subcontractors on the approach to administration of ECM to minimize divergence in how ECM will be implemented between Contractor and its Subcontractors, and to ensure a streamlined,

seamless experience for ECM Providers and Members.

14. Payment of ECM Providers

A. Contractor must pay ECM Providers for the provision of ECM in accordance with contracts established between Contractor and each ECM Provider.

B. Contractor must ensure that ECM Providers are eligible to receive payment when ECM is initiated for any given Member, as defined in Provision 10, Initiating Delivery of ECM of this Attachment.

C. Contractor may tie ECM Provider payments to value, including payment strategies and arrangements that focus on achieving outcomes related to high-quality care and improved health status.

D. Contractor must utilize the claims timeframes as described in Exhibit A, Attachment 8, Provision 5, Claims Processing.

15. DHCS Oversight of ECM

A. Contractor must submit the following data and reports to DHCS to support DHCS oversight of ECM:

1) Encounter Data

a) Contractor must submit all ECM Encounter Data to DHCS using national standard specifications and code sets to be defined by DHCS.

b) Contractor must be responsible for submitting to DHCS all Encounter Data for ECM services to its Members, regardless of the number of levels of delegation or sub-delegation between Contractor and the ECM Provider.

c) In the event the ECM Provider is unable to submit ECM Encounter Data to Contractor using the national standard specifications and code sets to be defined by DHCS, Contractor is responsible for converting the ECM Provider's Encounter Data information into the national standard specifications and code sets, for submission to DHCS.

2) ECM supplemental reports, on a schedule and in a format to be defined by DHCS.

B. Contractor must track and report to DHCS, on a schedule and in a format specified by DHCS, information about outreach efforts related to Members who could potentially 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 17, Sanctions.

16. ECM Quality and Performance Incentive Program

A. Contractor must 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 other performance milestones and measures, to be defined in forthcoming DHCS guidance.

Community Supports (formerly In Lieu of Services)

Community Supports Definitions

1. **Community Supports:** substitute services or settings to those required under the California Medicaid State Plan that Contractor may select and offer to their Members when the substitute service or setting is and are medically appropriate and more cost-effective that the service or setting listed in the California Medicaid State Plan.

2. **Community Supports Provider:** a contracted Provider of DHCS-approved Community Supports. Community Supports Providers are entities with experience and expertise providing one or more of the Community Supports approved by DHCS.

Community Supports

1. Contractor's Responsibility for Administration of Community Supports

A. Contractor may provide DHCS pre-approved Community Supports as described in Provision 19, DHCS Pre-Approved Community Supports of this Attachment.

The remainder of Exhibit A, Attachment 22 refers only to Community Supports that Contractor may choose to offer, unless otherwise specified.

B. In accordance with 42 CFR section 438.3(e)(2), all applicable APLs, and the Community Supports Policy Guide, Contractor may select and offer Community Supports from the list of Community Supports pre-approved by DHCS as medically appropriate and cost-effective substitutes for Covered Services or settings under the State Plan. See Provision 19, DHCS Pre-Approved Community Supports below for list.

1) Contractor must ensure medically appropriate State Plan services are available to the Member regardless of whether the Member has been offered a Community Supports, is currently receiving a Community Supports, or has received a Community Supports in the past.

2) Contractor may not require a Member to utilize a Community Supports. Members always retain their right to receive the California Medicaid State Plan Covered Services on the same terms as would apply if a Community Supports was not an option in accordance with regulatory requirements.

3) Contractor must not use Community Supports to reduce, discourage, or jeopardize Members' access to State Plan services.

4) Contractor may submit a request to DHCS to offer Community Supports in addition to the pre-approved Community Supports.

C. With respect to pre-approved Community Supports, Contractor must adhere to DHCS' guidance on service definitions, eligible populations, code sets, potential

Community Supports Providers, and parameters for each Community Supports, referenced in APL 21-017 and the Community Supports Policy Guide, that Contractor chooses to provide. Upon approval from DHCS, Contractor may adopt a more narrowly defined eligible population than outlined in the Community Supports Policy Guide.

1) Contractor is not permitted to extend a Community Supports to Members beyond those for whom DHCS has determined the Community Supports will be cost-effective and medically appropriate, as indicated in the DHCS guidance on eligible populations.

2) Contractor must provide public notice of any limitations on Community Supports when Contractor requests an alternate approach involving narrowing eligible populations, including specifying such limitations in the Member Services Guide/EOC and on Contractor's website, in addition to receiving DHCS' written approval.

D. If Contractor elects to offer one (1) or more pre-approved Community Supports, it need not offer the Community Supports in each county it serves. Contractor must report to DHCS the counties in which it intends to offer the Community Supports. Contractor must provide Community Supports in a county selected by Contractor in accordance with the requirements set forth below in Provision 21, Community Supports Provider Capacity.

E. Contractor must identify Members who may benefit from Community Supports and for whom Community Supports will be a medically appropriate and cost-effective substitute for Covered Services, and accept requests for Community Supports from Members and Members' Providers and organizations that serve them, including community-based organizations as described below in Provision 23, Identifying Members for Community Supports.

F. Contractor must authorize Community Supports for Members deemed eligible in accordance below with Provision 24, Authorizing Members for Community Supports and Communication of Authorization Status.

G. Contractor may elect to offer value-added services in addition to offering one (1) or more Community Supports. Offering Community Supports does not preclude Contractor from offering value-added services.

H. In the event of any discontinuation of Community Supports resulting in a change in the availability of services, Contractor must adhere to the requirements set forth in Exhibit A, Attachment 9, Provision 10, Changes in Availability or Location of Covered Services, and Exhibit A, Attachment 13, Provision 4, Notification of Changes in Access to Covered Services.

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

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

2. DHCS Pre-Approved Community Supports

A. Contractor may choose to offer Members one (1) or more of the following pre-approved Community Supports, and any subsequent Community Supports additions pre-approved by DHCS, in each county:

1) Housing Transition Navigation Services;

2) Housing Deposits;

3) Housing Tenancy and Sustaining Services;

4) Short-Term Post-Hospitalization Housing;

5) Recuperative Care (Medical Respite);

6) Respite Services;

7) Day Habilitation Programs;

8) Nursing Facility Transition/Diversion to Assisted Living Facilities;

9) Community Transition Services/Nursing Facility Transition to a Home;

10) Personal Care and Homemaker Services;

11) Environmental Accessibility Adaptations;

12) Medically Tailored Meals/Medically Supportive Food;

13) Sobering Centers; and

14) Asthma Remediation.

B. Contractor must list all Community Supports it offers in its Contractor's Community Supports MOC template and Community Supports MOC amendments.

C. Contractor must ensure Community Supports are provided in accordance with all applicable APLs, unless DHCS has provided written approval of an alternate approach requested by Contractor.

D. Contractor must ensure Community Supports are provided to Members in a timely manner, and must develop policies and procedures outlining its approach to managing Community Supports Provider shortages or other barriers to ensure timely provision of Community Supports.

E. Contractor may discontinue offering Community Supports annually with notice to DHCS at least 90 calendar days prior to the discontinuation date.

   Contractor must ensure Community Supports that were authorized for a Member prior to the discontinuation of those specific Community Supports are not disrupted by a change in Community Supports offerings, either by completing the authorized service or by seamlessly transitioning the Member into other Medically Necessary services or programs that meet the Member's needs.

F. At least 30 calendar days before discontinuing Community Supports, Contractor must notify Members affected by the discontinuation of the Community Supports of the following:

   1) The change and timing of discontinuation, and

   2) The procedures that will be used to ensure completion of the authorized Community Supports or a transition into other comparable Medically Necessary services.

G. Contractor may provide voluntary services that are neither State-approved Community Supports nor Covered Services when medically appropriate for the Member, in accordance with 42 CFR section 438.3(e)(1). Such voluntary services are not subject to the terms of Provision 18, Contractor's Responsibility for Administration of Community Supports, through Provision 31, Community Supports Quality and Performance Incentive Program, and are subject to the limitations of 42 CFR section 438.3(e)(1).

3. Community Supports Providers

A. Community Supports Providers are entities that Contractor has determined can provide the Community Supports to eligible Members in an effective manner consistent with culturally and linguistically appropriate care, as outlined in Exhibit A, Attachment 9, Provision 13, Cultural and Linguistic Program.

B. Contractor must enter into Subcontractor Agreements with Community Supports Providers for the delivery of elected Community Supports elected by Contactor.

C. Contractor must ensure all Community Supports Providers for whom a State-level enrollment pathway exists enroll in Medi-Cal, pursuant to relevant APLs, including APL 19-004. If APL 19-004 does not apply to a Community Supports Provider, Contractor must have a process for verifying qualifications and experience of Community Supports Providers, which must extend to individuals employed by or delivering services on behalf of the Community Supports Provider. Contractor must ensure that all Community Supports Providers meet the capabilities and standards required to be a Community Supports Provider.

D. In accordance with Provision 26 below, Data System Requirements and Data Sharing to Support Community Supports, Contractor must support Community Supports Provider access to systems and processes allowing them to do the following, at a minimum:

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

   2) Contractor must also support Community Supports Provider notification to Contractor and ECM Providers and Member's PCP, as applicable, when a referral has been fulfilled, as described below in Provision 26, Data System Requirements and Data Sharing to Support Community Supports.

E. To the extent Contractor elects to offer Community Supports, Contractor may coordinate its approach with other Medi-Cal Managed Care Health Plans offering Community Supports in the same county.

4. Community Supports Provider Capacity

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

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

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

5. Community Supports Model of Care

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

B. In developing and executing Subcontractor Agreements with Community Supports Providers, Contractor must incorporate all requirements and policies and procedures described in its Community Supports MOC, in addition to all applicable APLs.

C. Contractor may collaborate with other Medi-Cal Managed Care Health Plans within the same county, on the development of its Community Supports MOC.

D. Contractor must submit its Community Supports MOC for DHCS review and approval. Contractor must submit to DHCS any Significant Changes to its Community Supports MOC for DHCS review and approval at least 60 calendar days in advance of any occurrence of changes or updates, in accordance with DHCS policies and guidance, including all applicable APLs. Significant Changes may include, but are not limited to, changes to Contractor's approach to administer or deliver Community Supports services, approved policies and procedures, and Subcontractor Agreement boilerplates.

6. Identifying Members for Community Supports

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

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

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

   2) How Contractor will notify Members; and

   3) How Contractor will accept requests for Community Supports from Providers, other community-based entities, and Member or Member's family, legal guardians, authorized representatives, caregivers, and other authorized support persons.

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

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

E. Transition of WPC and HHP to Community Supports

   1) In HHP and WPC pilot counties, Contractor may offer Community Supports to HHP and WPC Members who receive similar services through WPC or HHP for continuity of the services being delivered as part of those programs.

   2) In HHP and WPC pilot counties, Contractor must enter into Subcontractor Agreements with all WPC Lead Entities and HHP CB-CMEs as Community Supports Providers, regardless of whether Contractor offers Community Supports on a county-wide basis, unless Contractor receives prior written approval from DHCS, through the Community Supports MOC review process, based on one (1) or more of the following exceptions:

      a) The Community Supports Provider does not provide the Community Supports that Contractor elected to offer;

      b) There is a justified quality of care concern with the Community Supports Provider;

      c) Contractor and the Community Supports Provider are unable to agree on contracted rates;

d) The Community Supports Provider is unwilling to enter into a Subcontractor Agreement;

e) The Community Supports Provider is unresponsive to multiple attempts to enter into a Subcontractor Agreement;

f) The Community Supports Provider is unable to comply with the Medi-Cal enrollment process or vetting by Contractor; or

g) The Community Supports Provider without a State-level pathway to Medi-Cal enrollment is unable to comply with Contractor's processes for vetting qualifications and experience.

7. Authorizing Members for Community Supports and Communication of Authorization Status

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

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

C. For Members with an assessed risk of incurring other California Medicaid State Plan services, such as inpatient hospitalizations, skilled nursing facility stays, or emergency department visits, Contractor must develop policies and procedures to ensure appropriate clinical support authorization of Community Supports for Members. Contractor's policies and procedures must include detailed documentation that a Network Provider using their professional judgement has determined it to be medically appropriate for the Member to receive Community Supports as it is likely to reduce or prevent the need for acute care or other California Medicaid State Plan services in accordance with all applicable APLs and to be defined in forthcoming guidance.

D. Contractor must not restrict the authorization of Community Supports only to Members transitioning from WPC or HHP.

E. Contractor must develop and maintain policies and procedures to ensure Members do not experience undue delays pending the authorization process for Community Supports.

1) If Medically Necessary, Contractor must make available the California Medicaid State Plan services that the Community Supports replaces, pending authorization of the requested Community Supports.

2) Contractor must evaluate and document whether a service is medically appropriate and cost-effective when determining whether to provide Community Supports to a Member. Providing particular Community Supports to a Member in one (1) instance does not automatically mean that providing other Community Supports to the same Member, the same Community Supports to another Member, or the same Community Supports to the same Member in a different instance would be medically appropriate and cost-effective.

F. Contractor must have policies and procedures for expediting the authorization of certain Community Supports for urgent needs, as appropriate, and that identify the circumstances in which any expedited authorization processes apply, in accordance with all applicable APLs.

G. When a Member has requested Community Supports, directly or through a Provider, community-based organization, or other entity, Contractor must notify the requesting entity and Member of Contractor's decision regarding Community Supports authorization, in accordance with all applicable APLs. If the Member is enrolled in ECM, Contractor must ensure the ECM Provider is informed of the Community Supports authorization decision.

H. Member always retains the right to file Appeals and/or Grievances if they request one (1) or more Community Supports offered by Contractor, but were not authorized to receive the requested Community Supports because of a determination that it was not medically appropriate or cost effective.

I. For Members who sought Community Supports offered by Contractor, but were not authorized to receive the Community Supports, Contractor must submit necessary data to monitor Appeals and Grievances as well as follow its standard Grievances and Appeals process outlined in Exhibit A, Attachment 14, Member Grievance and Appeal System and APL 21-011.

8. Referring Members to Community Supports Providers for Community Supports

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

1) For Members enrolled in ECM, policies and procedures must address how Contractor will work with the ECM Provider to coordinate the Community Supports referral and communicate the outcome of the referral back to the ECM Provider, such as using closed loop referrals.

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

B. If the Member prefers a particular Community Supports Provider are known, Contractor must follow those preferences, to the extent practicable.

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

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

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

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

   1) Ensure the Member agrees to receive Community Supports;

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

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

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

9. Data System Requirements and Data Sharing to Support Community Supports

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

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

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

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

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

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

C. Contractor must use defined federal and State standards, specifications, code sets, and terminologies when sharing physical, behavioral, social, and administrative data with Community Supports Providers and with DHCS.

10. Contractor's Oversight of Community Supports Providers

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

B. Contractor must perform oversight of Community Support Providers, holding them accountable to all Community Supports requirements contained in this Contract and all applicable APLs.

C. Contractor must use all applicable APLs to develop its Subcontractor Agreements with Community Support Providers and must incorporate all of its Community Supports Provider requirements. Contractor must submit its Subcontractor Agreements with Community Supports Providers to DHCS for review and approval in a form and manner specified by DHCS.

D. To streamline Community Supports implementation, Contractor must ensure the following:

1) Contractor must hold Community Supports Providers responsible for the same reporting requirements as are required of Contractor by DHCS.

2) Contractor must not impose mandatory reporting requirements that are alternative or additional to those required for Encounter and supplemental reporting.

3) Contractor may collaborate with other Medi-Cal Managed Care Health Plans within the same county on reporting requirements and oversight.

E. Contractor must not utilize tools developed or promulgated by NCQA to perform oversight of Community Supports Providers, unless by mutual consent with the Community Supports Provider.

F. Contractor must provide Community Supports training and technical assistance to Community Supports Providers, including in-person sessions, webinars, and calls, as necessary, in addition to Network Provider training requirements as described in Exhibit A, Attachment 7, Provision 5, Network Provider Training.

11. Delegation of Community Supports Administration to Subcontractor(s)

A. Contractor may enter into Subcontractor Agreements with other entities to administer Community Supports in accordance with the following:

1) Contractor must maintain and be responsible for oversight of compliance with all Contract provisions and Covered Services, as described in Exhibit A, Attachment 6, Provision 14, Network Provider Agreements and Subcontractor Agreements;

2) Contractor is 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, Network Provider Agreements and Subcontractor Agreements;

3) Contractor must evaluate the prospective Subcontractor's ability to perform services as described in Exhibit A, Attachment 6, Provision 14, Network Provider Agreements and Subcontractor Agreements;

4) Contractor must ensure the Subcontractor's Community Supports Provider capacity is sufficient to serve all Populations of Focus;

5) Contractor must report to DHCS the names of all Subcontractors by 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, Subcontractor Reports; and

6) Contractor must 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, Network Provider Agreements and Subcontractor Agreements.

B. Contractor must ensure that the Subcontractor Agreement mirror the requirements set forth in this Contract and all applicable APLs, as applicable to the Subcontractor.

C. Contractor may collaborate with its Subcontractors on its approach to Community Supports to minimize divergence in how the Community Supports will be implemented between Contractor and its Subcontractor(s) and ensure a streamlined, seamless experience for Community Supports Providers and Members.

12. Payment of Community Supports Providers

A. Contractor must pay contracted Community Supports Providers for the provision of authorized Community Supports to Members in accordance with established Subcontractor Agreements between Contractor and each Community Supports Provider.

B. Contractor must utilize the claims timeline and process as described in Exhibit A, Attachment 8, Provision 5, Claims Processing.

C. Contractor must identify any circumstances under which payment for Community Supports must be expedited to facilitate timely delivery of the Community Supports to the Member, such as recuperative care for an individual who is homeless and being discharged from the hospital.

   For such circumstances, Contractor must develop and maintain policies and procedures to ensure payment to the Community Supports Provider is expedited. Contractor must submit these policies and procedures to DHCS for review and approval prior to implementation.

D. Contractor shall ensure Community Supports Providers submit a claim for rendered Community Supports, to the greatest extent possible.

   1) If a Community Supports Provider is unable to submit a claim for Community Supports rendered, Contractor must ensure the Community Supports Provider documents services rendered using an invoice approved by DHCS.

   2) Upon receipt of such invoice, Contractor must document the Encounter for the Community Supports rendered.

13. DHCS Oversight of Community Supports

A. In the Community Supports MOC, Contractor must include details on the Community Supports Contractor plans to offer, including which counties Community Supports will be offered and its network of Community Supports Providers, in accordance with all applicable APLs.

B. After implementation of Community Supports, Contractor must submit the following data and reports to DHCS to support DHCS oversight of Community Supports:

   1) Encounter Data

      a) Contractor must submit all Community Supports Encounter Data to DHCS using national standard specifications and code sets to be defined by DHCS. Contractor must be compliant with DHCS guidance on invoicing standards for Contractor to use with Community Supports Providers.

      b) Contractor must submit to DHCS all Community Supports Encounter Data, including Encounter Data for Community Supports generated under Subcontractor Agreements.

c) In the event the Community Supports Provider is unable to submit Community Supports Encounter Data to Contractor using the national standard specifications and code sets to be defined by DHCS, Contractor must convert Community Supports Providers' invoice data into the national standard specifications and code sets, for submission to DHCS.

d) Encounter Data, when possible, must include data necessary for DHCS to stratify services by age, sex, race, ethnicity, and language spoken to inform health equity initiatives and efforts to mitigate health disparities undertaken by the DHCS.

2) Supplemental reporting on a schedule and in a form to be defined by DHCS.

C. Contractor must timely submit any related data requested by DHCS, CMS, or an independent entity conducting an evaluation of Community Supports including, but not limited to:

1) Data to evaluate the utilization and effectiveness of a Community Supports.

2) Data necessary to monitor health outcomes and quality metrics at the local and aggregate levels through timely and accurate Encounter Data and supplemental reporting on health outcomes and equity of care. When possible, metrics must be stratified by age, sex, race, ethnicity, and language spoken.

3) Data necessary to monitor Member Appeals and Grievances associated with Community Supports.

D. In the event of underperformance by Contractor in relation to its administration of Community Supports, DHCS may impose sanctions in accordance with Exhibit E, Attachment 2, Provision 17, Sanctions.

14. Community Supports Quality and Performance Incentive Program

A. Contractor must meet all quality management and Quality Improvement requirements described in Exhibit A, Attachment 4, Quality Improvement System and any additional quality requirements for Community Supports set forth in associated guidance from DHCS.

B. Contractor may participate in a performance incentive program related to adoption of Community Supports, building infrastructure and Provider capacity for Community Supports, related health care quality and outcomes, and other

performance milestones and measures, in accordance with DHCS policies and guidance.

Medi-Cal Community Supports, or In Lieu of Services (ILOS), Policy Guide

April 2022

Table of Contents

I. Introduction to Community Supports (ILOS)

California Advancing and Innovating Medi-Cal (CalAIM), establishes the framework to address social determinants of health and improve health equity statewide. A key feature of CalAIM is the introduction of a menu of Community Supports, or in lieu of services (ILOS), in managed care.

What are Community Supports?

Community Supports are services or settings that MCPs may offer in place of services or settings covered under the California Medicaid State Plan and that are a medically appropriate, cost-effective alternative to a State Plan Covered Service. Community Supports are optional for MCPs to offer and for Members to utilize. MCPs may not require Members to use a Community Support instead of a service or setting listed in the Medicaid State Plan.

This Program Guide

Community Supports are a significant change and a high priority for DHCS. DHCS recognizes the work California MCPs and communities will be doing to operationalize these new initiatives under CalAIM and transition smoothly services provided under the Whole Person Care Pilots and Health Home Program even as they continue to address the COVID-19 Public Health Emergency.

Throughout 2021, DHCS is offering a range of technical assistance and support including detailed implementation requirements and guidance presented in this Program Guide. In addition, DHCS is making available materials posted on the DHCS CalAIM ECM and Community Supports website, webinars, non-binding Community Supports pricing information, and other opportunities for discussion to support the implementation of these initiatives. All information provided in this fact sheet is preliminary and subject to change. This Program Guide is for informational purposes and is not intended to replace future guidance and state and/or federal requirements.

For specific questions about Community Supports, please submit to: CalAIMECMILOS@dhcs.ca.gov. Questions about CalAIM generally should be submitted to: CalAIM@dhcs.ca.gov.

An FAQ which provides up-to-date information about the Community Supports implementation and will be updated regularly and is available from the Community Supports Resource Directory.

Requirements for Providing Community Supports

Pursuant to 42 CFR 438.3, MCPs may not provide Community Supports without first applying to the State and obtaining State approval to offer the Community Support by demonstrating all the requirements will be met. MCPs may voluntarily agree to provide any service to a Member outside of an approved Community Supports construct; however, the cost of any such voluntary services may not be included in determining MCP rates.

Once approved by DHCS, the Community Support will be added to the MCP's contract and posted on the DHCS website as a State-Approved ILOS.

Community Supports may be offered by MCPs beginning January 1, 2022. Additional Community Supports may be added thereafter on a 6-month cadence.

II. What are Community Supports, or ILOS?

Introduction

CalAIM is a new initiative by the Department of Health Care Services (DHCS) to improve the quality of life and health outcomes of Medi-Cal beneficiaries by implementing broad delivery system, programmatic, and payment system reforms. A key feature of CalAIM is the introduction of a new menu of in lieu of services (ILOS), or Community Supports, which, at the option of a Medi-Cal managed care health plan (MCP) and a Member, can substitute for covered Medi-Cal services as cost-effective alternatives. MCPs will be responsible for administering Community Supports. For more information about CalAIM, see DHCS' Revised CalAIM Proposal released on 1/8/21.[1]

Overview of Community Supports

Community Supports are medically appropriate and cost-effective alternatives to services covered under the State Plan. Federal regulation allows states permit Medicaid managed care organizations to offer Community Supports as an option to Members.[2] Community Supports can substitute for and potentially decrease utilization of a range of covered Medi-Cal benefits, such as hospital care, nursing facility care, and emergency department (ED) use.

Community Supports are an important part of care delivery for Members enrolled in Enhanced Care Management (ECM), another CalAIM initiative that will address the clinical and non-clinical needs of high-need, high-cost Medi-Cal Members through systematic coordination of services and comprehensive care management.[3] As such, DHCS encourages MCPs to offer a robust menu of 14 pre-approved Community Supports to comprehensively address the needs of Members—including those with the most complex challenges affecting health such as homelessness, unstable and unsafe housing, food insecurity, and/or other social needs.

By design, the list of pre-approved Community Supports is drawn in part from the foundational work done as part of the Whole Person Care (WPC) Pilots and Health Homes Program (HHP). A key goal of Community Supports is to allow Members to obtain care in the least restrictive setting possible and to keep them in the community as medically appropriate. Community Supports will build on WPC and HHP efforts and activities and expand access to services that were previously available only through home and community-based services initiatives while addressing health-related social needs.

MCPs will have the opportunity to provide details on their elected Community Supports to DHCS as part of their Model of Care (MOC) responses to DHCS. MCPs in all Counties are encouraged to offer one or more of the following Community Supports starting on January 1, 2022:[4]

- Housing Transition Navigation Services;

[1] Revised CalAIM Proposal, January 2021.
[2] 42 CFR 438.3(e)(2).
[3] ECM Fact Sheet
[4] See the "Community Supports Service Descriptions" for more detail about each Community Support option.

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- 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 the 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);
- Medically-Supportive Food/Meals/Medically Tailored Meals;
- Sobering Centers; and
- Asthma Remediation.

Community Supports are Optional, but Strongly Encouraged

MCPs are strongly encouraged to elect to offer some or all of these pre-approved Community Supports and are expected to detail their Community Supports offerings in their MOC. As part of the MOC response, MCPs will describe which Community Supports they will offer, the date each elected Community Support is expected to launch, and the MCP's plans for operationalizing the Community Support including the Community Support provider network. DHCS expects that MCPs in WPC and HHP counties will offer the pre-approved Community Supports that correspond to the services previously offered through those programs to ensure a seamless transition for those Members. MCPs may propose additional Community Supports to DHCS for review and approval. MCPs may choose to offer different Community Supports in different Counties. MCPs may add or remove Community Supports at defined intervals: every six (6) months for an addition and annually for removal of a previously offered Community Support.

Community Supports Implementation Timeline

MCPs in all Counties may launch pre-approved Community Supports beginning January 1, 2022. DHCS strongly encourages all MCPs to begin offering Community Supports at this time. The timely offering of Community Supports will help to improve care for Members, support the goals of CalAIM, and contribute to the smooth transition of Members receiving services through WPC Pilots into Medi-Cal managed care.

Enhanced Care Management (ECM) and Community Supports Website Requirements

Managed Care Plan websites must be updated to include the following for Enhanced Care Management (ECM) and Community Supports:

- Up to date Member and provider facing information about ECM and how to request access to ECM.
- As required in A.B. 133 14184.206(e), Cal Assembly, 2021 Reg. Sess. (CA 2021) https://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=202120220AB133: Up to date information about all the Community Supports being offered by the MCP, including, at minimum:
    - A short description of each available service that is consistent with the service definitions listed in the DHCS Community Supports Policy Guide. Terminology should not differ from DHCS' terminology.
    - The eligible population(s) for each service, inclusive of any **DHCS approved** approach to narrow or limit the eligible populations (Reminder: any such limitation must meet the requirements in the CalAIM Waiver Special Terms and Conditions, pp. 7-8 and be approved by DHCS). Any such limitations must also be included in Member Handbooks.
    - Member and provider facing information about how to access the Community Supports offered by the MCP.

III. Community Supports – Service Definitions

Community Supports 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. Community Supports 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) Members are not required to use the Community Supports and 3) the Community Supports are authorized and identified in the managed care plan contracts.

Each set of pre-approved 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)
- Medically-Supportive Food/Meals/Medically Tailored Meals
- Sobering Centers
- Asthma Remediation

Housing Transition Navigation Services

Description/Overview

Housing transition services assist Members with obtaining housing and include:

1. Conducting a tenant screening and housing assessment that identifies the member's preferences and barriers related to successful tenancy. The assessment may include collecting information on the member'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 member'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 HUD's Housing Choice Voucher Program (Section 8), or state and local assistance programs) and matching available rental subsidy resources to Members.
7. Identifying and securing resources to cover expenses, such as security deposit, moving costs, adaptive aids, environmental modifications, moving costs, and other one-time expenses.[5]
8. Assisting with requests for reasonable accommodation, if necessary.[6]
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 Member with landlords.

[5] Actual payment of these housing deposits and move-in expenses is a separate in-lieu service under Housing Deposits.

[6] Related to expenses incurred by the housing navigator supporting the member moving into the home

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.[7]
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, securing, or funding environmental modifications to install necessary accommodations for accessibility (see Environmental Accessibility Adaptations Community Support).

The services provided should be based on individualized assessment of needs and documented in the individualized housing support plan. Members may require and access only a subset of the services listed above.

The services provided should utilize best practices for Members 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. These entities may include County Health, Public Health, Substance Use, Mental Health and Social Services Departments; County and City Housing Authorities; Continuums of Care and Coordinated Entry System; Sheriff's Department and Probation Officers, as applicable and to the extent possible; local legal service programs, community-based organizations housing providers, local housing agencies, and housing development agencies. For Members 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 Members) is also funded by county behavioral health agencies, and Medi-Cal managed care plans and their contracted Community Supports providers should expect to coordinate access to these housing resources through county behavioral health when appropriate.

Final program guidelines should adopt, as a standard, the demonstrated need to ensure seamless service to Members experiencing homelessness entering the Housing Transition Navigation Services Community Support.

[7] The services associated with the crisis plan are a separate in-lieu service under Housing Tenancy and Sustaining Services.

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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)

- 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 because 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 this service, qualifying institutions include hospitals, correctional facilities, mental health residential treatment facility, substance use disorder residential treatment facility, recovery residences, Institutions for Mental Disease, and State Hospitals; 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

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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.

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 or have a Serious Emotional Disturbance (children and adolescents);

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- 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 domestic violence.

Restrictions and Limitations

Housing Transition/Navigation services must be identified as reasonable and necessary in the individual's individualized housing support plan. Service duration can be as long as necessary.

Community supports shall supplement and not supplant services received by the Medi-Cal beneficiary through other State, local, or federally-funded programs, in accordance with the CalAIM STCs and federal and DHCS guidance.

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, pursuant to relevant DHCS APLs including Provider Credentialing/Recredentialing and Screening/Enrollment APL 19-004. If there is

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no state-level enrollment pathway, managed care plans must have a process for vetting the Community Supports Provider, which may extend to individuals employed by or delivering services on behalf of the Community Supports Provider, to ensure it can meet the capabilities and standards required to be a Community Supports Provider. Members 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, Community Supports should be managed in coordination with enhanced care management providers. When members 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 members and to improve overall care coordination and management.[8]

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.

[8] One exception to this is for benefits advocacy, which may require providers with a specialized skill set.

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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 Members 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 Community Support 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 because 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 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.

Restrictions and Limitations

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 Member 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.

Community supports shall supplement and not supplant services received by the Medi-Cal beneficiary through other State, local, or federally-funded programs, in accordance with the CalAIM STCs and federal and DHCS guidance.

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, pursuant to relevant DHCS APLs including Provider

Credentialing/Recredentialing and Screening/Enrollment APL 19-004. If there is no state-level enrollment pathway, managed care plans must have a process for vetting the Community Supports Provider, which may extend to individuals employed by or delivering services on behalf of the Community Supports Provider, to ensure it can meet the capabilities and standards required to be a Community Supports Provider.

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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 Member 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[9].
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).

[9] Does not include housing quality inspections.

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 Members 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. Final program guidelines should adopt, as a standard, the demonstrated need to ensure seamless serving to Members experiencing homelessness entering the Housing Tenancy and Sustaining Services Community Support.

Services do not include the provision of room and board or payment of rental costs.

Eligibility (Population Subset)

- Any individual who received Housing Transition/Navigation Services Community Support 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 because 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 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 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

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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

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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 are determined to be at risk of experiencing homelessness are eligible to receive Housing Tenancy and Sustaining 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 o 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 domestic violence.

Restrictions/Limitations

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 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. Service duration can be as long as necessary.

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 prerequisite for eligibility.

Community supports shall supplement and not supplant services received by the Medi-Cal beneficiary through other State, local, or federally-funded programs, in accordance with the CalAIM STCs and federal and DHCS guidance.

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, pursuant to relevant DHCS APLs including Provider Credentialing/Recredentialing and Screening/Enrollment APL 19-004. If there is no state-level enrollment pathway, managed care plans must have a process for vetting the Community Supports Provider, which may extend to individuals employed by or delivering services on behalf of the Community Supports Provider, to ensure it can meet the capabilities and standards required to be a Community Supports Provider.

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.

Members 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, Community Supports should be managed in coordination with enhanced care management providers. When Members receive more

than one of these services, the managed care plan should ensure coordination by an enhanced care management provider whenever possible to minimize the number of care/case management transitions experienced by Members and to improve overall care coordination and management.

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Short-Term Post-Hospitalization Housing

Description/Overview

Short-Term Post-Hospitalization Housing provides Members who do not have a residence and who have high medical or behavioral health needs with the opportunity to continue their medical/psychiatric/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 and avoid further utilization of State plan services.[10]

This setting must provide 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.[11]

This setting may include an individual or shared interim housing setting, where residents receive the services described above.

Members 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.[12]

The services provided should utilize best practices for Members 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 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

[10] Up to 90 days of recuperative care is available under specified circumstances as a separate Community Support.
[11] Housing Transition/Navigation is a separate Community Support.
[12] The development of a housing assessment and individualized support plan are covered as a separate Community Support under Housing Transition/Navigation Services.

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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;

- 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

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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.

Individuals who are determined to be at risk of experiencing homelessness are eligible to receive Short-Term Post-Hospitalization Housing 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 o 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 domestic violence.

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

Short-Term Post-Hospitalization services are available once in an individual's lifetime and are not to exceed a duration of six (6) months (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.

Community supports shall supplement and not supplant services received by the Medi-Cal beneficiary through other State, local, or federally-funded programs, in accordance with the CalAIM STCs and federal and DHCS guidance.

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.

Medi-Cal managed care plan network providers that have a state-level enrollment pathway must enroll in the Medi-Cal program, pursuant to relevant DHCS APLs including Provider Credentialing/Recredentialing and Screening/Enrollment APL 19-004. If there is no state-level enrollment pathway, managed care plans must have a process for vetting the Community Supports Provider, which may extend to individuals employed by or delivering services on behalf of the Community Supports Provider, to ensure it can meet the capabilities and standards required to be a Community Supports Provider.

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. An extended stay in a recovery care setting 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, suchas 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 Community Supports. Whenever possible, other available housing Community Supports should be provided to Members onsite in the recuperative care facility. When enrolled in enhanced care management, Community Supports should be managed in coordination with enhanced care management providers.

The services provided should utilize best practices for Members 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. [13]
- 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;
- 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

[13] For this population, the service could be coordinated with home modifications (which are covered as a separate Community Support) and serve as a temporary placement until the Member can safely return home.

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.

Individuals who are determined to be at risk of experiencing homelessness are eligible to receive Recuperative Care 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 o 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 domestic violence.

Restrictions/Limitations

Recuperative care/medical respite is an allowable Community Supports 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.

Community Supports shall supplement and not supplant services received by the Medi-Cal beneficiary through other State, local, or federally-funded programs, in accordance with the CalAIM STCs and federal and DHCS guidance.

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
- 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.

Medi-Cal managed care plan network providers that have a state-level enrollment pathway must enroll in the Medi-Cal program, pursuant to relevant DHCS APLs including Provider Credentialing/Recredentialing and Screening/Enrollment APL 19-004. If there is no state-level enrollment pathway, managed care plans must have a process for vetting the Community Supports Provider, which may extend to individuals employed by or delivering services on behalf of the Community Supports Provider, to ensure it can meet the capabilities and standards required to be a Community Supports Provider.

Respite Services

Description/Overview

Respite Services are provided to caregivers of Members who require intermittent temporary supervision. The services are provided on a short-term basis because of the absence or need for relief of those 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 Member's basic self-help needs and other activities of daily living, including interaction, socialization and continuation of usual daily routinesthat would ordinarily be performed by those persons who normally care for and/or supervise them.

Home Respite Services are provided to the Member in his or her own home or another location being used as the home.

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, Members enrolled in California Children's Services, and Genetically Handicapped Persons Program (GHPP), and Members with Complex Care Needs.

Restrictions/Limitations

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.

Community supports shall supplement and not supplant services received by the Medi-Cal beneficiary through other State, local, or federally-funded programs, in accordance with the CalAIM STCs and federal and DHCS guidance.

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 HealthFacilities (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
  - County Agencies
  - 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 FamilyHomes (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 FamilyHome (AFH)/Family Teaching Home (FTH)

- Respite Facility; Residential Facility: Adult Residential Facility for Persons withSpecial Health Care Needs
- Respite Facility; Residential Facility: Foster Family Homes (FFHs) (Children Only)
- Short-term Residential Therapeutic Program Providers or other care providers who are serving youth with complex needs

Medi-Cal managed care plan network providers that have a state-level enrollment pathway must enroll in the Medi-Cal program, pursuant to relevant DHCS APLs including Provider Credentialing/Recredentialing and Screening/Enrollment APL 19-004. If there is no state-level enrollment pathway, managed care plans must have a process for vetting the Community Supports Provider, which may extend to individuals employed by or delivering services on behalf of the Community Supports Provider, to ensure it can meet the capabilities and standards required to be a Community Supports Provider.

Day Habilitation Programs

Description/Overview

Day Habilitation Programs are provided in a Member's home or an out-of-home, non-facility setting. The programs are designed to assist the Member in acquiring, retaining,and improving self-help, socialization, and adaptive skills necessary to reside successfully in the 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 Members experiencing homelessness who are receiving enhanced care management or other Community Supports, day habilitation programs can provide a physical location for Members 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 Members 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, the following:

1. Selecting and moving into a home;[14]
2. Locating and choosing suitable housemates;
3. Locating household furnishings;
4. Settling disputes with landlords;[15]
5. Managing personal financial affairs;
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;

[14] Refer to the Housing Transition/Navigation Services Community Support
[15] Refer to the Housing Tenancy and Sustaining Services Community Support

9. Building and maintaining interpersonal relationships, including a circle of support;
10. Coordination with Medi-Cal managed care plan to link Member to any Community Supports and/or enhanced care management services for which the Member may be eligible;
11. Referral to non-Community Supports housing resources if Member does not meet Housing Transition/Navigation Services Community Support eligibility criteria;
12. Assistance with income and benefits advocacy including General Assistance/ General Relief and SSI if Member is not receiving these services through Community Supports or Enhanced Care Management; and
13. Coordination with Medi-Cal managed care plan to link Member to health care, mental health services, and substance use disorder services based on the individual needs of the Member for Members who are not receiving this linkage through Community Supports or Enhanced Care Management.

The services provided should utilize best practices for Members who are experiencing homelessness or formerly experienced homelessness including Housing First, Harm Reduction, Progressive Engagement, Motivational Interviewing, and Trauma-Informed Care.

Program services are available for as long as necessary. Services can be provided continuously, or through intermittent meetings, in an individual or group setting.

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

Community supports shall supplement and not supplant services received by the Medi-Cal beneficiary through other State, local, or federally-funded programs, in accordance with the CalAIM STCs and federal and DHCS guidance.

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 plan network providers that have a state-level enrollment pathway must enroll in the Medi-Cal program, pursuant to relevant DHCS APLs including Provider Credentialing/Recredentialing and Screening/Enrollment APL 19-004. If there is no state-level enrollment pathway, managed care plans must have a process for vetting the Community Supports Provider, which may extend to individuals employed by or delivering services on behalf of the Community Supports Provider, to ensure it can meet the capabilities and standards required to be a Community Supports Provider.

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 Members 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 Member, 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 wrap-around services: assistance w/ ADLs and IADLs as needed, companion services, medication oversight, and therapeutic social and recreational programming provided in a home-like environment. Includes 24-hour direct care staff on-site to meet scheduled unpredictable needs in a way that promotes maximum dignity and independence, and to provide supervision, safety, and security. Allowable expenses are those necessary to enable a person to establish a community facility residence (except room and board), including, but not limited to:

1. Assessing the Member's housing needs and presenting options.[16]
2. Assessing the service needs of the Member to determine if the Member needs enhanced onsite services at the RCFE/ARF so the Member 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 Members who need enhanced services to be safely and stably housed in RCFE/ ARF settings have Community Supports and/or Enhanced Care Management services that provide the necessary enhanced services.
    A. Managed care plans may also fund RCFE/ARF operators directly to provide these enhanced services.

[16] Refer to Housing Transition/Navigation Services Community Support 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 nursing facility 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

Individuals are directly responsible for paying their own living expenses.

Community supports shall supplement and not supplant services received by the Medi-Cal beneficiary through other State, local, or federally-funded programs, in accordance with the CalAIM STCs and federal and DHCS guidance.

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, pursuant to relevant DHCS APLs including Provider Credentialing/Recredentialing and Screening/Enrollment APL 19-004. If there is

no state-level enrollment pathway, managed care plans must have a process for vetting the Community Supports Provider, which may extend to individuals employed by or delivering services on behalf of the Community Supports Provider, to ensure it can meet the capabilities and standards required to be a Community Supports Provider.

RCFE/ARFs are licensed and regulated by the California Department of Social Services, Community Care Licensing (CCL) Division.

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 Member's housing needs and presenting options.[17]
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.[18]

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.[19]

Eligibility (Population Subset)

1. Currently receiving medically necessary nursing facility Level of Care (LOC)

[17] Refer to the Housing Transition/Navigation Services and/or Housing Tenancy/Sustaining Services Community Support for additional details.

[18] Refer to the Environmental Accessibility Adaptations and/or Asthma Remediation Community Support for additional details.

[19] Refer to the Housing Deposits Community Support for additional details.

services and, in lieu of remaining in the nursing facility or Medical Respite setting, is choosing to transition home and continue to receive medically necessary nursing facility LOC services; and

2. Has lived 60+ days in a nursing home and/or Medical Respite setting; and
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

- 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 $7,500.00. The only exception to the $7,500.00 total maximum is if the Member 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 Member, and without which the Member would be unable to move to the private residence and would then require continued or re- institutionalization.

Community supports shall supplement and not supplant services received by the Medi-Cal beneficiary through other State, local, or federally funded programs, in accordance with the CalAIM STCs and federal and DHCS guidance.

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, pursuant to relevant DHCS APLs including Provider Credentialing/Recredentialing and Screening/Enrollment APL 19-004. If there is no state-level enrollment pathway, managed care plans must have a process for vetting the Community Supports Provider, which may extend to individuals employed by or delivering services on behalf of the Community Supports Provider, to ensure it can meet the capabilities and standards required to be a Community Supports Provider.

Personal Care and Homemaker Services

Description/Overview

Personal Care Services and Homemaker Services provided for individuals who need assistance with Activities of Daily Living (ADLs) such as bathing, dressing, toileting, ambulation, or feeding. Personal Care Services can also include assistance with Instrumental Activities of Daily Living (IADLs) such as meal preparation, grocery shopping, and money management.

Includes services provided through the In-Home Support Services (In-Home Supportive Services) program include house cleaning, 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.

Services also include help with tasks such as cleaning and shopping, laundry, and grocery shopping. Personal Care and Homemaker programs aid individuals who could otherwise not remain in their homes.

The Personal Care and Homemaker Services Community Support 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 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

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 the Personal Care and Homemaker Services Community Support during this reassessment waiting period.

Community supports shall supplement and not supplant services received by the Medi-Cal beneficiary through other State, local, or federally funded programs, in accordance with the CalAIM STCs and federal and DHCS guidance.

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, pursuant to relevant DHCS APLs including Provider Credentialing/Recredentialing and Screening/Enrollment APL 19-004. If there is no state-level enrollment pathway, managed care plans must have a process for vetting the Community Supports Provider, which may extend to individuals employed by or delivering services on behalf of the Community Supports Provider, to ensure it can meet the capabilities and standards required to be a Community Supports Provider.

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 Member would require institutionalization.

Examples of environmental accessibility adaptions include:

- Ramps and grab-bars to assist Members in accessing the home;
- Doorway widening for Members 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 Member; and
- Installation and testing of a Personal Emergency Response System (PERS) for Members 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 Member. For a home that is not owned by the Member, the Member 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 a Community Support, the managed care plan must receive and document an order from the Member'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 Member, 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 Member describing how and why the equipment or service meets the needs of the Member will still be necessary.

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 Member and the current equipment needs specific to the Member, describing how/why the current equipment does not meet the needs of the Member;

B. An evaluation of the requested equipment or service that includes a description of how/why it is necessary for the Member *and reduces the risk of institutionalization*. This should also include information on the ability of the Member 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 Member and a description of the inadequacy.

2. If possible, a minimum of two bids from appropriate providers of the requested service, which itemize the services, cost, labor, and applicable warranties; and

3. 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

- 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 $7,500. The only exceptions to the $7,500 total maximum are if the Member's place of residence changes or if the Member's condition has changed so significantly those additional modifications are necessary to ensure the health, welfare, and safety of the Member, or are necessary to enable the Member to function with greater independence in the home and avoid institutionalization or hospitalization.
- 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 Member and exclude adaptations or improvements that are of general utilityto 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 Member 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 Member ceases to reside at the residence.

Community supports shall supplement and not supplant services received by the Medi-Cal beneficiary through other State, local, or federally funded programs, in accordance with the CalAIM STCs and federal and DHCS guidance.

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, pursuant to relevant DHCS APLs including Provider Credentialing/Recredentialing and Screening/Enrollment APL 19-004. If there is no state-level enrollment pathway, managed care plans must have a process for vetting the Community Supports Provider, which may extend to individuals employed by or delivering services on behalf of the Community Supports Provider, to ensure it can meet the capabilities and standards required to be a Community Supports Provider.

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 except for a PERS installation, whichmay be performed in accordance with the system's installation requirements.

Medically Tailored Meals/Medically-Supportive Food

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/or side effects to ensure the best possible nutrition-related health outcomes.

4. Medically-supportive food and nutrition services, including medically tailored groceries, healthy food vouchers, and food pharmacies.

5. Behavioral, cooking, and/or nutrition education is included when paired with direct food assistance as enumerated above.

Managed care plans have the discretion to define criteria for the level of services determined to be both medically appropriate and cost-effective for Members (e.g., Medically Tailored meals, groceries, food vouchers, etc.).

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

- Up to two (2) 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.

Community supports shall supplement and not supplant services received by the Medi-Cal beneficiary through other State, local, or federally funded programs, in accordance with the CalAIM STCs and federal and DHCS guidance.

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
- Medically-Supportive Food & Nutrition Providers

Medi-Cal managed care plan network providers that have a state-level enrollment pathway must enroll in the Medi-Cal program, pursuant to relevant DHCS APLs including Provider Credentialing/Recredentialing and Screening/Enrollment APL 19-004. If there is no state-level enrollment pathway, managed care plans must have a process for vetting the Community Supports Provider, which may extend to individuals employed by or delivering services on behalf of the Community Supports Provider, to ensure it can meet the capabilities and standards required to be a Community Supports Provider.

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 andhousing 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 Members 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 Members 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.

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

This service is covered for a duration of less than 24 hours.

Community supports shall supplement and not supplant services received by the Medi-Cal beneficiary through other State, local, or federally funded programs, in accordance with the CalAIM STCs and federal and DHCS guidance.

Licensing/Allowable Providers

Providers must have experience and expertise with providing these unique services with these unique populations. 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, pursuant to relevant DHCS APLs including Provider Credentialing/Recredentialing and Screening/Enrollment APL 19-004. If there is no state-level enrollment pathway, managed care plans must have a process for vetting the Community Supports Provider, which may extend to individuals employed by or delivering services on behalf of the Community Supports Provider, to ensure it can meet the capabilities and standards required to be a Community Supports Provider.

Asthma Remediation[20]

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 Member or their caregiver.

When authorizing Asthma Remediation as a Community Support, the managed care plan must receive and document:

- A current licensed health care provider's order specifying the requested remediation(s) for the Member;
- A brief written evaluation specific to the Member describing how and why the remediation(s) meets the needs of the individual, required for cases of "Other interventions identified to be medically appropriate and cost-effective.;
- That a home visit has been conducted to determine the suitability of any requested remediation(s) for the Member.

Asthma Remediation includes providing information to Members 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.

[20] Asthma Remediation should not interfere with EPSDT benefits. All appropriate EPSDT services should be provided, and Community Supports should be complementary. See https://www.hud.gov/sites/dfiles/HH/documents/HUD%20Asthma%20Guide%20Document_Final_7_18.pdf; Appendix B)

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.

The Centers for Disease Control, the Environmental Protection Agency, and Housing and Urban Development collaborated to produce an asthma trigger checklist[21] which MCPs may utilize in determining the appropriateness of these interventions. An accompanying training[22] provides additional details about the connections between asthma triggers and lung health.

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

- 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.

- Asthma remediations are payable up to a total lifetime maximum of $7,500. The only exception to the $7,500 total maximum is if the Member's condition has changed so significantly those additional modifications are necessary to ensure the health, welfare, and safety of the Member, or are necessary to enable the Member to function with greater independence in the home and avoid institutionalization or hospitalization.

- Asthma Remediation modifications are limited to those that are of direct medical orremedial benefit to the Member 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.

[21] https://www.cdc.gov/asthma/pdfs/home_assess_checklist_P.pdf
[22] https://www.epa.gov/sites/production/files/2020-06/home_characteristics_and_asthma_triggers_training_for_home_visitors_0.pptx

- Before commencement of a permanent physical adaptation to the home or installation of equipment in the home, such as installation of an exhaust fan or replacement of moldy drywall, the managed care plan must provide the owner and Member 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 Member ceases to reside at the residence. This requirement does not apply to the provision of supplies that are not permanent adaptations or installations, including but not limited to: allergen-impermeable mattress and pillow dust covers; high-efficiency particulate air (HEPA) filtered vacuums; de-humidifiers; portable air filters; and asthma-friendly cleaning products and supplies.

Community supports shall supplement and not supplant services received by the Medi-Cal beneficiary through other State, local, or federally funded programs, in accordance with the CalAIM STCs and federal and DHCS guidance.

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.

- Lung health organizations
- Healthy housing organizations
- 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, pursuant to relevant DHCS APLs including

Provider Credentialing/Recredentialing and Screening/Enrollment APL 19-004. If there is no state-level enrollment pathway, managed care plans must have a process for vetting the Community Supports Provider, which may extend to individuals employed by or delivering services on behalf of the Community Supports Provider, to ensure it can meet the capabilities and standards required to be a Community Supports Provider.

IV. Community Supports to State Plan Service Crosswalk

Background: The below chart summarizes potential state plan services or settings that each of California's "pre-approved" Community Supports may substitute for. Community Supports may represent an immediate substitute for a State Plan-covered service/setting or a substitute for a State Plan-covered service/setting over a longer timeframe. Additional detail on the cost-effectiveness and medical appropriateness of each service/setting is available in the CA ILOS Evidence Library Executive Summary document posted on the Department's website at: https://www.dhcs.ca.gov/Documents/MCQMD/CA-ILOS-Evidence-Library-Executive-Summary-August-2021.pdf

#	Community Support (ILOS)	Potential State Plan Service/Setting Substitute
1	**Housing Transition/ Navigation Services**	Emergency Department Services
		Emergency Transport Services
		Inpatient Services
		Outpatient Hospital Services
		Outpatient Mental Health
		Rehabilitation Center Outpatient Services
		Skilled Nursing Facility Services
		Transitional Inpatient Care Services
2	**Housing Deposits**	Emergency Department Services
		Emergency Transport Services
		Inpatient Services
		Outpatient Hospital Services
		Outpatient Mental Health
		Rehabilitation Center Outpatient Services
		Skilled Nursing Facility Services
		Transitional Inpatient Care Services
3	**Housing Tenancy and Sustaining Services**	Emergency Department Visit
		Emergency Transport Services
		Inpatient Services
		Outpatient Hospital Services
		Outpatient Mental Health
		Rehabilitation Center Outpatient Services
		Skilled Nursing Facility Services
		Transitional Inpatient Care Services
4	**Short-Term Post-Hospitalization Housing**	Emergency Department Services
		Emergency Transport Services
		Inpatient Services
		Outpatient Hospital Services

#	Community Support (ILOS)	Potential State Plan Service/Setting Substitute
		Post-Acute care
		Skilled Nursing Facility Services
5	**Recuperative Care (Medical Respite)**	Emergency Department Services
		Emergency Transport Services
		Inpatient Services
		Outpatient Hospital Services
		Post-Acute care
		Skilled Nursing Facility Services
6	**Respite Care**	Home Health Agency
		Home Health Aide
		Intermediate Care Facility Services
		Intermediate Care Facility Services for the Developmentally Disabled
		Intermediate Care Facility Services for the Developmentally Disabled Habilitative
		Personal Care Services
		Skilled Nursing Facility Stay
		Specialized Rehabilitative Services in Skilled Nursing Facilities and Intermediate Care Facilities
7	**Day Habilitation Programs**	Emergency Department Services
		Occupational Therapy
		Outpatient Hospital Services
		Outpatient Mental Health
		Rehabilitation Center Outpatient Services
		Targeted Case Management and Services
8	**Nursing Facility Transition/**	Emergency Department Visit
		Inpatient Services

#	Community Support (ILOS)	Potential State Plan Service/Setting Substitute
	Diversion to Assisted Living Facility	Intermediate Care Facility Services
		Intermediate Care Facility Services for the Developmentally Disabled
		Intermediate Care Facility Services for the Developmentally Disabled Habilitative
		Skilled Nursing Facility Stay
		Specialized Rehabilitative Services in Skilled Nursing Facilities and Intermediate Care Facilities
9	**Community Transition Services/Nursing Facility Transition to Home**	Emergency Department Services
		Inpatient Services
		Intermediate Care Facility Services
		Intermediate Care Facility Services for the Developmentally Disabled
		Intermediate Care Facility Services for the Developmentally Disabled Habilitative
		Intermediate Care Facility Services for the Developmentally Disabled - Nursing
		Skilled Nursing Facility Stay
		Specialized Rehabilitative Services in Skilled Nursing Facilities and Intermediate Care Facilities
10	**Personal Care and Homemaker Services**	Home Health Agency Services
		Home Health Aide Services
		Inpatient Services
		Intermediate Care Facility Services
		Intermediate Care Facility Services for the Developmentally Disabled
		Intermediate Care Facility Services for the Developmentally Disabled Habilitative
		Skilled Nursing Facility Stay

#	Community Support (ILOS)	Potential State Plan Service/Setting Substitute
		Specialized Rehabilitative Services in Skilled Nursing Facilities and Intermediate Care Facilities
11	**Environmental Accessibility Adaptations (Home Modifications)**	Emergency Department Services
		Home Health Agency Services
		Home Health Aide Services
		Inpatient Services
		Intermediate Care Facility Services
		Intermediate Care Facility Services for the Developmentally Disabled
		Intermediate Care Facility Services for the Developmentally Disabled Habilitative
		Personal Care Services
		Skilled Nursing Facility Stay
		Specialized Rehabilitative Services in Skilled Nursing Facilities and Intermediate Care Facilities
12	**Medically Tailored Meals/Medically Supportive Foods**	Emergency Department Services
		Emergency Transport Services
		Home Health Agency Services
		Home Health Aide Services
		Inpatient Services
		Outpatient Hospital Services
		Personal Care Services
13	**Sobering Centers**	Emergency Department Services
		Emergency Transport Services
		Inpatient Services
		Emergency Transport Services
14		Asthma-related primary care and specialty visits

#	Community Support (ILOS)	Potential State Plan Service/Setting Substitute
	Asthma Remediation	Emergency Department Services
		Home Health Aide
		Home Health Agency
		Inpatient Stay
		Outpatient Hospital Services
		Personal Care Services

V. Requesting Approval for New Community Supports

MCPs must apply for and obtain State approval prior to offering any new Community Support, and demonstrate that all the following requirements will be met through the submission of a Community Supports Model of Care:

- Community Supports are voluntary. MCPs cannot require a Member to use a Community Support instead of a State Plan-covered service.
- The alternative services are medically appropriate and cost-effective.
- The population and criteria for the Community Support is clearly defined, and the Community Support will be offered in an equitable and nondiscriminatory manner to eligible Members.
- The MCP has demonstrated capability to calculate the cost-benefit analysis for each Community Support, including tracking and reporting on Community Supports expenditures in a manner and format established by DHCS.
- MCPs must use the HCPCS rate codes through encounter data that have been approved by DHCS to track the claiming and provision of Community Supports.
- Community Supports may not include expenditures prohibited by CMS, such as room and board.

Once DHCS approves an MCP's submitted Community Supports Model of Care, the Community Support must be added to the MCP's contract, subject to federal approval, and will be posted on the DHCS website as a State Approved Community Support. The cost and utilization of the Community Support will be factored into the medical portion of the MCP's rates.

Members always retain the right to file appeals and/or grievances if they request one or more Community Support offered by the MCP but were not authorized to receive the requested Support because of a determination that it was not medically appropriate or cost effective. Community Supports are additionally subject to the State Fair Hearings process. DHCS may terminate an MCP's Community Supports offering if it is determined to be harmful to the Member or is not cost-effective. MCPs may terminate a Community Support upon notice to DHCS once annually at the end of the calendar year, except in cases where the Community Support is terminated due to Member health, safety, or welfare concerns. If an MCP terminates a Community Support, they must publicize the service end date and provide at least 30 days' notice to their Members and implement a plan for continuity of care for Members receiving that Community Support.

See the Community Supports Resource Directory for more information and to access the Model of Care.

VI. Provider Enrollment, Credentialing, and Vetting Requirements

Community Supports Providers as Medi-Cal Enrolled Providers

MCP Network Providers (including those who will operate as Community Supports Providers) are required to enroll as a Medi-Cal Provider if there is a state-level enrollment pathway for them to do so. However, many Community Supports Providers (e.g., housing agencies, medically tailored meal Providers) may not have a corresponding state-level enrollment pathway and are not required to enroll in the Medi-Cal program. Instead, these Providers must be vetted by the MCP to participate as Community Supports Providers.

Process for Medi-Cal enrollment

For those Community Supports Providers with a state-level Medi-Cal enrollment pathway, the Provider would have to enroll through the DHCS Provider Enrollment Division or the MCP can choose to have a separate enrollment process.

Clarifying the Provider "Credentialing" Requirements of APL 19-004

The credentialing requirements articulated in APL 19-004: Provider Credentialing/Recredentialing and Screening/Enrollment only apply to Providers with a state-level pathway for Medi-Cal enrollment. Therefore, Community Supports Providers without a state-level pathway to Medi-Cal enrollment are not required to meet the credentialing requirements in APL 19-004 to become "in-network" ECM and/or Community Supports Providers but must be vetted by the MCP to participate.

MCP Requirements Related to Vetting Community Supports Providers Without a State-level Pathway for Medi-Cal Enrollment

To include a Community Supports Provider in their networks when there is no state-level Medi-Cal enrollment pathway, MCPs are required to vet the qualifications of the Provider or Provider organization to ensure they can meet the standards and capabilities required to be a Community Supports Provider. MCPs must submit Policies and Procedures for how they will vet the qualifications of ECM and Community Supports Providers in their Part 2 submission of the MOC. MCPs must create and implement their own processes to do so. Factors MCPs may want to consider as part of their process includes, but are not limited to:

- Ability to receive referrals from MCPs for the authorized Community Supports;
- Sufficient experience to provide services similar to the specific Community Supports for which they are contracted to provide within the service area;
- Ability to submit claims or invoices for Community Supports using standardized protocols;
- Business licensing that meets industry standards;
- Capability to comply with all reporting and oversight requirements;
- History of fraud, waste, and/or abuse;

- Recent history of criminal activity, including a history of criminal activities that endanger Members and/or their families; and
- History of liability claims against the Provider.

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VII. Billing & Payments

Community Supports Billing and Invoicing Guidance

DHCS has developed more comprehensive guidance that describes the minimum set of data elements required to be included in an invoice, available from the Community Supports Resource Directory.

Non-Binding Community Supports Pricing Guidance

The Cal-AIM initiative and, in particular, the introduction of the 14 pre-approved health-related Community Supports, prompts MCPs to work and contract with a new set of "non-traditional" Providers that offer services and supports that historically have not been well integrated into the health care system. These Providers include, but are not limited to, housing service Providers, home modification companies, sobering centers, and organizations that prepare and deliver medically-supportive food and nutrition. While many MCPs and Community Supports Providers have some experience working together, particularly in WPC Pilot counties, CalAIM is designed to encourage and support broader contracting and partnerships throughout the State. In recognition that this requires MCPs and Community Supports Providers to engage in new contracting and payment relationships, DHCS has prepared non-binding Community Supports Pricing Guidance. It offers information on potential rates for each of the 14 pre-approved Community Supports, including mid-point benchmarks and a discussion of key cost drivers that MCPs and Community Supports Providers may want to consider as they establish their own contracting and payment arrangements.

Critically, this pricing guidance is designed to serve as a tool to support discussions regarding rates**; it is in no way binding on MCPs or Community Supports Providers**. MCPs and Community Supports Providers have full flexibility and discretion to agree to Community Supports rates that are different than those outlined in this document, particularly because the rates in the pricing guidance are based on data and assumptions that reflect the statewide average cost of inputs. DHCS reserves the right to make modifications to the pricing guidance on an as needed basis based on experience with the Community Supports initiative and its evolution over time.

The Non-Binding Community Supports Pricing Guidance can be accessed from the Community Supports Resource Directory.

Community Supports HCPCS Codes

The ECM and Community Supports Coding Options guidance lists the HCPCS codes that must be used for Community Supports services. The HCPCS code and modifier combined define the service as Community Supports.

MCPs must use the HCPCS codes listed in the table to report Community Supports services. The HCPCS code and modifier combined define the service as Community Supports.

DHCS expects MCPs to support their Community Supports Providers in reporting and translating their delivered Community Supports to these required HCPCS codes. While MCPs must use the below HCPCS codes and modifiers for reporting applicable Community Supports encounters to DHCS, MCPs may utilize alternative payment approaches with Community Supports providers. For example, an MCP might opt to pay a provider for Housing Transition and Navigation Services as a per member per month (PMPM) payment. That MCP must still report encounters to DHCS as a per diem for every service rendered by that provider, using the HCPCS codes and modifiers below. **If a Community Support is provided through telehealth, the additional modifier GQ must be used. All telehealth services must be provided in accordance with DHCS policy.**[23]

The Finalized ECM & Community Supports (ILOS) Coding Options can be accessed from the Community Supports Resource Directory.

[23] For more information refer to the DHCS Medi-Cal Provider Manuals

VIII. Consent, Authorization, & Data Sharing

The vision of Community Supports is to embrace and integrate a diversity of Providers in the delivery of whole-person care, and not just traditional health care providers. DHCS acknowledges the tremendous investment required of both MCPs and Provider organizations to realize this from an information technology infrastructure and data sharing perspective. To that end, listed below are high-level data system requirements for MCPs, along with data sharing requirements for MCPs and Community Supports Providers.

Data System Requirements

MCPs are required to have an IT infrastructure and data analytic capabilities to support Community Supports, including the capabilities to:

- Consume and use claims and encounter data, as well as other data types listed in Community Supports Contract Template Section 7: Identifying Members for Community Supports;
- Assign Members to Community Supports Providers;
- Keep records of Members receiving Community Supports and their consent;
- Securely share data with Community Supports Provider;
- Receive, process, and send encounters and invoices from Community Supports Providers to DHCS in accordance with DHCS standards;
- Receive and process supplemental reports from Community Supports Providers;
- Send Community Supports supplemental reports to DHCS; and
- Open, track, and manage referrals to Community Supports Providers.

Data Sharing Requirements for MCPs

To support Community Supports, MCPs shall provide, at a minimum, the following information to all Community Supports Providers:

- Physical, behavioral, administrative, and information indicating Member social determinants of health (SDOH) needs, as specified on previously submitted claims encounters or identified through other data sources (e.g., HMIS)[24] for assigned Members; and
- Reports of performance on quality measures and/or metrics, as requested.

MCPs are required to use defined federal and State standards, specifications, code sets, and terminologies when sharing physical, behavioral, social, and administrative data with Community Supports Providers and with DHCS.

[24] As part of the population health management (PHM) initiative of CalAIM, DHCS has issued guidance encouraging MCPs to incorporate the use of DHCS Priority SDOH Codes; please refer to APL 21-009 for more information.

Data Sharing Requirements for Community Supports Providers

DHCS' vision is that Community Supports Providers will submit encounters to MCPs for transmission to DHCS. Providers that do not have these capabilities will be allowed to submit invoices to MCPs and MCPs will then convert the invoices to encounters for submission to the DHCS.

DHCS is not specifying the payment model between MCPs and Providers for Community Supports, though DHCS encourages plans and Providers to adopt or progress to value based payment (VBP) models for Community Supports.

If the Community Supports Provider is paid by the MCP on a fee-for-service (FFS) basis, they will be expected to generate a claim and send it to the MCP for payment processing. If the Community Supports Provider is unable to send a compliant 837P claim to the MCP, they will be expected to send an invoice with a minimum set of data elements necessary for the MCP to convert that information into a compliant 837P encounter that they will subsequently submit to DHCS according to current DHCS policy.

If a Community Supports Provider is paid by the MCP on a capitated basis, then the Provider will still be expected to generate and submit a compliant encounter to MCPs. In the event that Community Supports Provider is unable to submit a compliant 837P encounter, they will be expected to send a paid invoice with a minimum set of data elements necessary for the MCP to convert that information into a compliant 837P encounter that the plan will subsequently submit to DHCS according to current DHCS policy.

Community Supports Providers and MCPs may need to re-configure their existing systems to meet these requirements.

Authorization Process

To support Members' access to any offered Community Supports, MCPs must have nondiscriminatory authorization processes in place to determine eligibility for Members for each Community Support, in accordance with the service definitions or other narrower eligibility definitions that have been approved by the Department in advance, in accordance with the MCP's contract with DHCS.

As part of the authorization process, MCPs must document their process for ensuring documentation of appropriate clinical support for the medical appropriateness of the Community Support. This process must detail that provision of the Community Support, recommended by a provider at the plan or network level using their professional judgement, is likely to reduce or prevent the need for acute care or other Medicaid services, including but not limited to inpatient hospitalizations, skilled nursing facility stays, or emergency department visits. Therefore, the Community Support is medically appropriate for that Member.

This process may be incorporated into the MCP's utilization management process or may include provider-level documentation in an individual's care plan or other record. The service definitions for several Community Supports already require this documentation. For example:

- Recipients of the Housing Transition Navigation Services, Housing Deposits, and Housing Tenancy and Sustaining Services Community Supports are required to have individualized housing support plans. MCPs may use these plans to document the member needs that qualify them for this service and ensure it is a medically appropriate substitute for State Plan services. Per the service definitions, this documentation could include, for example, documented evidence of a serious chronic condition and/or serious mental illness and could include a documented risk of institutionalization or requiring residential services because of a substance use disorder.

- When authorizing Asthma Remediation Services, managed care plans are required to provide a written evaluation specific to the member describing how and why the remediation meets the member's needs. MCPs may use these evaluations to document the member needs that qualify them for this service and ensure it is a medically appropriate substitute for State Plan services. Per the service definition, this documentation could include documentation of poorly controlled asthma and documentation from a licensed health care Provider that the service will likely help avoid asthma-related hospitalizations, emergency department visits, or other high-cost services.

In addition to these specific examples, most individuals who receive Community Supports will also qualify for either enhanced care management (ECM) or Complex Case Management (CCM). In these instances, MCPs may use ECM or CCM care plans to document member needs that qualify them for a Community Support and ensure it is a medically appropriate substitute for a State Plan service. This process may apply to any Community Support provided to a recipient who is also in one of these care/case management programs.

MCPs may review requests or referrals for Community Supports services for cost-effectiveness as part of MCPs' utilization management processes during authorization.

Graduation/Deauthorization Process

MCPs must have processes in place for graduating or discontinuing Community Supports for members who no longer qualify for, no longer require, or no longer want to receive Community Supports services. A Notice of Action Letter is required in all situations except for when an eligible member chooses not to participate.

IX. Monitoring, Oversight, and Reporting

Oversight of Community Supports Providers

MCP Requirements

MCPs are required to perform oversight of Community Supports Providers, holding them accountable to all Community Supports requirements contained in the ECM and Community Supports Contract Template, the MCP's MOC, and any associated guidance issued by DHCS. MCPs are expected to use Community Supports Provider Standard Terms and Conditions to develop Community Supports contracts with Community Supports Providers and are expected to incorporate all Community Supports Provider requirements reviewed and approved by DHCS as part of its MOC, including all monitoring and reporting criteria. To streamline the Community Supports implementation:

- MCPs must hold Community Supports Providers responsible for the same reporting requirements as those that the MCP must report to DHCS.
- The MCPs will not impose mandatory reporting requirements that differ from or are additional to those required for encounter and supplemental reporting; and
- MCPs are encouraged to collaborate with other MCPs within the same county on oversight of Community Supports Providers.

Subcontractors

MCPs may subcontract with other entities to administer Community Supports, provided they adhere to the below requirements:

- MCPs will maintain and be responsible for oversight of compliance with all Contract provisions and Covered Services, regardless of the number of layers of subcontracting;
- MCPs will be responsible for developing and maintaining DHCS approved Policies and Procedures to ensure Subcontractors meet required responsibilities and functions;
- MCPs will be responsible for evaluating the prospective Subcontractor's ability to perform services;
- MCPs will remain responsible for ensuring the Subcontractor's Community Supports Provider capacity is sufficient to serve eligible Members;
- MCPs will 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; and
- MCPs will 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.

MCPs will ensure their agreements with any Subcontractor mirrors the requirements set forth in ECM and Community Supports Contract Template, and the ECM and Community Supports Provider Standard Terms and Conditions, as applicable to Subcontractor. MCPs are encouraged to collaborate with their Subcontractors on the approach to Community Supports to minimize variance in how Community Supports will be implemented and to ensure a streamlined, seamless experience for Community Supports Providers and Members.

Model of Care (MOC) and Approval Process

The ECM and Community Supports MOC is each MCP's framework for providing ECM and Community Supports. Each MCP's MOC will include its overall approach to ECM and Community Supports; its detailed Policies and Procedures regarding ECM and Community Supports Provider (including non-traditional Providers) contracting and oversight; its ECM and Community Supports Provider network capacity; and the contract language that will define key aspects of its arrangements with its ECM and Community Supports Providers. The MOC also includes specific "Transition and Coordination" content for MCPs operating in Whole Person Care (WPC) and/or Health Home Program (HHP) Counties. MCPs in these Counties must describe how they will ensure smooth transitions for their Members from WPC and HHP into ECM and Community Supports.

DHCS will use each MCP's MOC submission to determine its readiness to meet ECM and Community Supports requirements. MCPs must lay out their MOCs using the DHCS-developed standard template (MOC Template) and submit them to DHCS for review and approval prior to initial ECM and Community Supports implementation in 2022. MCPs must make updates to their MOCs to reflect any Community Supports changes.

MCPs should expect review of the MOC to be an iterative process with DHCS during each review period. DHCS may require resubmission of certain questions or additional material to ensure alignment with DHCS requirements.

Encounter Data Submission Process

DHCS requires MCPs to submit encounter data in accordance with requirements in the MCP contract and All Plan Letter 14-019, or any subsequent updates. MCPs are required to submit encounter data for Community Supports through the existing encounter data reporting mechanisms for all covered services for which they have incurred any financial liability, whether directly or through subcontracts or other arrangements, using ASC X12 837 version 5010 x223 Institutional and Professional transactions or NCPDP 2.2 or 4.2 transactions and the new Community Supports coding requirements, to the Post Adjudicated Claims and Encounters System (PACES) beginning on January 1, 2022.

Scope of Monitoring Activities

DHCS will monitor MCPs implementation of and compliance with ECM and Community Supports requirements across multiple domains including, Membership, Service Provision, Grievances and Appeals, Provider Capacity, and Quality. DHCS will monitor MCP compliance with ECM and Community Supports using existing monitoring processes as well as through submission of time-limited quarterly Implementation Monitoring Report Templates.

X. Performance Incentive Program

CalAIM's ECM and Community Supports programs will require significant new investments in care management capabilities, Community Supports infrastructure, information technology (IT) and data exchange, and workforce capacity at both the 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 Community Supports.

DHCS has designed an 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. Infrastructure development, ECM and Community Supports Provider capacity building, and Community Supports take-up are priority areas for Program Year 1 (i.e., Calendar Year 2022). DHCS will incorporate behavioral and physical health integration and health disparities reduction measures within those priority areas. Quality will emerge as a priority area for Program Year 2 (i.e., Calendar Year 2023).

Additional guidance on the Performance Incentive Program, as well more details on available Projects for Assistance in Transition from Homelessness (PATH) Funding, is available on the ECM & Community Supports webpage.

Listed below are the goals and design principles of the program.

Performance Incentive Goals:

- Build appropriate and sustainable ECM and Community Supports capacity
- Drive MCP investment in necessary delivery system infrastructure
- Incentivize MCP take-up of Community Supports
- Bridge current silos across physical and behavioral health delivery
- Reduce health disparities and promote health equity
- Achieve improvements in quality performance

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

XI. Community Supports Resource Directory

Community Supports Resource Directory	
Resource	**Description**
ECM and Community Supports (ILOS) Website	Online repository for ECM & Community Supports (ILOS) program documents and technical assistance. Future guidance will be posted here.
Community Supports Fact Sheet	Overview of Community Supports and DHCS' vision for the Community Supports initiative
Frequently Asked Questions Document	Answers to key Community Supports policy questions. Document will be updated with new questions/answers on an ad hoc basis
ECM & Community Supports Change Memo	Summary of key policy changes DHCS made to ECM and Community Supports requirements documents based on stakeholder feedback.
DHCS-MCP ECM and Community Supports (ILOS) Contract Template	Community Supports contract requirements for MCPs.
ECM and Community Supports (ILOS) Standard Provider Terms and Conditions	Standardized language that MCPs must include in all contracts with Community Supports Providers.

CalAIM ECM and Community Supports Model of Care Cover Note: Instructions and Timeline **CalAIM ECM and Community Supports (ILOS) Model of Care Template**	Template for MCP to outline proposed protocols for implementation and provision of Community Supports. Each MOC must be reviewed and approved by DHCS prior to Community Supports implementation.
ECM and Community Supports (ILOS) Coding Guidance	Guidance on encounter data submissions and a list of HCPCS Level II Codes for Community Supports services delivered.
Community Supports (ILOS) Evidence Library – Executive Summary	Select highlights and key findings of DHCS' research on the measurable impacts Community Supports may have on health care costs, utilization, and health outcomes
Non-Binding Community Supports Pricing Guidance*	Non-Binding guidance on pricing for Community Supports services.
Community Supports Billing & Invoicing Guidance*	Guidance defining the standard, "minimum necessary" data elements MCPs will collect from Community Supports Providers.
Community Supports Quarterly Implementation Reporting Framework*	Guidance defining DHCS' strategy for monitoring the implementation of Community Supports.
Community Supports Explainer	Overview of Community Supports for providers or others interested in learning more about these services.

*Check the ECM and Community Supports (ILOS) Website for the latest updates and versions of Community Supports documents.

XII. Glossary of Terms

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 isan "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 intomanaged 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 complexityand 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 need 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 releaseto 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 ina COHS county receive their care from the COHS health plan.

Cal MediConnect: A program that coordinates medical, behavioral, and long-termservices and supports (i.e., both Medicare and Medi-Cal benefits) for dual eligibles in seven California CCI counties.

Community Supports (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 a Member cannot be required to use them.

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, andcommunity-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).

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 carefor 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 programfor 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 SystemReform 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 offunding 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 oncePRIME expired.

Regional Rates: A CalAIM proposal to develop regional managed care capitation rates, rather than plan- and county-based rates, to simplify the rate-setting process forthe 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 theMedi-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 eligibleindividuals to gain access to needed medical, social, educational, and other services. TheTCM 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 December31, 2020, with approval pending to extend through calendar year 2021.

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,

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

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

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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

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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:

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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

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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.

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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

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.**

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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**

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

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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

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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

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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*

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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

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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

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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,

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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;

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- 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;

- 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

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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

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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.

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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.

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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

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- 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.

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- 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

- 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

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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

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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;

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        - 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

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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

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- 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

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- 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.

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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.

18. Contractor's Responsibility for Administration of Community Supports

A. Contractor may provide DHCS pre-approved Community Supports as described in Provision 19, DHCS Pre-Approved Community Supports of this Attachment.

The remainder of Exhibit A, Attachment 22 refers only to Community Supports that Contractor may choose to offer, unless otherwise specified.

B. In accordance with 42 CFR section 438.3(e)(2), all applicable APLs, and the Community Supports Policy Guide, Contractor may select and offer Community Supports from the list of Community Supports pre-approved by DHCS as medically appropriate and cost-effective substitutes for Covered Services or settings under the State Plan. See Provision 19, DHCS Pre-Approved Community Supports below for list.

1) Contractor must ensure medically appropriate State Plan services are available to the Member regardless of whether the Member has been offered a Community Supports, is currently receiving a Community Supports, or has received a Community Supports in the past.

2) Contractor may not require a Member to utilize a Community Supports. Members always retain their right to receive the California Medicaid State Plan Covered Services on the same terms as would apply if a Community Supports was not an option in accordance with regulatory requirements.

3) Contractor must not use Community Supports to reduce, discourage, or jeopardize Members' access to State Plan services.

4) Contractor may submit a request to DHCS to offer Community Supports in addition to the pre-approved Community Supports.

C. With respect to pre-approved Community Supports, Contractor must adhere to DHCS' guidance on service definitions, eligible populations, code sets, potential Community Supports Providers, and parameters for each

Community Supports, referenced in APL 21-017 and the Community Supports Policy Guide, that Contractor chooses to provide. Upon approval from DHCS, Contractor may adopt a more narrowly defined eligible population than outlined in the Community Supports Policy Guide.

1) Contractor is not permitted to extend a Community Supports to Members beyond those for whom DHCS has determined the Community Supports will be cost-effective and medically appropriate, as indicated in the DHCS guidance on eligible populations.

2) Contractor must provide public notice of any limitations on Community Supports when Contractor requests an alternate approach involving narrowing eligible populations, including specifying such limitations in the Member Services Guide/EOC and on Contractor's website, in addition to receiving DHCS' written approval.

D. If Contractor elects to offer one (1) or more pre-approved Community Supports, it need not offer the Community Supports in each county it serves. Contractor must report to DHCS the counties in which it intends to offer the Community Supports. Contractor must provide Community Supports in a county selected by Contractor in accordance with the requirements set forth below in Provision 21, Community Supports Provider Capacity.

E. Contractor must identify Members who may benefit from Community Supports and for whom Community Supports will be a medically appropriate and cost-effective substitute for Covered Services, and accept requests for Community Supports from Members and Members' Providers and organizations that serve them, including community-based organizations as described below in Provision 23, Identifying Members for Community Supports.

F. Contractor must authorize Community Supports for Members deemed eligible in accordance below with Provision 24, Authorizing Members for Community Supports and Communication of Authorization Status.

G. Contractor may elect to offer value-added services in addition to offering one (1) or more Community Supports. Offering Community Supports does not preclude Contractor from

offering value-added services.

H. In the event of any discontinuation of Community Supports resulting in a change in the availability of services, Contractor must adhere to the requirements set forth in Exhibit A, Attachment 9, Provision 10, Changes in Availability or Location of Covered Services, and Exhibit A, Attachment 13, Provision 4, Notification of Changes in Access to Covered Services.

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

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

19. DHCS Pre-Approved Community Supports

A. Contractor may choose to offer Members one (1) or more of the following pre-approved Community Supports, and any subsequent Community Supports additions pre-approved by DHCS, in each county:

1) Housing Transition Navigation Services;

2) Housing Deposits;

3) Housing Tenancy and Sustaining Services;

4) Short-Term Post-Hospitalization Housing;

5) Recuperative Care (Medical Respite);

6) Respite Services;

7) Day Habilitation Programs;

8) Nursing Facility Transition/Diversion to Assisted Living Facilities;

9) Community Transition Services/Nursing Facility Transition to a Home;

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10) Personal Care and Homemaker Services;

11) Environmental Accessibility Adaptations;

12) Medically Tailored Meals/Medically Supportive Food;

13) Sobering Centers; and

14) Asthma Remediation.

B. Contractor must list all Community Supports it offers in its Contractor's Community Supports MOC template and Community Supports MOC amendments.

C. Contractor must ensure Community Supports are provided in accordance with all applicable APLs, unless DHCS has provided written approval of an alternate approach requested by Contractor.

D. Contractor must ensure Community Supports are provided to Members in a timely manner, and must develop policies and procedures outlining its approach to managing Community Supports Provider shortages or other barriers to ensure timely provision of Community Supports.

E. Contractor may discontinue offering Community Supports annually with notice to DHCS at least 90 calendar days prior to the discontinuation date.

Contractor must ensure Community Supports that were authorized for a Member prior to the discontinuation of those specific Community Supports are not disrupted by a change in Community Supports offerings, either by completing the authorized service or by seamlessly transitioning the Member into other Medically Necessary services or programs that meet the Member's needs.

F. At least 30 calendar days before discontinuing Community Supports, Contractor must notify Members affected by the discontinuation of the Community Supports of the following:

1) The change and timing of discontinuation, and

2) The procedures that will be used to ensure completion of the authorized Community Supports or a transition

into other comparable Medically Necessary services.

G. Contractor may provide voluntary services that are neither State-approved Community Supports nor Covered Services when medically appropriate for the Member, in accordance with 42 CFR section 438.3(e)(1). Such voluntary services are not subject to the terms of Provision 18, Contractor's Responsibility for Administration of Community Supports, through Provision 31, Community Supports Quality and Performance Incentive Program, and are subject to the limitations of 42 CFR section 438.3(e)(1).

20. Community Supports Providers

A. Community Supports Providers are entities that Contractor has determined can provide the Community Supports to eligible Members in an effective manner consistent with culturally and linguistically appropriate care, as outlined in Exhibit A, Attachment 9, Provision 13, Cultural and Linguistic Program.

B. Contractor must enter into Subcontractor Agreements with Community Supports Providers for the delivery of elected Community Supports elected by Contactor.

C. Contractor must ensure all Community Supports Providers for whom a State-level enrollment pathway exists enroll in Medi-Cal, pursuant to relevant APLs, including APL 19-004. If APL 19-004 does not apply to a Community Supports Provider, Contractor must have a process for verifying qualifications and experience of Community Supports Providers, which must extend to individuals employed by or delivering services on behalf of the Community Supports Provider. Contractor must ensure that all Community Supports Providers meet the capabilities and standards required to be a Community Supports Provider.

D. In accordance with Provision 26 below, Data System Requirements and Data Sharing to Support Community Supports, Contractor must support Community Supports Provider access to systems and processes allowing them to do the following, at a minimum:

1) Obtain and document Member information including eligibility, Community Supports authorization status,

Member authorization for data sharing to the extent required by law, and other relevant demographic and administrative information; and

2) Contractor must also support Community Supports Provider notification to Contractor and ECM Providers and Member's PCP, as applicable, when a referral has been fulfilled, as described below in Provision 26, Data System Requirements and Data Sharing to Support Community Supports.

D. To the extent Contractor elects to offer Community Supports, Contractor may coordinate its approach with other Medi-Cal Managed Care Health Plans offering Community Supports in the same county.

21. Community Supports Provider Capacity

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

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

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

22. Community Supports MOC

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

B. In developing and executing Subcontractor Agreements with Community Supports Providers, Contractor must incorporate

all requirements and policies and procedures described in its Community Supports MOC, in addition to all applicable APLs.

C. Contractor may collaborate with other Medi-Cal Managed Care Health Plans within the same county, on the development of its Community Supports MOC.

D. Contractor must submit its Community Supports MOC for DHCS review and approval. Contractor must submit to DHCS any Significant Changes to its Community Supports MOC for DHCS review and approval at least 60 calendar days in advance of any occurrence of changes or updates, in accordance with DHCS policies and guidance, including all applicable APLs. Significant Changes may include, but are not limited to, changes to Contractor's approach to administer or deliver Community Supports services, approved policies and procedures, and Subcontractor Agreement boilerplates.

23. Identifying Members for Community Supports

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

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

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

2) How Contractor will notify Members; and

3) How Contractor will accept requests for Community Supports from Providers, other community-based entities, and Member or Member's family, legal guardians, authorized representatives, caregivers, and other authorized support persons.

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

D. Contractor must ensure that Member identification methods

for Community Supports are equitable and do not exacerbate or contribute to existing racial and ethnic disparities.

E. Transition of WPC and HHP to Community Supports

1) In HHP and WPC pilot counties, Contractor may offer Community Supports to HHP and WPC Members who receive similar services through WPC or HHP for continuity of the services being delivered as part of those programs.

2) In HHP and WPC pilot counties, Contractor must enter into Subcontractor Agreements with all WPC Lead Entities and HHP CB-CMEs as Community Supports Providers, regardless of whether Contractor offers Community Supports on a county-wide basis, unless Contractor receives prior written approval from DHCS, through the Community Supports MOC review process, based on one (1) or more of the following exceptions:

a) The Community Supports Provider does not provide the Community Supports that Contractor elected to offer;

b) There is a justified quality of care concern with the Community Supports Provider;

c) Contractor and the Community Supports Provider are unable to agree on contracted rates;

d) The Community Supports Provider is unwilling to enter into a Subcontractor Agreement;

e) The Community Supports Provider is unresponsive to multiple attempts to enter into a Subcontractor Agreement;

f) The Community Supports Provider is unable to comply with the Medi-Cal enrollment process or vetting by Contractor; or

g) The Community Supports Provider without a State-level pathway to Medi-Cal enrollment is unable to comply with Contractor's processes for vetting qualifications and experience.

24. Authorizing Members for Community Supports and Communication of Authorization Status

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

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

C. For Members with an assessed risk of incurring other California Medicaid State Plan services, such as inpatient hospitalizations, skilled nursing facility stays, or emergency department visits, Contractor must develop policies and procedures to ensure appropriate clinical support authorization of Community Supports for Members. Contractor's policies and procedures must include detailed documentation that a Network Provider using their professional judgement has determined it to be medically appropriate for the Member to receive Community Supports as it is likely to reduce or prevent the need for acute care or other California Medicaid State Plan services in accordance with all applicable APLs and to be defined in forthcoming guidance.

D. Contractor must not restrict the authorization of Community Supports only to Members transitioning from WPC or HHP.

E. Contractor must develop and maintain policies and procedures to ensure Members do not experience undue delays pending the authorization process for Community Supports.

1) If Medically Necessary, Contractor must make available the California Medicaid State Plan services that the Community Supports replaces, pending authorization of the requested Community Supports.

2) Contractor must evaluate and document whether a

service is medically appropriate and cost-effective when determining whether to provide Community Supports to a Member. Providing particular Community Supports to a Member in one (1) instance does not automatically mean that providing other Community Supports to the same Member, the same Community Supports to another Member, or the same Community Supports to the same Member in a different instance would be medically appropriate and cost-effective.

F. Contractor must have policies and procedures for expediting the authorization of certain Community Supports for urgent needs, as appropriate, and that identify the circumstances in which any expedited authorization processes apply, in accordance with all applicable APLs.

G. When a Member has requested Community Supports, directly or through a Provider, community-based organization, or other entity, Contractor must notify the requesting entity and Member of Contractor's decision regarding Community Supports authorization, in accordance with all applicable APLs. If the Member is enrolled in ECM, Contractor must ensure the ECM Provider is informed of the Community Supports authorization decision.

H. Member always retains the right to file Appeals and/or Grievances if they request one (1) or more Community Supports offered by Contractor, but were not authorized to receive the requested Community Supports because of a determination that it was not medically appropriate or cost effective.

I. For Members who sought Community Supports offered by Contractor, but were not authorized to receive the Community Supports, Contractor must submit necessary data to monitor Appeals and Grievances as well as follow its standard Grievances and Appeals process outlined in Exhibit A, Attachment 14, Member Grievance and Appeal System and APL 21-011.

25. Referring Members to Community Supports Providers for Community Supports

A. Contractor must develop and maintain policies and procedures to define how Community Supports Provider

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referrals will occur. Contractor's policies and procedures must be submitted to DHCS for review and approval prior to implementation.

1) For Members enrolled in ECM, policies and procedures must address how Contractor will work with the ECM Provider to coordinate the Community Supports referral and communicate the outcome of the referral back to the ECM Provider, such as using closed loop referrals.

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

B. If the Member prefers a particular Community Supports Provider are known, Contractor must follow those preferences, to the extent practicable.

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

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

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

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

1) Ensure the Member agrees to receive Community Supports;

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

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

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

26. Data System Requirements and Data Sharing to Support Community Supports

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

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

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

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

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

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

C. Contractor must use defined federal and State standards, specifications, code sets, and terminologies when sharing physical, behavioral, social, and administrative data with Community Supports Providers and with DHCS.

27. Contractor's Oversight of Community Supports Providers

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

B. Contractor must perform oversight of Community Support Providers, holding them accountable to all Community Supports requirements contained in this Contract, and all applicable APLs.

C. Contractor must use all applicable APLs to develop its Subcontractor Agreements with Community Support Providers and must incorporate all of its Community Supports Provider requirements. Contractor must submit its Subcontractor Agreements with Community Supports Providers to DHCS for review and approval in a form and manner specified by DHCS.

D. To streamline Community Supports implementation, Contractor must ensure the following:

1) Contractor must hold Community Supports Providers responsible for the same reporting requirements as are required of Contractor by DHCS.

2) Contractor must not impose mandatory reporting requirements that are alternative or additional to those required for Encounter and supplemental reporting.

3) Contractor may collaborate with other Medi-Cal Managed Care Health Plans within the same county on reporting requirements and oversight.

E. Contractor must not utilize tools developed or promulgated by NCQA to perform oversight of Community Supports Providers, unless by mutual consent with the Community Supports Provider.

F. Contractor must provide Community Supports training and technical assistance to Community Supports Providers, including in-person sessions, webinars, and calls, as necessary, in addition to Network Provider training requirements as described in Exhibit A, Attachment 7, Provision 5, Network Provider Training.

28. Delegation of Community Supports Administration to

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Subcontractors

A. Contractor may enter into Subcontractor Agreements with other entities to administer Community Supports in accordance with the following:

1) Contractor must maintain and be responsible for oversight of compliance with all Contract provisions and Covered Services, as described in Exhibit A, Attachment 6, Provision 14, Network Provider Agreements and Subcontractor Agreements;

2) Contractor is 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, Network Provider Agreements and Subcontractor Agreements;

3) Contractor must evaluate the prospective Subcontractor's ability to perform services as described in Exhibit A, Attachment 6, Provision 14, Network Provider Agreements and Subcontractor Agreements;

4) Contractor must ensure the Subcontractor's Community Supports Provider capacity is sufficient to serve all Populations of Focus;

5) Contractor must report to DHCS the names of all Subcontractors by 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, Subcontractor Reports; and

6) Contractor must 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, Network Provider Agreements and Subcontractor Agreements.

B. Contractor must ensure that the Subcontractor Agreement mirror the requirements set forth in this Contract and all applicable APLs, as applicable to the Subcontractor.

C. Contractor may collaborate with its Subcontractors on its approach to Community Supports to minimize divergence in how the Community Supports will be implemented between Contractor and its Subcontractor(s) and ensure a streamlined, seamless experience for Community Supports Providers and Members.

29. Payment of Community Support Providers

A. Contractor must pay contracted Community Supports Providers for the provision of authorized Community Supports to Members in accordance with established Subcontractor Agreements between Contractor and each Community Supports Provider.

B. Contractor must utilize the claims timeline and process as described in Exhibit A, Attachment 8, Provision 5, Claims Processing.

C. Contractor must identify any circumstances under which payment for Community Supports must be expedited to facilitate timely delivery of the Community Supports to the Member, such as recuperative care for an individual who is homeless and being discharged from the hospital.

For such circumstances, Contractor must develop and maintain policies and procedures to ensure payment to the Community Supports Provider is expedited. Contractor must submit these policies and procedures to DHCS for review and approval prior to implementation.

D. Contractor shall ensure Community Supports Providers submit a claim for rendered Community Supports, to the greatest extent possible.

1) If a Community Supports Provider is unable to submit a claim for Community Supports rendered, Contractor must ensure the Community Supports Provider documents services rendered using an invoice approved by DHCS.

2) Upon receipt of such invoice, Contractor must document the Encounter for the Community Supports rendered.

30. DHCS Oversight of Community Supports

A. In the Community Supports MOC, Contractor must include details on the Community Supports Contractor plans to offer, including which counties Community Supports will be offered and its network of Community Supports Providers, in accordance with all applicable APLs.

B. After implementation of Community Supports, Contractor must submit the following data and reports to DHCS to support DHCS oversight of Community Supports:

1) Encounter Data

a) Contractor must submit all Community Supports Encounter Data to DHCS using national standard specifications and code sets to be defined by DHCS. Contractor must be compliant with DHCS guidance on invoicing standards for Contractor to use with Community Supports Providers.

b) Contractor must submit to DHCS all Community Supports Encounter Data, including Encounter Data for Community Supports generated under Subcontractor Agreements.

c) In the event the Community Supports Provider is unable to submit Community Supports Encounter Data to Contractor using the national standard specifications and code sets to be defined by DHCS, Contractor must convert Community Supports Providers' invoice data into the national standard specifications and code sets, for submission to DHCS.

d) Encounter Data, when possible, must include data necessary for DHCS to stratify services by age, sex, race, ethnicity, and language spoken to inform health equity initiatives and efforts to mitigate health disparities undertaken by the DHCS.

2) Supplemental reporting on a schedule and in a form to be defined by DHCS.

C. Contractor must timely submit any related data requested by DHCS, CMS, or an independent entity conducting an evaluation of Community Supports including, but not limited to:

1) Data to evaluate the utilization and effectiveness of a Community Supports.

2) Data necessary to monitor health outcomes and quality metrics at the local and aggregate levels through timely and accurate Encounter Data and supplemental reporting on health outcomes and equity of care. When possible, metrics must be stratified by age, sex, race, ethnicity, and language spoken.

3) Data necessary to monitor Member Appeals and Grievances associated with Community Supports.

D. In the event of underperformance by Contractor in relation to its administration of Community Supports, DHCS may impose sanctions in accordance with Exhibit E, Attachment 2, Provision 17, Sanctions.

31. Community Supports Quality and Performance Incentive Program

A. Contractor must meet all quality management and Quality Improvement requirements described in Exhibit A, Attachment 4, Quality Improvement System and any additional quality requirements for Community Supports set forth in associated guidance from DHCS.

B. Contractor may participate in a performance incentive program related to adoption of Community Supports, building infrastructure and Provider capacity for Community Supports, related health care quality and outcomes, and other performance milestones and measures, in accordance with DHCS policies and guidance.

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken June 2, 2022
Regular Meeting of the CalOptima Board of Directors

Consent Calendar
10. Approve Modifications to CalOptima Policy HH.2021: Exclusion and Preclusion Monitoring

Contact
Carmen Dobry, Executive Director, Compliance, (657) 235-6997

Recommended Action
Pursuant to CalOptima's policy review process:
1. Approve modifications to Policy HH.2021: Exclusion and Preclusion Monitoring

Background/Discussion
CalOptima regularly reviews its policies and procedures to ensure they are up to date and aligned with federal and state health care program requirements, contractual obligations, laws, and CalOptima operations.

Below is a description of the impacted policy, followed by a list of substantive changes to the policy, which are reflected in the attached redline policy. The 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).

Policy HH.2021: Exclusion and Preclusion Monitoring outlines the process for verifying and monitoring the eligibility of employees (permanent, temporary, volunteer, and as-needed employees); members of the Governing Body; first tier, downstream and related entities (FDRs); non-contracted providers; and vendors to participate in CalOptima federal and/or state health care programs through state and federal exclusions, preclusion, and ineligible person/entity lists. This policy was revised to clarify scenarios under which CalOptima can remain contracted with individuals or entities identified on a state Medicaid exclusion list for reasons unrelated to fraud, integrity, or quality.

Policy Section	Change
II.A.5 and III.D	Added clarifying language to note that CalOptima can remain contracted with an individual or entity identified on a state Medicaid exclusion list for reasons unrelated to fraud, integrity, or quality as long as the individual/entity is not listed on a federal or California exclusion list.

Fiscal Impact
The recommended action to modify CalOptima Policy HH.2021 is operational in nature and has no additional fiscal impact beyond what was incorporated in the CalOptima Fiscal Year 2021-22 Operating Budget.

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Rationale for Recommendation

To ensure CalOptima's continuing commitment to conducting its operations in compliance with all applicable state and federal laws and regulations, CalOptima staff recommends that the Board of Directors approve and adopt the presented CalOptima policy and procedure. The updated policy and procedure will supersede prior versions.

Concurrence

James Novello, Outside General Counsel, Kennaday Leavitt

Attachments

1. Attachment 1_HH.2021_Exclusion and Preclusion Monitoring

/s/ Michael Hunn — *05/27/2022*

Authorized Signature — **Date**

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Policy:	HH.2021Δ
Title:	**Exclusion and Preclusion Monitoring**
Department:	Office of Compliance
Section:	Regulatory Affairs & Compliance
CEO Approval:	*/s/*
Effective Date:	05/01/2012
Revised Date:	TBD
Applicable to:	☒ Medi-Cal ☒ OneCare ☒ OneCare Connect ☒ PACE ☐ Administrative

I. PURPOSE

This policy outlines a process for verifying and Monitoring, the eligibility of Employees (permanent, temporary, volunteer, and as-needed Employees), Members of the Governing Body, First Tier, Downstream, and Related Entities (FDRs), non-contracted Providers, and vendors to participate in CalOptima federal and/or state health care programs through state and federal Exclusions, Preclusion, and ineligible person/entity lists.

II. POLICY

A. CalOptima shall ensure all Employees, Members of the Governing Body, FDRs, non-contracted Providers, and vendors are eligible to participate in CalOptima federal and/or state health care programs, and shall be responsible for:

1. Requiring an Employee, Member of the Governing Body, FDR, non-contracted Provider, or vendor to disclose and report pending suspensions, Exclusions, Preclusions, or debarments, of the Employee, Member of the Governing Body, FDR, Providers, or vendor;

2. Conducting the initial eligibility verification of an Employee, Member of the Governing Body, FDR, non-contracted Provider, and vendor prior to hiring, renewing, or entering in any new agreement with CalOptima, or issuing payment thereto;

3. Performing eligibility verification of an Employee, Member of the Governing Body, FDR, non-contractor Providers, and vendor monthly thereafter; and

4. Maintaining records of all initial and monthly verification.

5. CalOptima shall not employ, consult, or contract with individuals or entities that are determined to be suspended, debarred, precluded, or Excluded from participation in federal or state health care programs. Individuals or entities identified on a state Medicaid exclusion list for reasons unrelated to fraud, integrity, or quality can remain contracted with CalOptima as long as the individuals or entities are not listed on a federal or California exclusion list including, but not limited to:

   a. The General Services Administration's (GSA) System for Award Management (SAM) website;

   b. Medi-Cal's Suspended and Ineligible (S&I) list;

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c. CMS Preclusion List;

d. Medi-Cal Restricted Provider Database (RPD);

e. Medi-Cal Procedure/Drug Code Limitation List;

f. OIG Exclusion Database (OIG LEIE Database);

g. Other Monitoring sources as identified in CalOptima Policies:

B. CalOptima shall not reimburse or make payment for services provided under the medical direction or on the prescription of an Excluded person or entity, or make payment to, an individual or entity that is verified to be suspended, debarred, precluded, or Excluded from participation in federal or state health care programs.

C. CalOptima will take immediate appropriate actions, with the assistance of its Legal Counsel, to terminate the employment of an individual, the contractual relationship with an FDR or vendor for all CalOptima programs, or the appointment of a Member of the Governing Body, if such individual or entity is verified to be suspended, debarred, Precluded or Excluded from participation in federal or state health care programs.

D. CalOptima shall utilize state and federal Preclusion, Exclusion, and ineligible person/entity list sources referenced in this Policy to verify the eligibility of an Employee, Member of the Governing Body, FDR, non-contracted Provider, or vendor and shall maintain a record of completion.

E. All CalOptima FDRs and vendors shall verify the eligibility of all its Employees and/or Downstream Entities prior to hiring/contracting/performing services and monthly thereafter. The FDR and vendors shall maintain a record of completion.

F. In the event a CalOptima FDR or vendor identifies its employees and/or Downstream Entities on an Exclusion, Preclusion, and/or ineligible person/entity list, the FDR or vendor must immediately notify CalOptima of the identified ineligible person/entity. CalOptima in its sole discretion will determine whether it is appropriate to immediately suspend/remove/terminate the identified person/entity from furnishing items and services for CalOptima programs and/or suspend/terminate the applicable FDR or vendor contract.

G. The Office of Compliance may Audit CalOptima departments responsible for exclusion and Preclusion activities, as necessary.

H. CalOptima may contract with a Network Provider and/or Subcontractor that has been suspended or excluded from participation in the Medi-Cal program when the suspension and/or Exclusion has been lifted.

III. PROCEDURE

A. Initial Verification

1. Prior to hiring an Employee, having an individual become a Member of the Governing Body or a CalOptima committee, or contracting with an FDR or vendor, or approving payment to a non-contracted Provider the responsible department identified in the chart in Section III.B.2. of this

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Policy shall verify that the individual or entity is not Excluded or Precluded by reviewing the applicable Monitoring sources to retrieve verification and eligibility data, including, but not limited to:

a. The General Services Administration's (GSA) System for Award Management (SAM) website;

b. Medi-Cal's Suspended and Ineligible (S&I) list;

c. CMS Preclusion List;

d. Medi-Cal Restricted Provider Database (RPD);

e. Medi-Cal Procedure/Drug Code Limitation List;

f. OIG Exclusion Database (OIG LEIE Database);

g. Other Monitoring sources as identified in CalOptima Policies:

i. GG.1607Δ: Monitoring Adverse Actions;

ii. GG.1650Δ: Credentialing and Recredentialing of Practitioners; and

iii. GG.1651Δ: Assessment and Re-Assessment of Organizational Providers.

h. As required by the Centers for Medicare & Medicaid Services (CMS) and the Department of Health Care Services (DHCS):

i. DHCS All Plan Letter (APL) 19-004: Provider Credentialing/Recredentialing and Screening/Enrollment.

B. Evidence of Verification

1. CalOptima shall utilize applicable state and federal Preclusion, Exclusion, and ineligible person/entity list sources referenced in this Policy to verify the eligibility of an Employee, Member of the Governing Body, FDR, non-contracted Provider, or vendor and shall maintain a record of completion indicating, at minimum:

a. The date of verification;

b. The Exclusion, Preclusion, and ineligible person/entity list source(s);

c. Verification results; and

d. The name of the person who conducted the verification.

2. CalOptima is to refer to the chart below to determine the responsible departments that conduct initial and/or monthly Exclusions and Preclusions checks thereafter.

Responsible Department	Initial (Prior to contracting/hire, or payment of a non-contracted Provider)	Monthly
Accounting	Great Plains vendors ONLY; excluding all vendors whose initial Monitoring is the responsibility of other departments listed in this grid.	• FDRs and Vendors listed in Great Plains ONLY • Health Networks in Great Plains ONLY • Letter of Agreement in Great Plains ONLY • Medical Group Practices, Physician Medical Groups in Great Plains ONLY • Non-Medical Providers in Great Plains ONLY
Contracting	• Health Networks	N/A
Human Resources	• Employees • CalOptima Committees • CalOptima Members of the Governing Body (Board of Directors)	• Employees • CalOptima Committees • CalOptima Members of the Governing Body (Board of Directors)

PACE	• PACE Vendors ONLY
	  ○ This includes vendors that are NOT providing direct member care i.e., entertainment and will be invoiced
	• PACE Letter of Agreement (LOA) ONLY
	  ○ This includes non-medical Providers i.e., handyman and medical Providers not contracted
		• Refer to Accounting and/or Quality-Credentialing monthly Monitoring

Pharmacy Benefit Manager	• Pharmacies • Pharmacy Staff • Prescribers	• Pharmacies • Pharmacy Staff • Prescribers
Provider Data Management Services (PDMS)	• Medical Providers, Practitioners, Organizational Providers (OPs) NON-CONTRACTED ONLY	N/A
Quality- Credentialing	• Medical Providers, Practitioners, Organizational Providers (OPs) CCN CONTRACTED ONLY • Medical Group Practices • MSSP Non-Medical Providers • Physician Medical Groups • Letter of Agreement (LOA)	• Medical Providers • Practitioners • Organizational Providers (OPs) • Medical Group Practices • Physician Medical Groups • Letter of Agreement (LOA)
Utilization Management	• Letter of Agreement (LOA)	N/A
Vendor Management	• FDRs and Vendors excluding Medical Providers and Health Networks	N/A

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3. All CalOptima FDRs and vendors shall verify the eligibility of all its Employees and/or Downstream Entities on applicable Monitoring sources as required by CMS and/or DHCS prior to hiring/contracting/performing services and monthly thereafter. The FDR and vendors shall maintain a record of completion indicating, at minimum:

    a. Date of verification;

    b. The Exclusion, Preclusion, and ineligible person/entity list source(s);

    c. Verification results; and

    d. The name of the person who conducted the verification.

C. Monitoring

1. On a monthly basis, prior to publishing the next verification list update, the responsible department shall monitor Employees, FDRs, non-contracted Providers, vendors, and Members of the Governing Body and committees by reviewing the applicable Monitoring sources listed in section III.A.1. of this Policy.

D. Actions Based on Discovery of Exclusion

1. In accordance with Title 42, Code of Federal Regulations, section 1001.1901(b)(1), CalOptima shall immediately suspend and halt payment for services for an ineligible, or Excluded, Employee, Member of the Governing Body or CalOptima committee, FDR, non-contracted Provider, or vendor; or at the medical direction or on the prescription of a physician or an authorized individual who is Excluded when the person furnishing such item or service knew, or had reason to know, of the Exclusion. The payment prohibition applies regardless of whether the Excluded individual, or entity, submits claims for reimbursement to, or the method of reimbursement by, federal or state health care programs. Individuals or entities identified on a state Medicaid exclusion list for reasons unrelated to fraud, integrity, or quality can remain contracted with CalOptima as long as the individuals or entities are not listed on a federal or California exclusion list.

    a. The responsible department shall deem an Employee, Member of the Governing Body or committee, FDR, non-contracted Provider, or vendor Excluded, or ineligible, if identified on one (1) or more Monitoring sources. If applicable, the responsible department shall request an alert is added to notify all appropriate CalOptima departments of the Excluded, or ineligible, individual, or entity.

    b. The responsible department should refer the matter to the Office of Compliance for further investigation. As appropriate, the Office of Compliance may refer issues regarding the Excluded individual or entity to ~~Legal Affairs~~legal counsel for further action.

    c. CalOptima will take immediate appropriate actions, with the assistance of Legal Counsel, to terminate the contractual relationship for all CalOptima programs with a FDR, or vendor, or the appointment of a Member of the Governing Body, if such person, or entity, is determined to be Excluded. If the report identifies the removal of a suspended, Excluded, or terminated non-contracted Provider or FDR from CalOptima's Provider network, then the Office of Compliance shall report the action to DHCS within ten (10) business days and confirm that the Provider or FDR is no longer receiving payments in connection with the Medi-Cal program.

d. In the event, that an Employee is identified as Excluded, the applicable contractual relationship will also be reviewed to determine whether it may continue with the removal of the Employee.

e. CalOptima may recoup monies paid to the Employee, Member of the Governing Body, FDR, non-contracted Provider, or vendor while Excluded or Precluded. Exclusion and Preclusion findings will be referred to the Office of Compliance for further action in accordance with CalOptima policy. As appropriate, the Office of Compliance may refer issues regarding the Excluded or Precluded person to ~~Legal Affairs~~legal counsel for further action.

E. Actions Based on Discovery of Individuals/Entities listed in CMS Preclusion List

1. In accordance with Title 42, Code of Federal Regulations, sections 422.222, 422.224, 423.100, 423.120(c)(6), for Precluded Providers, FDRs, or vendors, CalOptima may not reimburse or make payment for claims (i.e., for covered items or services) or prescriptions with any individual or entities on the CMS Preclusion List, including for emergency or urgent care circumstances.

a. The responsible department shall deem an FDR, non-contracted Provider, or vendor Precluded if identified on the CMS Preclusion List. If applicable, the responsible department shall request an alert is added to notify all appropriate CalOptima departments of the Precluded FDR, non-contracted Provider, or vendor. CalOptima is also to notify the Health Networks to remove any contracted Provider and any contracted pharmacy found on the CMS Preclusion List from their network as soon as possible.

b. CalOptima shall notify Precluded FDRs, non-contracted Providers, or vendors in writing that they can no longer treat Members and notify all impacted Members, including Members assigned to Health Networks, in writing who have received care or prescription from the Precluded FDR, non-contracted Provider, or vendor in the last twelve (12) months as soon as possible, but no later than thirty (30) calendar days after the date the FDR, non-contracted Provider, or vendor was Precluded. CalOptima will also remove the FDR or vendor from the Provider Directory no later than thirty (30) calendar days after the date the FDR or vendor was Precluded.

c. CalOptima will have thirty (30) calendar days to review the CMS Preclusion List and notify in writing impacted Members, including Members assigned to Health Networks, no later than thirty (30) calendar days from the posting of the updated list. Members should be given at least sixty (60) calendar days advance notice before payment denials and claims rejections begin~~.~~.

d. CalOptima should not deny payments and/or reject claims earlier than 90 calendar days after publication of the associated Preclusion list.

e. For FDRs, non-contracted Providers, or vendors identified on both the Exclusion sources and the CMS Preclusion List, CalOptima's processes for an Excluded individual or entity supersedes those of a Precluded individual or entity.

F. Actions Based on Discovery of Individuals/Entities listed in the Medi-Cal Restricted Provider Database (RPD)/Procedure/Drug Code Limitation List

1. If CalOptima or FDR (as applicable) identifies a Network Provider or Subcontractor listed on the Medi-Cal RPD as a payment suspension, CalOptima may continue the contractual relationship, but must withhold reimbursements for Medi-Cal covered services in accordance with Attachment A: Exclusionary Databases and Lists as referenced in DHCS All Plan Letter (APL) 21 – 003: Medi-Cal Network Provider Terminations and Subcontractor Terminations. If CalOptima chooses to terminate the contract, it shall submit the appropriate documentation in accordance with Attachment A: Exclusionary Databases and Lists and as outlined in DHCS All Plan Letter (APL) 21-003: Medi-Cal Network Provider Terminations and Subcontractor Terminations.

2. If CalOptima or FDR identifies a Network Provider or Subcontractor listed on the RPD as a temporary suspension, it shall initiate a contract termination and submit appropriate documentation in accordance with Attachment A: Exclusionary Databases and Lists, and as outlined in DHCS All Plan Letter (APL) 21-003: Medi-Cal Network Provider and Subcontractor Terminations (Attachment A).

3. If CalOptima or FDR identifies a Network Provider or Subcontractor on the Medi-Cal Procedure/Drug Code Limitation List, CalOptima may continue to contract with the Network Provider or Subcontractor but shall not pay for services provided by a restricted provider or receive reimbursement for those services under restriction. If CalOptima chooses to terminate the contract, it shall submit appropriate documentation, in accordance with DHCS All Plan Letter (APL) 21-003: Medi-Cal Network Provider and Subcontractor Terminations (Attachment A), including:

   a. CalOptima's transition plan or narrative description of how CalOptima intends to provide Covered Services to affected Members to DHCS in accordance with CalOptima Policy GG.1652: DHCS Notification of Change in the Availability or Location of Covered Services.

   b. CalOptima's submission of Network Review Documents to DHCS if CalOptima is unable to comply with any of the Annual Network Certification (ANC) components as outlined in CalOptima Policy GG.1600: Access and Availability Standards.

G. FDRs and Vendors

1. If CalOptima intends to deny a prospective FDR or vendor participation in CalOptima program(s) or suspend payment (applicable only to Medi-Cal RPD and Medi-Cal Procedure/Drug Code Limitation List), or terminate an existing FDR's or vendor's contract, on the basis of an Exclusion or Preclusion, it shall notify the FDR or vendor, in writing, noting the reason for denial. The prospective or existing FDR or vendor may contest the denial if they feel there is an error or inappropriate Exclusion. If CalOptima determines that there is an inappropriate Exclusion, correction shall be made, as stated in the Centers for Medicare & Medicaid Services (CMS) Center for Program Integrity Center for Medicare Letter issued June 29, 2011.

2. If a previously Excluded or Precluded FDR or vendor has been re-instated by a Monitoring source listed on this Policy and is now in good standing and able to participate in CalOptima federal and/or state health care programs, the FDR or vendor may express interest in participating with CalOptima. CalOptima will require evidence to verify reinstatement into federally funded health care programs. In addition, the FDR or vendor will undergo re-processing through contracting and/or Credentialing.

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

A. CalOptima Compliance Plan
B. CalOptima Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
C. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal
D. CalOptima PACE Program Agreement
E. CalOptima Policy DD.2012: Member Notification of Change in the Availability or Location of Covered Services
F. CalOptima Policy GG.1304: Continuity of Care during Health Network or Provider Termination to assure transition of affected Members for Covered Services
G. CalOptima Policy GG.1600: Access and Availability Standards
H. CalOptima Policy GG.1607Δ: Monitoring Adverse Actions
I. CalOptima Policy GG.1650Δ: Credentialing and Recredentialing of Practitioners
J. CalOptima Policy GG.1651Δ: Assessment and Re-Assessment of Organizational Providers
K. CalOptima Policy GG.1652: DHCS Notification of Change in the Availability or Location of Covered Services
L. CalOptima Three-Way Contract with the Centers for Medicare & Medicaid Services (CMS) and the Department of Health Care Services (DHCS) for Cal MediConnect
M. Department of Health Care Services All Plan Letter (APL) 19-004: Provider Credentialing / Recredentialing and Screening / Enrollment (supersedes APL 17-019)
N. Department of Health Care Services All Plan Letter (APL) 21-003: Medi-Cal Network Provider and Subcontractor Terminations (supersedes APL 16-001)
O. Medicare Managed Care Manual, Chapter 21
P. Medicare Prescription Drug Benefit Manual, Chapter 9
Q. Medicaid Program Integrity Manual, Revised June 19, 2020
R. Medicare Program Integrity Manual, Chapter 4, Revised July 27, 2020
S. Sections 1128 and 156 of the Social Security Act
T. Title 42, Code of Federal Regulations (CFR), §§422.222, 422.224, 423.100, and 423.120(c)(6)
U. Title 42, Code of Federal Regulations (CFR), §1001.1901
V. Title 42, United States Code (US.C), §1320a-7(a)(1)(D), (a)(4)(c), 1320a-7(b)(8)
W. Updated: Special Advisory Bulletin on the Effect of Exclusion from Participation in Federal Health Care Programs, Issued May 8, 2013

VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency	Response
07/26/2021	Department of Health Care Services (DHCS)	Approved as Submitted

VII. BOARD ACTION(S)

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Date	Meeting
12/07/2017	Regular Meeting of the CalOptima Board of Directors
12/01/2016	Regular Meeting of the CalOptima Board of Directors
12/05/2019	Regular Meeting of the CalOptima Board of Directors
12/03/2020	Regular Meeting of the CalOptima Board of Directors
12/20/2021	Special Meeting of the CalOptima Board of Directors
TBD	Special Meeting of the CalOptima Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	05/01/2012	HH.2021	Vendor Exclusion Monitoring and Audits	Medi-Cal
Revised	08/01/2013	HH.2021Δ	Vendor Exclusion Monitoring and Audits	Medi-Cal OneCare
Effective	05/01/2014	MA.9121	Exclusion Monitoring	OneCare
Revised	09/01/2015	HH.2021	Exclusion Monitoring	Medi-Cal
Revised	09/01/2015	MA.9121	Exclusion Monitoring	OneCare OneCare Connect PACE
Retired	12/01/2016	MA.9121	Exclusion Monitoring	OneCare OneCare Connect PACE
Revised	12/01/2016	HH.2021Δ	Exclusion Monitoring	Medi-Cal OneCare OneCare Connect PACE
Revised	12/07/2017	HH.2021Δ	Exclusion Monitoring	Medi-Cal OneCare OneCare Connect PACE
Revised	12/06/2018	HH.2021Δ	Exclusion Monitoring	Medi-Cal OneCare OneCare Connect PACE
Revised	12/05/2019	HH.2021Δ	Exclusion Monitoring and Preclusion Monitoring	Medi-Cal OneCare OneCare Connect PACE
Revised	12/03/2020	HH.2021Δ	Exclusion Monitoring and Preclusion Monitoring	Medi-Cal OneCare OneCare Connect PACE

Action	Date	Policy	Policy Title	Program(s)
Revised	12/20/2021	HH.2021Δ	Exclusion Monitoring and Preclusion Monitoring	Medi-Cal OneCare OneCare Connect PACE
Revised	TBD	HH.2021Δ	Exclusion Monitoring and Preclusion Monitoring	Medi-Cal OneCare OneCare Connect PACE

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IX. GLOSSARY

Term	Definition
Audit	A formal, systematic, and disciplined approach designed to review, evaluate, and improve the effectiveness of processes and related controls using a particular set of standards (e.g., policies and procedures, laws and regulations) used as base measures. Auditing is governed by professional standards and completed by individuals independent of the process being audited and normally performed by individuals with one of several acknowledged certifications.
Covered Services	Medi-Cal: Those services provided in the Fee-For-Service Medi-Cal program (as set forth in Title 22, CCR, Division 3, Subdivision 1, Chapter 3, beginning with Section 51301), the Child Health and Disability Prevention program (as set forth in Title 17, CCR, Division 1, Chapter 4, Subchapter 13, Article 4, beginning with section 6842), and the California Children's Services (as set forth in Title 22, CCR, Division 2, subdivision 7, and Welfare and Institutions Code, Division 9, Part 3, Chapter 7, Article 2.985, beginning with section 14094.4) under the Whole-Child Model program, to the extent those services are included as Covered Services under CalOptima's Medi-Cal Contract with DHCS and are Medically Necessary, along with chiropractic services (as defined in Section 51308 of Title 22, CCR), podiatry services (as defined in Section 51310 of Title 22, CCR), speech pathology services and audiology services (as defined in Section 51309 of Title 22, CCR), and ~~Health Homes Program (HHP) services~~Enhanced Care Management and Community Supports as part of the California Advancing and Innovating Medi-Cal (CalAIM) Initiative (as set forth in the CalAIM 1115 Demonstration & 1915(b) Waiver, DHCS All Plan Letter ~~18~~(APL) 21-012: Enhanced Care Management Requirements and APL 21-017: Community Supports Requirements, and Welfare and Institutions Code, Division 9, Part 3, Chapter 7, Article ~~3.95~~5.51, beginning with section ~~14127) for HHP Members with eligible physical chronic conditions and substance use disorders,~~14184.100), or other services as authorized by the CalOptima Board of Directors, which shall be covered for Members ~~not withstanding~~notwithstanding whether such benefits are provided under the Fee-For-Service Medi-Cal program. OneCare: Those medical services, equipment, or supplies that CalOptima is obligated to provide to Members under the Centers of Medicare & Medicaid Services (CMS) Contract. OneCare Connect: Those medical services, equipment, or supplies that CalOptima is obligated to provide to Members under the Three-Way Contract with the Department of Health Care Services (DHCS) and Centers for Medicare & Medicaid Services (CMS). PACE: Those services set for the in California Code of Regulations, title 22, chapter 3, article 4, beginning with section 51301, and title 17, division 1, chapter 4, subchapter 13, beginning with Section 6840, unless otherwise specifically excluded under the terms of the DHCS PACE Contract with CalOptima, or other services as authorized by the CalOptima Board of Directors.
Credentialing	The process of obtaining, verifying, assessing, and monitoring the qualifications of a Practitioner to provide quality and safe patient care services.

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Term	Definition
Downstream Entity	For purposes of this policy, any party that enters into a written arrangement, acceptable to DHCS and/or CMS, with persons or entities involved with a CalOptima Program benefit, below the level of arrangement between CalOptima and a First Tier Entity. These written arrangements continue down to the level of the ultimate Provider of both health and administrative services.
Employee	For purposes of this policy, any and all employees of CalOptima, including all senior management, officers, managers, supervisors and other employed personnel, as well as temporary employees and volunteers.
Excluded or Exclusion	Suspension, exclusion, or debarment from participation in Federal and/or state health care programs.
First Tier, Downstream, and Related Entities (FDR)	First Tier, Downstream or Related Entity, as separately defined herein. For the purposes of this policy, the term FDR includes delegated entities, contracted Providers, Health Networks, Physician Medical Groups, Physician Hospital Consortia, and Health Maintenance Organizations.
First Tier Entity (FTE)	Any party that enters into a written arrangement, acceptable to DHCS and/or CMS, with CalOptima to provide administrative services or health care services to a Member under a CalOptima Program.
Governing Body	The Board of Directors of CalOptima.
Health Network	A Physician Hospital Consortium (PHC), physician group under a shared risk contract, or health care service plan, such as a Health Maintenance Organization (HMO) that contracts with CalOptima to provide Covered Services to Members assigned to that Health Network.
Member	A beneficiary enrolled in a CalOptima Program.
Monitoring	An on-going process usually directed by management to ensure processes are working as intended. Monitoring is an effective detective control within a process and is typically completed by department staff and communicated to department management.
Network Provider	A Provider that subcontracts with CalOptima for the delivery of Medi-Cal covered services.
Precluded or Preclusion	A type of exclusion. The CMS Preclusion List is a list of Providers and prescribers who are precluded from receiving payment for Medicare Advantage (MA) items and services or Part D drugs furnished or prescribed to Medicare beneficiaries.

Term	Definition
Provider	Medi-Cal: A physician, nurse, nurse mid-wife, nurse practitioner, medical technician, physician assistant, hospital, laboratory, ancillary provider, or other person or institution that furnishes Covered Services. OneCare: Any Medicare provider (e.g., hospital, skilled nursing facility, home health agency, outpatient physical therapy, comprehensive outpatient rehabilitation facility, end-stage renal disease facility, hospice, physician, non-physician provider, laboratory, supplier, etc.) providing Covered Services under Medicare Part B. Any organization, institution, or individual that provides Covered Services to Medicare members. Physicians, ambulatory surgical centers, and outpatient clinics are some of the providers of Covered Services under Medicare Part B. ~~OneCare: A physician, pharmacist, nurse, nurse mid-wife, nurse practitioner, medical technician, physician assistant, hospital, laboratory, health maintenance organization, Health Network, or other person or institution who furnishes Covered Services.~~ OneCare Connect: A physician, pharmacist, nurse, nurse mid-wife, nurse practitioner, medical technician, physician assistant, hospital, laboratory, health maintenance organization, Health Network, physician group, or other person or institution who furnishes Covered Services.
Related Entity	Any entity that is related to CalOptima by common ownership or control and that: performs some of CalOptima's management functions under contract or delegation; furnishes services to Members under an oral or written agreement; or leases real property or sells materials to CalOptima at a cost of more than $2,500 during a contract period.
Subcontractor	An individual or entity who has a Subcontract with CalOptima that relates directly or indirectly to the performance of CalOptima's obligations under contract with DHCS.

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Policy:	HH.2021Δ
Title:	**Exclusion and Preclusion Monitoring**
Department:	Office of Compliance
Section:	Regulatory Affairs & Compliance
CEO Approval:	*/s/*
Effective Date:	05/01/2012
Revised Date:	TBD
Applicable to:	☒ Medi-Cal ☒ OneCare ☒ OneCare Connect ☒ PACE ☐ Administrative

I. PURPOSE

This policy outlines a process for verifying and Monitoring, the eligibility of Employees (permanent, temporary, volunteer, and as-needed Employees), Members of the Governing Body, First Tier, Downstream, and Related Entities (FDRs), non-contracted Providers, and vendors to participate in CalOptima federal and/or state health care programs through state and federal Exclusions, Preclusion, and ineligible person/entity lists.

II. POLICY

A. CalOptima shall ensure all Employees, Members of the Governing Body, FDRs, non-contracted Providers, and vendors are eligible to participate in CalOptima federal and/or state health care programs, and shall be responsible for:

1. Requiring an Employee, Member of the Governing Body, FDR, non-contracted Provider, or vendor to disclose and report pending suspensions, Exclusions, Preclusions, or debarments, of the Employee, Member of the Governing Body, FDR, Providers, or vendor;

2. Conducting the initial eligibility verification of an Employee, Member of the Governing Body, FDR, non-contracted Provider, and vendor prior to hiring, renewing, or entering in any new agreement with CalOptima, or issuing payment thereto;

3. Performing eligibility verification of an Employee, Member of the Governing Body, FDR, non-contractor Providers, and vendor monthly thereafter; and

4. Maintaining records of all initial and monthly verification.

5. CalOptima shall not employ, consult, or contract with individuals or entities that are determined to be suspended, debarred, precluded, or Excluded from participation in federal or state health care programs. Individuals or entities identified on a state Medicaid exclusion list for reasons unrelated to fraud, integrity, or quality can remain contracted with CalOptima as long as the individuals or entities are not listed on a federal or California exclusion list including, but not limited to:

   a. The General Services Administration's (GSA) System for Award Management (SAM) website;

   b. Medi-Cal's Suspended and Ineligible (S&I) list;

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c. CMS Preclusion List;

d. Medi-Cal Restricted Provider Database (RPD);

e. Medi-Cal Procedure/Drug Code Limitation List;

f. OIG Exclusion Database (OIG LEIE Database);

g. Other Monitoring sources as identified in CalOptima Policies:

B. CalOptima shall not reimburse or make payment for services provided under the medical direction or on the prescription of an Excluded person or entity, or make payment to, an individual or entity that is verified to be suspended, debarred, precluded, or Excluded from participation in federal or state health care programs.

C. CalOptima will take immediate appropriate actions, with the assistance of its Legal Counsel, to terminate the employment of an individual, the contractual relationship with an FDR or vendor for all CalOptima programs, or the appointment of a Member of the Governing Body, if such individual or entity is verified to be suspended, debarred, Precluded or Excluded from participation in federal or state health care programs.

D. CalOptima shall utilize state and federal Preclusion, Exclusion, and ineligible person/entity list sources referenced in this Policy to verify the eligibility of an Employee, Member of the Governing Body, FDR, non-contracted Provider, or vendor and shall maintain a record of completion.

E. All CalOptima FDRs and vendors shall verify the eligibility of all its Employees and/or Downstream Entities prior to hiring/contracting/performing services and monthly thereafter. The FDR and vendors shall maintain a record of completion.

F. In the event a CalOptima FDR or vendor identifies its employees and/or Downstream Entities on an Exclusion, Preclusion, and/or ineligible person/entity list, the FDR or vendor must immediately notify CalOptima of the identified ineligible person/entity. CalOptima in its sole discretion will determine whether it is appropriate to immediately suspend/remove/terminate the identified person/entity from furnishing items and services for CalOptima programs and/or suspend/terminate the applicable FDR or vendor contract.

G. The Office of Compliance may Audit CalOptima departments responsible for exclusion and Preclusion activities, as necessary.

H. CalOptima may contract with a Network Provider and/or Subcontractor that has been suspended or excluded from participation in the Medi-Cal program when the suspension and/or Exclusion has been lifted.

III. PROCEDURE

A. Initial Verification

1. Prior to hiring an Employee, having an individual become a Member of the Governing Body or a CalOptima committee, or contracting with an FDR or vendor, or approving payment to a non-contracted Provider the responsible department identified in the chart in Section III.B.2. of this Policy shall verify that the individual or entity is not Excluded or Precluded by reviewing the

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applicable Monitoring sources to retrieve verification and eligibility data, including, but not limited to:

a. The General Services Administration's (GSA) System for Award Management (SAM) website;

b. Medi-Cal's Suspended and Ineligible (S&I) list;

c. CMS Preclusion List;

d. Medi-Cal Restricted Provider Database (RPD);

e. Medi-Cal Procedure/Drug Code Limitation List;

f. OIG Exclusion Database (OIG LEIE Database);

g. Other Monitoring sources as identified in CalOptima Policies:

i. GG.1607Δ: Monitoring Adverse Actions;

ii. GG.1650Δ: Credentialing and Recredentialing of Practitioners; and

iii. GG.1651Δ: Assessment and Re-Assessment of Organizational Providers.

h. As required by the Centers for Medicare & Medicaid Services (CMS) and the Department of Health Care Services (DHCS):

i. DHCS All Plan Letter (APL) 19-004: Provider Credentialing/Recredentialing and Screening/Enrollment.

B. Evidence of Verification

1. CalOptima shall utilize applicable state and federal Preclusion, Exclusion, and ineligible person/entity list sources referenced in this Policy to verify the eligibility of an Employee, Member of the Governing Body, FDR, non-contracted Provider, or vendor and shall maintain a record of completion indicating, at minimum:

a. The date of verification;

b. The Exclusion, Preclusion, and ineligible person/entity list source(s);

c. Verification results; and

d. The name of the person who conducted the verification.

2. CalOptima is to refer to the chart below to determine the responsible departments that conduct initial and/or monthly Exclusions and Preclusions checks thereafter.

Responsible Department	Initial (Prior to contracting/hire, or payment of a non-contracted Provider)	Monthly
Accounting	Great Plains vendors ONLY; excluding all vendors whose initial Monitoring is the responsibility of other departments listed in this grid.	• FDRs and Vendors listed in Great Plains ONLY • Health Networks in Great Plains ONLY • Letter of Agreement in Great Plains ONLY • Medical Group Practices, Physician Medical Groups in Great Plains ONLY • Non-Medical Providers in Great Plains ONLY
Contracting	• Health Networks	N/A
Human Resources	• Employees • CalOptima Committees • CalOptima Members of the Governing Body (Board of Directors)	• Employees • CalOptima Committees • CalOptima Members of the Governing Body (Board of Directors)

PACE	• PACE Vendors ONLY
	  ○ This includes vendors that are NOT providing direct member care i.e., entertainment and will be invoiced
	• PACE Letter of Agreement (LOA) ONLY
	  ○ This includes non-medical Providers i.e., handyman and medical Providers not contracted
		• Refer to Accounting and/or Quality-Credentialing monthly Monitoring

Pharmacy Benefit Manager	• Pharmacies • Pharmacy Staff • Prescribers	• Pharmacies • Pharmacy Staff • Prescribers
Provider Data Management Services (PDMS)	• Medical Providers, Practitioners, Organizational Providers (OPs) NON-CONTRACTED ONLY	N/A
Quality- Credentialing	• Medical Providers, Practitioners, Organizational Providers (OPs) CCN CONTRACTED ONLY • Medical Group Practices • MSSP Non-Medical Providers • Physician Medical Groups • Letter of Agreement (LOA)	• Medical Providers • Practitioners • Organizational Providers (OPs) • Medical Group Practices • Physician Medical Groups • Letter of Agreement (LOA)
Utilization Management	• Letter of Agreement (LOA)	N/A
Vendor Management	• FDRs and Vendors excluding Medical Providers and Health Networks	N/A

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3. All CalOptima FDRs and vendors shall verify the eligibility of all its Employees and/or Downstream Entities on applicable Monitoring sources as required by CMS and/or DHCS prior to hiring/contracting/performing services and monthly thereafter. The FDR and vendors shall maintain a record of completion indicating, at minimum:

    a. Date of verification;

    b. The Exclusion, Preclusion, and ineligible person/entity list source(s);

    c. Verification results; and

    d. The name of the person who conducted the verification.

C. Monitoring

1. On a monthly basis, prior to publishing the next verification list update, the responsible department shall monitor Employees, FDRs, non-contracted Providers, vendors, and Members of the Governing Body and committees by reviewing the applicable Monitoring sources listed in section III.A.1. of this Policy.

D. Actions Based on Discovery of Exclusion

1. In accordance with Title 42, Code of Federal Regulations, section 1001.1901(b)(1), CalOptima shall immediately suspend and halt payment for services for an ineligible, or Excluded, Employee, Member of the Governing Body or CalOptima committee, FDR, non-contracted Provider, or vendor; or at the medical direction or on the prescription of a physician or an authorized individual who is Excluded when the person furnishing such item or service knew, or had reason to know, of the Exclusion. The payment prohibition applies regardless of whether the Excluded individual, or entity, submits claims for reimbursement to, or the method of reimbursement by, federal or state health care programs. Individuals or entities identified on a state Medicaid exclusion list for reasons unrelated to fraud, integrity, or quality can remain contracted with CalOptima as long as the individuals or entities are not listed on a federal or California exclusion list.

    a. The responsible department shall deem an Employee, Member of the Governing Body or committee, FDR, non-contracted Provider, or vendor Excluded, or ineligible, if identified on one (1) or more Monitoring sources. If applicable, the responsible department shall request an alert is added to notify all appropriate CalOptima departments of the Excluded, or ineligible, individual, or entity.

    b. The responsible department should refer the matter to the Office of Compliance for further investigation. As appropriate, the Office of Compliance may refer issues regarding the Excluded individual or entity to legal counsel for further action.

    c. CalOptima will take immediate appropriate actions, with the assistance of Legal Counsel, to terminate the contractual relationship for all CalOptima programs with a FDR, or vendor, or the appointment of a Member of the Governing Body, if such person, or entity, is determined to be Excluded. If the report identifies the removal of a suspended, Excluded, or terminated non-contracted Provider or FDR from CalOptima's Provider network, then the Office of Compliance shall report the action to DHCS within ten (10) business days and confirm that the Provider or FDR is no longer receiving payments in connection with the Medi-Cal program.

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d. In the event, that an Employee is identified as Excluded, the applicable contractual relationship will also be reviewed to determine whether it may continue with the removal of the Employee.

e. CalOptima may recoup monies paid to the Employee, Member of the Governing Body, FDR, non-contracted Provider, or vendor while Excluded or Precluded. Exclusion and Preclusion findings will be referred to the Office of Compliance for further action in accordance with CalOptima policy. As appropriate, the Office of Compliance may refer issues regarding the Excluded or Precluded person to legal counsel for further action.

E. Actions Based on Discovery of Individuals/Entities listed in CMS Preclusion List

1. In accordance with Title 42, Code of Federal Regulations, sections 422.222, 422.224, 423.100, 423.120(c)(6), for Precluded Providers, FDRs, or vendors, CalOptima may not reimburse or make payment for claims (i.e., for covered items or services) or prescriptions with any individual or entities on the CMS Preclusion List, including for emergency or urgent care circumstances.

a. The responsible department shall deem an FDR, non-contracted Provider, or vendor Precluded if identified on the CMS Preclusion List. If applicable, the responsible department shall request an alert is added to notify all appropriate CalOptima departments of the Precluded FDR, non-contracted Provider, or vendor. CalOptima is also to notify the Health Networks to remove any contracted Provider and any contracted pharmacy found on the CMS Preclusion List from their network as soon as possible.

b. CalOptima shall notify Precluded FDRs, non-contracted Providers, or vendors in writing that they can no longer treat Members and notify all impacted Members, including Members assigned to Health Networks, in writing who have received care or prescription from the Precluded FDR, non-contracted Provider, or vendor in the last twelve (12) months as soon as possible, but no later than thirty (30) calendar days after the date the FDR, non-contracted Provider, or vendor was Precluded. CalOptima will also remove the FDR or vendor from the Provider Directory no later than thirty (30) calendar days after the date the FDR or vendor was Precluded.

c. CalOptima will have thirty (30) calendar days to review the CMS Preclusion List and notify in writing impacted Members, including Members assigned to Health Networks, no later than thirty (30) calendar days from the posting of the updated list. Members should be given at least sixty (60) calendar days advance notice before payment denials and claims rejections begin.

d. CalOptima should not deny payments and/or reject claims earlier than 90 calendar days after publication of the associated Preclusion list.

e. For FDRs, non-contracted Providers, or vendors identified on both the Exclusion sources and the CMS Preclusion List, CalOptima's processes for an Excluded individual or entity supersedes those of a Precluded individual or entity.

F. Actions Based on Discovery of Individuals/Entities listed in the Medi-Cal Restricted Provider Database (RPD)/Procedure/Drug Code Limitation List

1. If CalOptima or FDR (as applicable) identifies a Network Provider or Subcontractor listed on the Medi-Cal RPD as a payment suspension, CalOptima may continue the contractual relationship, but must withhold reimbursements for Medi-Cal covered services in accordance

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with Attachment A: Exclusionary Databases and Lists as referenced in DHCS All Plan Letter (APL) 21 – 003: Medi-Cal Network Provider Terminations and Subcontractor Terminations. If CalOptima chooses to terminate the contract, it shall submit the appropriate documentation in accordance with Attachment A: Exclusionary Databases and Lists and as outlined in DHCS All Plan Letter (APL) 21-003: Medi-Cal Network Provider Terminations and Subcontractor Terminations.

2. If CalOptima or FDR identifies a Network Provider or Subcontractor listed on the RPD as a temporary suspension, it shall initiate a contract termination and submit appropriate documentation in accordance with Attachment A: Exclusionary Databases and Lists, and as outlined in DHCS All Plan Letter (APL) 21-003: Medi-Cal Network Provider and Subcontractor Terminations (Attachment A).

3. If CalOptima or FDR identifies a Network Provider or Subcontractor on the Medi-Cal Procedure/Drug Code Limitation List, CalOptima may continue to contract with the Network Provider or Subcontractor but shall not pay for services provided by a restricted provider or receive reimbursement for those services under restriction. If CalOptima chooses to terminate the contract, it shall submit appropriate documentation, in accordance with DHCS All Plan Letter (APL) 21-003: Medi-Cal Network Provider and Subcontractor Terminations (Attachment A), including:

   a. CalOptima's transition plan or narrative description of how CalOptima intends to provide Covered Services to affected Members to DHCS in accordance with CalOptima Policy GG.1652: DHCS Notification of Change in the Availability or Location of Covered Services.

   b. CalOptima's submission of Network Review Documents to DHCS if CalOptima is unable to comply with any of the Annual Network Certification (ANC) components as outlined in CalOptima Policy GG.1600: Access and Availability Standards.

G. FDRs and Vendors

1. If CalOptima intends to deny a prospective FDR or vendor participation in CalOptima program(s) or suspend payment (applicable only to Medi-Cal RPD and Medi-Cal Procedure/Drug Code Limitation List), or terminate an existing FDR's or vendor's contract, on the basis of an Exclusion or Preclusion, it shall notify the FDR or vendor, in writing, noting the reason for denial. The prospective or existing FDR or vendor may contest the denial if they feel there is an error or inappropriate Exclusion. If CalOptima determines that there is an inappropriate Exclusion, correction shall be made, as stated in the Centers for Medicare & Medicaid Services (CMS) Center for Program Integrity Center for Medicare Letter issued June 29, 2011.

2. If a previously Excluded or Precluded FDR or vendor has been re-instated by a Monitoring source listed on this Policy and is now in good standing and able to participate in CalOptima federal and/or state health care programs, the FDR or vendor may express interest in participating with CalOptima. CalOptima will require evidence to verify reinstatement into federally funded health care programs. In addition, the FDR or vendor will undergo re-processing through contracting and/or Credentialing.

IV. ATTACHMENT(S)

Not Applicable

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V. REFERENCE(S)

A. CalOptima Compliance Plan
B. CalOptima Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
C. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal
D. CalOptima PACE Program Agreement
E. CalOptima Policy DD.2012: Member Notification of Change in the Availability or Location of Covered Services
F. CalOptima Policy GG.1304: Continuity of Care during Health Network or Provider Termination to assure transition of affected Members for Covered Services
G. CalOptima Policy GG.1600: Access and Availability Standards
H. CalOptima Policy GG.1607Δ: Monitoring Adverse Actions
I. CalOptima Policy GG.1650Δ: Credentialing and Recredentialing of Practitioners
J. CalOptima Policy GG.1651Δ: Assessment and Re-Assessment of Organizational Providers
K. CalOptima Policy GG.1652: DHCS Notification of Change in the Availability or Location of Covered Services
L. CalOptima Three-Way Contract with the Centers for Medicare & Medicaid Services (CMS) and the Department of Health Care Services (DHCS) for Cal MediConnect
M. Department of Health Care Services All Plan Letter (APL) 19-004: Provider Credentialing / Recredentialing and Screening / Enrollment (supersedes APL 17-019)
N. Department of Health Care Services All Plan Letter (APL) 21-003: Medi-Cal Network Provider and Subcontractor Terminations (supersedes APL 16-001)
O. Medicare Managed Care Manual, Chapter 21
P. Medicare Prescription Drug Benefit Manual, Chapter 9
Q. Medicaid Program Integrity Manual, Revised June 19, 2020
R. Medicare Program Integrity Manual, Chapter 4, Revised July 27, 2020
S. Sections 1128 and 156 of the Social Security Act
T. Title 42, Code of Federal Regulations (CFR), §§422.222, 422.224, 423.100, and 423.120(c)(6)
U. Title 42, Code of Federal Regulations (CFR), §1001.1901
V. Title 42, United States Code (U.S.C), §1320a-7(a)(1)(D), (a)(4)(c), 1320a-7(b)(8)
W. Updated: Special Advisory Bulletin on the Effect of Exclusion from Participation in Federal Health Care Programs, Issued May 8, 2013

VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency	Response
07/26/2021	Department of Health Care Services (DHCS)	Approved as Submitted

VII. BOARD ACTION(S)

Date	Meeting
12/07/2017	Regular Meeting of the CalOptima Board of Directors
12/01/2016	Regular Meeting of the CalOptima Board of Directors
12/05/2019	Regular Meeting of the CalOptima Board of Directors
12/03/2020	Regular Meeting of the CalOptima Board of Directors
12/20/2021	Special Meeting of the CalOptima Board of Directors
TBD	Regular Meeting of the CalOptima Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	05/01/2012	HH.2021	Vendor Exclusion Monitoring and Audits	Medi-Cal
Revised	08/01/2013	HH.2021Δ	Vendor Exclusion Monitoring and Audits	Medi-Cal OneCare
Effective	05/01/2014	MA.9121	Exclusion Monitoring	OneCare
Revised	09/01/2015	HH.2021	Exclusion Monitoring	Medi-Cal
Revised	09/01/2015	MA.9121	Exclusion Monitoring	OneCare OneCare Connect PACE
Retired	12/01/2016	MA.9121	Exclusion Monitoring	OneCare OneCare Connect PACE
Revised	12/01/2016	HH.2021Δ	Exclusion Monitoring	Medi-Cal OneCare OneCare Connect PACE
Revised	12/07/2017	HH.2021Δ	Exclusion Monitoring	Medi-Cal OneCare OneCare Connect PACE
Revised	12/06/2018	HH.2021Δ	Exclusion Monitoring	Medi-Cal OneCare OneCare Connect PACE
Revised	12/05/2019	HH.2021Δ	Exclusion Monitoring and Preclusion Monitoring	Medi-Cal OneCare OneCare Connect PACE
Revised	12/03/2020	HH.2021Δ	Exclusion Monitoring and Preclusion Monitoring	Medi-Cal OneCare OneCare Connect PACE
Revised	12/20/2021	HH.2021Δ	Exclusion Monitoring and Preclusion Monitoring	Medi-Cal OneCare OneCare Connect PACE
Revised	TBD	HH.2021Δ	Exclusion Monitoring and Preclusion Monitoring	Medi-Cal OneCare OneCare Connect PACE

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Term	Definition
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Employee	For purposes of this policy, any and all employees of CalOptima, including all senior management, officers, managers, supervisors and other employed personnel, as well as temporary employees and volunteers.
Excluded or Exclusion	Suspension, exclusion, or debarment from participation in Federal and/or state health care programs.
First Tier, Downstream, and Related Entities (FDR)	First Tier, Downstream or Related Entity, as separately defined herein. For the purposes of this policy, the term FDR includes delegated entities, contracted Providers, Health Networks, Physician Medical Groups, Physician Hospital Consortia, and Health Maintenance Organizations.
First Tier Entity (FTE)	Any party that enters into a written arrangement, acceptable to DHCS and/or CMS, with CalOptima to provide administrative services or health care services to a Member under a CalOptima Program.
Governing Body	The Board of Directors of CalOptima.
Health Network	A Physician Hospital Consortium (PHC), physician group under a shared risk contract, or health care service plan, such as a Health Maintenance Organization (HMO) that contracts with CalOptima to provide Covered Services to Members assigned to that Health Network.
Member	A beneficiary enrolled in a CalOptima Program.
Monitoring	An on-going process usually directed by management to ensure processes are working as intended. Monitoring is an effective detective control within a process and is typically completed by department staff and communicated to department management.
Network Provider	A Provider that subcontracts with CalOptima for the delivery of Medi-Cal covered services.
Precluded or Preclusion	A type of exclusion. The CMS Preclusion List is a list of Providers and prescribers who are precluded from receiving payment for Medicare Advantage (MA) items and services or Part D drugs furnished or prescribed to Medicare beneficiaries.
Provider	Medi-Cal: A physician, nurse, nurse mid-wife, nurse practitioner, medical technician, physician assistant, hospital, laboratory, ancillary provider, or other person or institution that furnishes Covered Services. OneCare: Any Medicare provider (e.g., hospital, skilled nursing facility, home health agency, outpatient physical therapy, comprehensive outpatient rehabilitation facility, end-stage renal disease facility, hospice, physician, non-physician provider, laboratory, supplier, etc.) providing Covered Services under Medicare Part B. Any organization, institution, or individual that provides Covered Services to Medicare members. Physicians, ambulatory surgical centers, and outpatient clinics are some of the providers of Covered Services under Medicare Part B. OneCare Connect: A physician, pharmacist, nurse, nurse mid-wife, nurse practitioner, medical technician, physician assistant, hospital, laboratory, health maintenance organization, Health Network, physician group, or other person or institution who furnishes Covered Services.

Term	Definition
Related Entity	Any entity that is related to CalOptima by common ownership or control and that: performs some of CalOptima's management functions under contract or delegation; furnishes services to Members under an oral or written agreement; or leases real property or sells materials to CalOptima at a cost of more than $2,500 during a contract period.
Subcontractor	An individual or entity who has a Subcontract with CalOptima that relates directly or indirectly to the performance of CalOptima's obligations under contract with DHCS.

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken June 2, 2022
Regular Meeting of the CalOptima Board of Directors

Consent Calendar

11. Appointments to the CalOptima Board of Directors' Member Advisory Committee

Contacts

Ladan Khamseh, Executive Director, Operations, (714) 246-8866
Yunkyung Kim, Chief Operating Officer, (714) 246-8408

Recommended Actions

The CalOptima Member Advisory Committee (MAC) recommends:

1. Reappointment of the following individuals to serve two-year terms on the MAC, effective July 1, 2022:
    a. Lee Lombardo as the Children Representative for a term ending June 30, 2024;
    b. Katrina Polezhaev as the Consumer Representative for a term ending June 30, 2024; and
    c. Christine Tolbert as the Persons with Special Needs Representative for a term ending June 30, 2024.

2. Appointment of the following individuals to serve two-year terms on the MAC, effective July 1, 2022:
    a. Iliana Soto Welty as the Behavioral/Mental Health Representative for a term ending June 30, 2024;
    b. Alyssa Vandenberg as the Foster Children Representative for a term ending June 30, 2024;
    c. Sara Lee as the Long-Term Services and Supports Representative for a term ending June 30, 2024; and
    d. Ryan Yamamoto as the Medical Safety Net Representative for a term ending June 30, 2024.

Background

The CalOptima Board of Directors established the MAC by resolution on February 14, 1995, to provide input to the Board. The MAC is comprised of fifteen voting members. Pursuant to the resolution, MAC members serve two-year terms, except for the two standing seats, which are representatives from the County of Orange Social Services Agency (SSA) and the Orange County Health Care Agency (HCA). The CalOptima Board is responsible for the appointment of all MAC members.

With the fiscal year ending on June 30, 2022, seven MAC seats will expire: Behavioral/Mental Health, Children, Consumer, Foster Children, Long-Term Services and Supports, Medical Safety Net, and Persons with Special Needs.

Discussion

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

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The MAC Nominations Ad Hoc Subcommittee, composed of MAC committee members Vice Chair Maura Byron, Members Hai Hoang, and Steve Thronson evaluated each of the applicants for the impending openings and forwarded the proposed slate of candidates for the seven vacancies to the MAC. At the May 12, 2022, MAC meeting, members approved the recommended slate of candidates as proposed by the MAC Nominations Ad Hoc Subcommittee and requested that the proposed slate of candidates be forwarded to the CalOptima Board for consideration

The candidates for the open positions are as follows:

Behavioral/Mental Health Candidate

Illiana Soto Welty

Illiana Soto Welty is currently the community partnerships consultant at Mind OC, where she works with government agencies, nonprofits, and community groups to help create community transformation initiatives. Prior to working at Mind OC, Ms. Soto Welty was the executive director of the Multi-Ethnic Collaborative of Community Agencies (MECCA), where she helped to advance health equity, eliminate racial and ethnic disparities, and improve the lives of the underserved communities in Orange County. She is also the community co-chair of the HCA Behavioral Health Equity Collaborative, where she participates as a representative for Mind OC in the Equity in OC initiative.

Children Candidate

Lee Lombardo

Lee Lombardo is a licensed clinical social worker and the current associate executive director of YMCA community services at the YMCA of Orange County. Ms. Lombardo has worked in the mental health field with children, teens, families, and adults, including those with co-occurring mental health and developmental disabilities. She also works with Orange County and state agencies on the Developmental Screening Cohort through Help Me Grow OC, the Orange County Child Care and Development Planning Council and its Inclusion Subcommittee, and the Be Well OC Prevent and Act Early Workgroup.

Consumer Representative

Katerina Polezhaev

Katerina Polezhaev is a current CalOptima Medi-Cal member and a full-time student at California State University, Fullerton. She is a certified clinical medical assistant (CCMA) and is an active volunteer in the Anaheim community. She has served on the MAC since October 2020.

Foster Children Candidate

Alyssa Vandenberg

Alyssa Vandenberg is an intake and dependency investigations senior social worker with the Orange County Children and Family Services Social Services Agency. Ms. Vandenberg's experience includes working with foster children who receive Medi-Cal benefits through CalOptima. Ms. Vandenberg investigates allegations of abuse and neglect of children, including effectively planning and conducting investigations with children, family members, and collateral contacts in collaboration with law enforcement agencies and health care providers.

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Long-Term Services and Supports Candidate

Sara Lee

Sara Lee is an attorney at Community Legal Aid SoCal (CLA SoCal), a partner of the statewide Health Consumer Alliance, where she is the supervising attorney of the Health Consumer Action Center (HCAC) unit. Ms. Lee is a current member of CalOptima's OneCare Connect Member Advisory Committee (OCC MAC), serving as the Ethnic and Cultural Community Representative and advocating on behalf of CalOptima's OCC members. She also serves as the OCC MAC's Ombudsman.

Medical Safety Net Candidate

Ryan Yamamoto

Ryan Yamamoto is the chief operating officer for the Coalition of Orange County Community Health Centers (CoalitionOC). CoalitionOC currently serves over 370,000 low-income, underinsured, and uninsured patients in the county. In addition to working with member health centers, Mr. Yamamoto is responsible for establishing, developing, and maintaining relationships with other non-medical safety net providers who address social determinants of health for the underserved. Before his employment with CoalitionOC, Mr. Yamamoto served on a national taskforce to solve homelessness among the frail and elderly in the City of Oakland. He also developed a homeless patient pilot program to support uninsured homeless patients that frequent two Kaiser Permanente Medical Center Emergency Departments in Southern California.

Persons with Special Needs Candidate

Christine Tolbert

Christine Tolbert's current work for the State Council on Developmental Disabilities has allowed her to advocate for thousands of people dealing with an expansive number of medical and/or special needs conditions. She has helped transition people from the state hospital into the community, helping them access health care services through managed care. Ms. Tolbert currently holds the Persons with Special Needs seat and has served as the MAC Chair since 2019.

Fiscal Impact

There is no fiscal impact.

Rationale for Recommendation

As stated in policy AA.1219a, the MAC established a Nominations Ad Hoc Subcommittee to review potential candidates for vacancies on the committee. The MAC met to discuss the Nominations Ad Hoc Subcommittee's recommended slate of candidates and concurred with the Subcommittee's recommendations. The MAC forwards the recommended slate of candidates to the Board of Directors for consideration.

Concurrence

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

Attachments

None

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/s/ Michael Hunn *05/27/20222*
Authorized Signature **Date**

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CalOptima Board Action Agenda Referral

Action To Be Taken June 2, 2022
Regular Meeting of the CalOptima Board of Directors

Consent Calendar

12. Appointments to the CalOptima Board of Directors' Provider Advisory Committee

Contact

Yunkyung Kim, Chief Operating Officer (714) 246-8408

Recommended Actions

1. Appoint John Nishimoto, O.D., as the Allied Health Services Representative for a three-year term ending June 30, 2025.

2. Appoint Patty Mouton as the Long-Term Services and Supports Representative for a three-year term ending June 30, 2025.

3. Appoint Ji Ei Choi, L.Ac, as the Non-Physician Medical Practitioner for a three-year term ending June 30, 2025.

4. Appoint Mary Pham, Pharm.D., as the Pharmacy Representative for a three-year term ending June 30, 2025.

5. Appoint Timothy Korber, M.D., as the Physician Representative for a three-year term ending June 30, 2025.

Background

The CalOptima Board of Directors established the Provider Advisory Committee (PAC) by resolution on February 14, 1995, to provide input to the Board. The PAC is comprised of 15 voting members. Pursuant to resolution no. 15-0806-03, PAC members serve three-year terms, except for the one standing seat, which is a representative from Orange County Health Care Agency (HCA). The CalOptima Board is responsible for the appointment of all PAC members. With the fiscal year ending on June 30, 2022, six PAC seats will expire: Allied Health Services, Long-Term Services and Supports, Non-Physician Medical Practitioner, Pharmacy, and two (2) Physician seats. The PAC received one application for the physician seat, and recruitment is on-going to fill the second open seat.

Discussion

CalOptima conducted recruitment to ensure that there would be a diverse applicant pool from which to choose candidates. The recruitment included notification methods, such as sending outreach flyers to community-based organizations (CBOs) and targeting community outreach to agencies and CBOs serving the various open positions. Recruitment also consisted of emails to allied health services providers, physicians, health networks, long-term care facilities, hospitals, and pharmacies to reach all CalOptima providers for the open seats. CalOptima staff received the applications from interested candidates and submitted them to the Nominations Ad Hoc Subcommittee for review.

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Prior to the Nominations Ad Hoc Subcommittee meeting on April 25, 2022, subcommittee members evaluated each of the applicants. The subcommittee, consisting of Chair Junie Lazo-Pearson and PAC members Dr. Inglis and Dr. Sweidan, reviewed the candidates for each of the open seats and forwarded the proposed slate of candidates to the PAC for their consideration.

At the May 12, 2022, meeting, the PAC voted to accept the recommended slate of candidates as proposed by the Nominations Ad Hoc Subcommittee.

Information for the proposed slate of candidates is as follows:

Allied Health Services Representative
John Nishimoto, O.D., M.B.A., F.A.A.O.
Dr. Nishimoto is currently a professor and senior associate dean for Professional Affairs at Marshall B. Ketchum University and Southern California College of Optometry. He has active engagements with the leadership of the California Optometric Association (COA), the COA Health Care Delivery Systems Committee, and the leadership of the American Academy of Optometry and the California Academy of Physician Assistants. He is the chair for the Board of Integrated Health Care Solutions, which includes collaborative organizations such as Giving Children Hope and the Illumination Foundation. Dr. Nishimoto has served on the PAC since 2016, most recently as the Non-Physician Medical Practitioner, where his term will be ending on June 30, 2022. Dr. Nishimoto currently serves as the PAC Vice Chair and has served a previous two-year term as the PAC Chair.

Long-Term Services and Support Representatives
Patty Mouton
Patty Mouton has been the vice president of outreach and advocacy at Alzheimer's Orange County since 2005 and has worked in health care for older adults for over 20 years. She oversees professional and clinical activities and events, provides community education programs, and coordinates legislative advocacy and public policy-forming activities. In addition, she speaks to community groups about medical coverage issues and defines the continuum of care. Ms. Mouton holds the Senior Representative seat on the OneCare Connect Member Advisory Committee (OCC MAC) and has served as the committee chair since 2020. She is a past chair and former member of the MAC, having served until 2021. She holds a certificate in fundamentals of gerontology from the University of Southern California, a certificate in palliative care chaplaincy from California State University, San Marcos, and a bachelor of science in human services from Springfield College.

Non-Physician Medical Practitioner Representative
Ji Ei Choi, L.Ac
Dr. Choi is a licensed acupuncturist at Cornerstone Acupuncture Institute. Cornerstone is one of few acupuncture clinics in Orange County that have been credentialed to provide service to Medi-Cal members. Dr. Choi has direct experience with CalOptima members who experience chronic pain. She received a bachelor's degree in molecular, cell and developmental biology from UCLA and holds a master's degree in acupuncture and oriental medicine. She has been

working collaboratively with pain management doctors and works closely with several of CalOptima's health networks and providers to provide acupuncture services to members.

Pharmacy Representative

Mary Pham, Pharm.D, CHC

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

Physician Representative

Timothy Korber, M.D.

Dr. Korber is an emergency room physician and has been the emergency room director at Fountain Valley Regional Hospital for over 18 years. Dr. Korber currently treats CalOptima members during his shifts in the emergency room, including homeless members, members with drug addictions, and members with emergency medical problems. Dr. Korber received his medical degree from Penn State University and his emergency room credentials from Harbor UCLA. He has most recently received the Orange County Medical Association Physician of Excellence Award, having been a recipient of the award in previous years.

Fiscal Impact

There is no fiscal impact.

Rationale for Recommendation

As stated in policy AA. 1219b, the PAC established a Nominations Ad Hoc Subcommittee to review potential candidates for vacancies on the committee. The PAC met to discuss the recommended slate of candidates and concurred with the Nomination Ad Hoc Subcommittee's recommendations. The PAC forwards the recommended slate of candidates to the Board of Directors for their consideration.

Concurrence

PAC Advisory Committee Nominations Ad Hoc
PAC Advisory Committee
James Novello, Outside General Counsel Kennaday Leavitt

Attachments

None

/s/ Michael Hunn *05/27/2022*
Authorized Signature **Date**

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken June 2, 2022
Regular Meeting of the CalOptima Board of Directors

Consent Calendar

13. Appointments to the CalOptima Board of Directors' Whole-Child Model Family Advisory Committee

Contacts

Ladan Khamseh, Executive Director, Operations, (714) 246-8866
Yunkyung Kim, Chief Operating Officer, (714) 246-8408

Recommended Actions

The Whole-Child Model Family Advisory Committee recommends:

1. Reappointment of the following individuals to each serve two-year terms on the Whole-Child Family Advisory Committee, effective upon Board approval:
    a. Kristen Rogers as an Authorized Family Member Representative for a term ending June 30, 2024; and
    b. Maura Byron as a Community Based Organization Representative for a term ending June 30, 2024.

2. New appointment of the following individuals to each serve a two-year term on the Whole-Child Model Family Advisory Committee, effective upon Board approval:
    a. Tracy Jensen as an Authorized Family Member Representative for a term ending June 30, 2024;
    b. Jessica Potterman as an Authorized Family Member Representative for a term ending June 30, 2024;
    c. Lori Sato as an Authorized Family Member Representative to fulfill an existing term ending June 30, 2023;
    d. Erika Jewell as a Consumer Advocate Representative for a term ending June 30, 2024; and
    e. Malissa Watson as a Consumer Advocate Representative to fulfill an existing term ending June 30, 2023.

Background

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

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The WCM FAC is comprised of 11 voting members, seven to nine of whom are designated as family representatives and two to four of whom are designated as community seats representing the interests of children receiving CCS services. While two of the WCM FAC's 11 seats are designated as community seats, WCM FAC candidates representing the community may be considered for up to two additional WCM FAC seats if there are not enough family representative candidates to fill these seats.

Discussion

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

With the fiscal year ending on June 30, 2022, five WCM FAC seats will expire: three Authorized Family Member Representatives and two Community Based Organization/Consumer Advocate Representatives. In addition to the five expiring seats, there are two open seats for an Authorized Family Member Representative and a Consumer Advocate Representative on the committee, respectively, for a total of seven seats.

The WCM FAC Nominations Ad Hoc Subcommittee, composed of WCM FAC committee members Kathleen Lear, Monica Maier, and Sandra Cortez-Schultz, met on April 13, 2022, to evaluate each of the applicants for the impending openings and propose the slate of candidates for the seven vacancies be forwarded to the WCM FAC committee for consideration. However, since the WCM FAC has been unable to approve the recommendations due to lack of quorum, the WCM FAC Nominations Ad Hoc Committee is requesting that the proposed slate of candidates be forwarded to the CalOptima Board for consideration.

The candidates for the open positions are as follows:

Authorized Family Member Representative

Kristen Rogers (Reappointment)

Kristen Rogers is the mother of a teenager who receives CCS services and is currently a CalOptima member. Ms. Rogers is an active volunteer at Children's Health Orange County (CHOC) and has been a member in good standing of the WCM FAC since 2018. Since March 2019, Ms. Rogers has been on the California Children's Services Advisory Group, which meets quarterly in Sacramento, CA, where she represents CalOptima and the WCM FAC. She is currently the WCM FAC Chair and represents the committee at the Family Voices/Lucille Packard Foundation network meetings.

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Tracy Jensen (New Appointment)
Tracy Jensen is the mother of three disabled children, two of whom are CCS and Medi-Cal members since birth. She has a unique perspective about children with disabilities from being a caregiver for her own children. Ms. Jensen would like to help other families by sharing her knowledge, as she is passionate about helping other families deal with the many specialty services that she has had experience with over the last 15 years.

Jessica Potterman (New Appointment)
Jessica Potterman is the mother of a special needs child who currently receives CCS and Medi-Cal services. After 10 years of navigating with her son through CCS, she would like to assist other parents with her knowledge and expertise in this area, as she has made it a point to learn all that she can to advocate on behalf of her child.

Lori Sato (New Appointment)
Jessica Sato is the mother of a special needs child who currently receives CCS and Medi-Cal services. Ms. Sato has learned to navigate new systems to better advocate for children with special needs. She is familiar with medical therapy units for various therapies (physical and occupational) and for special equipment needs by CCS children. Ms. Sato has been inspired by other parents who are knowledgeable about the system to help CSS children get the care they need.

Community-Based Organization Representative

Maura Byron (Reappointment)
Maura Byron is the executive director of the Family Support Network (FSN) and is the parent of a young adult who aged out of CCS in September 2020. At FSN, she assists families of children with complex health care needs to maneuver within the health care system and secure services. In addition, she responds to families' questions and provides peer and emotional support. She has been a past Chair of CalOptima's WCM FAC and has served as a Community-Based Organization Representative since 2020.

Erika Jewell, LCSW, ACM (New Appointment)
Ms. Jewell is the manager of case management and social services at Children's Hospital of Orange County (CHOC) where she works closely with CHOC Health Alliance and other Medi-Cal patients and families to ensure they receive the social services support they need. Ms. Jewell is a licensed clinical social worker who has worked with CCS patients for over 22 years and participates in local stakeholder groups that benefit CCS patients. She also serves on the Tustin Unified School District's Special Education Advisory Committee.

Malissa Watson (New Appointment)
Malissa Watson is the mother of a child that received CCS services and desires to help families navigate CCS and Medi-Cal. Ms. Watson is active in the community, serving on the CHOC Hospital Parent Advisory Committee where she mentors other parents of

children with special needs. She has been an Authorized Family Member of the WCM FAC since its inception in 2018. Ms. Watson's son will be turning 21 in August 2022, and she would like to continue participating on the committee as a Consumer Advocate, which would allow her to use her CCS knowledge to help new members navigate through the system.

Fiscal Impact

Each authorized family member representative appointed to the WCM FAC may receive a stipend of up to $50 per committee meeting attended. Management will include funding for the stipends in the proposed Fiscal Year 2022-23 and future operating budgets. There is no additional fiscal impact related to the recommended actions.

Rationale for Recommendation

As stated in policy AA.1271, the WCM FAC established a Nominations Ad Hoc Subcommittee to review the potential candidates for vacancy on the committee. The WCM FAC Nominations Ad Hoc Subcommittee forwards the recommended slate of candidates to the Board of Directors for consideration as the committee has been unable to achieve quorum in past meetings to approve the slate of candidates.

Concurrence

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

Attachments

None

/s/ Michael Hunn *05/27/2022*
Authorized Signature **Date**

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken June 2, 2022
Regular Meeting of the CalOptima Board of Directors

Consent Calendar
14. Adopt the Proposed CalOptima Board of Directors Meeting Schedule for Fiscal Year 2022-23

Contact
Michael Hunn, Chief Executive Officer, (657) 900-1481

Recommended Action
Adopt the proposed meeting schedule of the CalOptima Board of Directors, the Finance and Audit Committee, and the Quality Assurance Committee for the period of July 1, 2022 through June 30, 2023.

Background
Section 5.2(b)(1) of the CalOptima Bylaws specifies that the Board shall conduct an annual organizational meeting at a regular meeting to be designated in advance by the Board. The annual organizational meeting is scheduled for the June Board meeting each year. At the annual organizational meeting, the Board shall adopt a schedule stating the dates, times, and places of the Board's regular meetings for the following year.

Discussion
The proposed schedule of meetings for the period of July 1, 2022 through June 30, 2023 is as follows:

1. The Board of Directors will meet at 2:00 p.m. on the first Thursday of each month, with the following exceptions:
   - Due to the Independence Day holiday, staff recommends that the Board consider not meeting in July. Should unanticipated items arise during July 2022 that require Board review/approval, the Chief Executive Officer (CEO) will confer with the Board Chair or Vice Chair, and items will be presented for ratification at the following regularly scheduled Board meeting.

   - Due to the New Year's holiday, staff recommends that the Board consider not meeting in January 2023. Should unanticipated items arise during January requiring Board review/approval, the CEO will confer with the Board Chair or Vice Chair, and items will be presented for ratification at the following regularly scheduled Board meeting.

2. The Finance and Audit Committee will meet quarterly at 3:00 p.m. on the third Thursday in the months of September, November, February, and May.

3. The Quality Assurance Committee will meet quarterly at 3:00 p.m. on the second Wednesday in the months of September, December, March, and June.

The meetings of the Board of Directors, the Finance and Audit Committee, and the Quality Assurance Committee are held at the CalOptima offices located at 505 City Parkway West, 1st Floor, Orange, California, unless notice of an alternate location is provided. The proposed Fiscal Year (FY) 2022-23 Board of Directors Meeting Schedule is attached.

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Fiscal Impact

The fiscal impact for FY 2022-23 Board of Directors Meetings is up to $18,000 in per diem costs and mileage reimbursement for certain Board members. Funding is included as part of the proposed CalOptima FY 2022-23 Operating Budget pending Board approval.

Rationale for Recommendation

The recommended action will confirm the Board's meeting schedule for the next fiscal year as required in Section 5.2 of the Bylaws.

Concurrence

Troy R. Szabo, Outside General Counsel, Kennaday Leavitt

Attachment

1. Proposed Schedule of Meetings of the CalOptima Board of Directors, the Finance and Audit Committee, and the Quality Assurance Committee – July 1, 2022 through June 30, 2023

/s/ Michael Hunn *05/27/2022*
Authorized Signature **Date**

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Board of Directors Meeting Schedule
July 1, 2022 – June 30, 2023

All meetings are held at the following location, unless notice of an alternate location is provided:

505 City Parkway West
Orange, California 92868

Board of Directors **Monthly – First Thursday** **Meeting Time: 2:00 p.m.**	**Finance and Audit Committee** **Quarterly – Third Thursday** **Meeting Time: 3:00 p.m.**	**Quality Assurance Committee** **Quarterly – Second Wednesday** **Meeting Time: 3:00 p.m.**
July 2022^		
August 4, 2022		
September 1, 2022	September 15, 2022	September 14, 2022
October 6, 2022		
November 3, 2022	November 17, 2022	
December 1, 2022		December 14, 2022
January 2023^		
February 2, 2023	February 16, 2023	
March 2, 2023		March 8, 2023
April 6, 2023		
May 4, 2023	May 18, 2023	
June 1, 2023[1]		June 14, 2023

^No Regular meeting scheduled
[1] Organizational Meeting

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Financial Summary

April 30, 2022

Board of Directors Meeting

June 2, 2022

Nancy Huang, Chief Financial Officer

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Financial Highlights: April 2022

Month-to-Date					Year-to-Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
891,610	836,436	55,174	6.6%	Member Months	8,694,703	8,413,003	281,700	3.3%
328,069,578	277,987,245	50,082,333	18.0%	Revenues	3,712,079,190	3,103,154,066	608,925,124	19.6%
277,692,040	268,508,729	(9,183,311)	(3.4%)	Medical Expenses	3,395,510,836	3,021,240,058	(374,270,778)	(12.4%)
15,664,544	15,404,362	(260,182)	(1.7%)	Administrative Expenses	124,964,727	148,494,038	23,529,311	15.8%
34,712,994	**(5,925,846)**	**40,638,840**	**685.8%**	**Operating Margin**	**191,603,627**	**(66,580,030)**	**258,183,657**	**387.8%**
(1,999,049)	833,333	(2,832,382)	(339.9%)	Non Operating Income (Loss)	(18,378,201)	8,333,333	(26,711,534)	(320.5%)
32,713,946	**(5,092,513)**	**37,806,459**	**742.4%**	**Change in Net Assets**	**173,225,426**	**(58,246,697)**	**231,472,123**	**397.4%**
84.6%	96.6%	(11.9%)		Medical Loss Ratio	91.5%	97.4%	(5.9%)	
4.8%	5.5%	0.8%		Administrative Loss Ratio	3.4%	4.8%	1.4%	
10.6%	(2.1%)	12.7%		Operating Margin Ratio	5.2%	(2.1%)	7.3%	
100.0%	100.0%			Total Operating	100.0%	100.0%		
84.6%	96.6%	(11.9%)		*MLR (excluding Directed Payments)	90.8%	97.4%	(6.6%)	
4.8%	5.5%	0.8%		*ALR (excluding Directed Payments)	3.6%	4.8%	1.2%	

*CalOptima updated the category of Directed Payments per Department of Health Care Services instructions

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Consolidated Performance: April 2022 (in millions)

April				July-April		
Actual	Budget	Variance		Actual	Budget	Variance
34.9	(5.5)	40.4	Medi-Cal	183.8	(62.8)	246.5
(1.0)	(0.4)	(0.6)	OCC	5.4	(4.1)	9.5
0.2	(0.1)	0.3	OneCare	(1.4)	(0.9)	(0.5)
0.6	0.1	0.5	PACE	3.9	1.3	2.7
(0.0)	(0.0)	0.0	MSSP	(0.0)	(0.1)	0.1
34.7	**(5.9)**	**40.6**	**Operating**	**191.6**	**(66.6)**	**258.2**
(2.0)	0.8	(2.8)	Inv./Rental Inc, MCO tax	(18.4)	8.3	(26.7)
(2.0)	**0.8**	**(2.8)**	**Non-Operating**	**(18.4)**	**8.3**	**(26.7)**
32.7	**(5.1)**	**37.8**	**TOTAL**	**173.2**	**(58.2)**	**231.5**

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FY 2021–22: Management Summary

- Change in Net Assets Surplus or (Deficit)
  - MTD (Apr 2022): $32.7 million, favorable to budget $37.8 million or 742.4%, primarily due to higher than anticipated Calendar Year (CY) 2022 Medi-Cal rates and deferred and delayed services
  - YTD (Jul 2021 – Apr 2022): $173.2 million, favorable to budget $231.5 million or 397.4%
- Enrollment
  - MTD: 891,610 members, favorable to budget 55,174 or 6.6%
  - YTD: 8,694,703 members, favorable to budget 281,700 or 3.3%
- Revenue
  - MTD: $328.1 million, favorable to budget $50.1 million or 18.0% driven by Medi-Cal (MC) line of business (LOB):
    - $51.6 million due to CY 2022 rate update and favorable enrollment
  - YTD: $3.7 billion, favorable to budget $608.9 million or 19.6% driven by MC LOB:
    - $294.1 million of Fiscal Year (FY) 2020 hospital Directed Payments (DP) and Intergovernmental Transfer (IGT) 10
    - $228.4 million due to favorable enrollment and Medi-Cal rates, increase in Long-Term Care (LTC) and pharmacy funding from the Department of Health Care Services (DHCS), and prior year retroactive eligibility changes
    - $113.9 million increase due to the extension of Proposition 56 and updates to the Proposition 56 risk corridor estimates
    - Offset by $32.7 million due to COVID-19 risk corridor

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FY 2021–22: Management Summary (cont.)

- Medical Expenses
  - MTD: $277.7 million, unfavorable to budget $9.2 million or 3.4% driven by MC LOB:
    - Provider Capitation expense unfavorable variance of $21.6 million due primarily to the extension of Proposition 56 and short-term supplemental rate increase due to COVID-19
    - Offset by favorable variance from all other expenses of $11.4 million
  - YTD: $3.4 billion, unfavorable to budget $374.3 million or 12.4% driven by MC LOB:
    - Reinsurance & Other expense unfavorable variance of $276.0 million due to FY 2020 hospital DP
    - Provider Capitation expense unfavorable variance of $161.0 million due primarily to the extension of Proposition 56 and short-term supplemental rate increase due to COVID-19
    - Offset by net favorable variance from all other expenses of $57.7 million

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FY 2021–22: Management Summary (cont.)

- Administrative Expenses
  - MTD: $15.7 million, unfavorable to budget $0.3 million or 1.7%
  - YTD: $125.0 million, favorable to budget $23.5 million or 15.8%
- Non-Operating Income (Loss)
  - MTD: ($2.0) million, unfavorable to budget $2.8 million or 339.9%
    - Unfavorable variance is primarily due to unrealized losses in treasuries, corporate bonds and municipals from the Federal Reserve's responses to inflation and continued increases to interest rates
  - YTD: ($18.4) million, unfavorable to budget $26.7 million or 320.5%

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FY 2021–22: Key Financial Ratios

- Medical Loss Ratio (MLR)
  - MTD: Actual 84.6%, (84.6% excluding DP),Budget 96.6%
  - YTD: Actual 91.5% (90.8% excluding DP), Budget 97.4%
- Administrative Loss Ratio (ALR)
  - MTD: Actual 4.8%, (4.8% excluding DP), Budget 5.5%
  - YTD: Actual 3.4% (3.6% excluding DP), Budget 4.8%
- Balance Sheet Ratios
  - *Current ratio: 1.82
  - Board-designated reserve funds level: 1.66
  - Net position: $1.5 billion, including required Tangible Net Equity (TNE) of $104.3 million

*Current ratio compares current assets to current liabilities. It measures CalOptima's ability to pay short-term obligations.

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Enrollment Summary: April 2022

Month-to-Date					Year-to-Date			
Actual	Budget	$ Variance	% Variance	Enrollment (by Aid Category)	Actual	Budget	$ Variance	% Variance
120,319	117,823	2,496	2.1%	SPD	1,191,325	1,173,587	17,738	1.5%
303,183	293,103	10,080	3.4%	TANF Child	3,008,451	2,960,321	48,130	1.6%
119,304	105,870	13,434	12.7%	TANF Adult	1,139,114	1,066,675	72,439	6.8%
3,154	3,191	(37)	(1.2%)	LTC	31,354	31,910	(556)	(1.7%)
316,531	287,914	28,617	9.9%	MCE	3,031,994	2,895,910	136,084	4.7%
11,681	11,159	522	4.7%	WCM	118,187	111,590	6,597	5.9%
874,172	**819,060**	**55,112**	**6.7%**	**Medi-Cal Total**	**8,520,425**	**8,239,993**	**280,432**	**3.4%**
14,490	**15,154**	**(664)**	**(4.4%)**	**OneCare Connect**	**147,309**	**151,145**	**(3,836)**	**(2.5%)**
2,531	**1,794**	**737**	**41.1%**	**OneCare**	**22,823**	**17,786**	**5,037**	**28.3%**
417	**428**	**(11)**	**(2.6%)**	**PACE**	**4,146**	**4,079**	**67**	**1.6%**
457	**625**	**(168)**	**(26.9%)**	**MSSP***	**1,825**	**2,160**	**(335)**	**(15.5%)**
891,610	**836,436**	**55,174**	**6.6%**	**CalOptima Total**	**8,694,703**	**8,413,003**	**281,700**	**3.3%**

*Note: CalOptima Total does not include MSSP

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Consolidated Revenue & Expenses: April 2022 MTD

	Medi-Cal Classic	Medi-Cal Expansion	Whole Child Model	Total Medi-Cal	OneCare Connect	OneCare	PACE	MSSP	Consolidated
MEMBER MONTHS	545,960	316,531	11,681	874,172	14,490	2,531	417	457	891,610
REVENUES									
Capitation Revenue	153,225,622	$ 120,028,867	$ 21,250,627	$ 294,505,116	$ 26,601,752	$ 3,214,422	$ 3,530,199	$ 218,089	$ 328,069,578
Total Operating Revenue	153,225,622	120,028,867	21,250,627	294,505,116	26,601,752	3,214,422	3,530,199	218,089	328,069,578
MEDICAL EXPENSES									
Provider Capitation	47,858,553	50,985,827	7,980,333	106,824,714	11,115,014	850,551			118,790,279
Facilities	25,441,150	25,775,537	6,345,350	57,562,037	4,274,500	777,673	798,081		63,412,291
Professional Claims	19,908,827	10,274,357	732,168	30,915,352	1,228,861	85,197	572,617		32,802,027
Prescription Drugs	(178,618)	(208,773)	(86,562)	(473,953)	6,459,392	1,023,182	321,449		7,330,069
MLTSS	34,824,927	3,928,008	1,695,952	40,448,888	1,351,662	(17,735)	83,470	28,686	41,894,971
Medical Management	2,786,940	1,924,906	368,269	5,080,115	1,283,296	43,231	847,001	132,848	7,386,491
Quality Incentives	2,767,079	816,598	224,521	3,808,198	213,585		5,213		4,026,996
Reinsurance & Other	1,080,820	605,681	9,030	1,695,531	213,768	2,775	136,842		2,048,916
Total Medical Expenses	134,489,679	94,102,141	17,269,061	245,860,881	26,140,079	2,764,874	2,764,672	161,534	277,692,040
Medical Loss Ratio	87.8%	78.4%	81.3%	83.5%	98.3%	86.0%	78.3%	74.1%	84.6%
GROSS MARGIN	**18,735,943**	**25,926,725**	**3,981,566**	**48,644,235**	**461,673**	**449,548**	**765,527**	**56,555**	**50,377,538**
ADMINISTRATIVE EXPENSES									
Salaries & Benefits				10,367,112	673,271	98,300	112,508	46,937	11,298,127
Professional fees				355,031	11,623	29,227		2,207	398,087
Purchased services				858,757	138,762	17,885	50,760		1,066,165
Printing & Postage				473,581	49,717	6,371	6,422		536,091
Depreciation & Amortization				329,683			370		330,053
Other expenses				1,600,949	2,992	-	5,476	3,891	1,613,308
Indirect cost allocation & Occupancy				(231,252)	578,216	59,743	11,733	4,273	422,713
Total Administrative Expenses				13,753,862	1,454,580	211,526	187,269	57,307	15,664,544
Admin Loss Ratio				4.7%	5.5%	6.6%	5.3%	26.3%	4.8%
INCOME (LOSS) FROM OPERATIONS				34,890,373	(992,907)	238,022	578,259	(752)	34,712,994
INVESTMENT INCOME									(3,137,059)
TOTAL MCO TAX				1,168,299					1,168,299
TOTAL GRANT INCOME				(30,303)					(30,303)
OTHER INCOME				15					15
CHANGE IN NET ASSETS				**$ 36,028,383**	**$ (992,907)**	**$ 238,022**	**$ 578,259**	**$ (752)**	**$ 32,713,946**
BUDGETED CHANGE IN NET ASSETS				(5,482,356)	(435,095)	(50,229)	54,602	(12,768)	(5,092,513)
VARIANCE TO BUDGET - FAV (UNFAV)				$ 41,510,739	$ (557,812)	$ 288,251	$ 523,657	$ 12,016	$ 37,806,459

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Consolidated Revenue & Expenses: April 2022 YTD

	Medi-Cal Classic	Medi-Cal Expansion	Whole Child Model	Total MC	OneCare Connect	OneCare	PACE	MSSP	Consolidated
MEMBER MONTHS	5,370,244	3,031,994	118,187	8,520,425	147,309	22,823	4,146	1,825	8,694,703
REVENUES									
Capitation Revenue	1,722,405,584	$ 1,401,674,237	$ 249,058,292	3,373,138,113	$ 275,320,034	$ 28,912,846	$ 33,869,927	838,270	$ 3,712,079,190
Other Income	-	-	-	-	-	-	-	-	-
Total Operating Revenue	1,722,405,584	1,401,674,237	249,058,292	3,373,138,113	275,320,034	28,912,846	33,869,927	838,270	3,712,079,190
MEDICAL EXPENSES									
Provider Capitation	460,137,487	496,604,505	89,118,637	1,045,860,628	109,998,162	7,933,925		-	1,163,792,715
Facilities	252,511,223	253,024,594	57,110,498	562,646,315	41,375,728	8,923,476	7,351,260	-	620,296,779
Professional Claims	215,645,208	111,942,231	13,498,733	341,086,172	11,279,447	1,023,524	7,692,238	-	361,081,381
Prescription Drugs	128,435,528	175,097,755	40,417,337	343,950,620	63,410,056	9,655,312	3,244,601	-	420,260,589
MLTSS	366,351,702	40,129,639	17,646,288	424,127,629	14,344,627	506,577	452,739	120,624	439,552,196
Medical Management	25,444,698	15,582,268	3,292,916	44,319,882	10,585,801	370,977	8,337,493	467,469	64,081,622
Quality Incentives	17,556,821	9,292,641	818,034	27,667,496	2,216,400		(32,534)	-	29,851,362
Reinsurance & Other	172,517,679	111,027,435	9,910,589	293,455,703	1,863,626	33,119	1,241,746	-	296,594,193
Total Medical Expenses	1,638,600,346	1,212,701,067	231,813,032	3,083,114,445	255,073,846	28,446,909	28,287,542	588,094	3,395,510,836
Medical Loss Ratio	95.1%	86.5%	93.1%	91.4%	92.6%	98.4%	83.5%	70.2%	91.5%
GROSS MARGIN	**83,805,238**	**188,973,170**	**17,245,260**	**290,023,668**	**20,246,188**	**465,937**	**5,582,385**	**250,176**	**316,568,354**
ADMINISTRATIVE EXPENSES									
Salaries & Benefits				73,553,403	6,954,635	790,425	1,071,426	206,483	82,576,373
Professional fees				2,934,503	169,851	298,432	7,251	7,330	3,417,367
Purchased services				9,577,407	1,116,389	120,258	267,570	-	11,081,623
Printing & Postage				3,255,126	848,470	90,400	135,606	-	4,329,601
Depreciation & Amortization				3,681,781			7,513	-	3,689,293
Other expenses				15,924,685	11,963	1,076	72,516	19,952	16,030,192
Indirect cost allocation & Occupancy				(2,659,746)	5,782,159	597,432	102,418	18,013	3,840,276
Total Administrative Expenses				106,267,160	14,883,466	1,898,023	1,664,301	251,778	124,964,727
Admin Loss Ratio				3.2%	5.4%	6.6%	4.9%	30.0%	3.4%
INCOME (LOSS) FROM OPERATIONS				183,756,508	5,362,722	(1,432,086)	3,918,084	(1,601)	191,603,627
INVESTMENT INCOME									(20,907,197)
TOTAL MCO TAX				2,580,779					2,580,779
TOTAL GRANT INCOME				(60,606)					(60,606)
OTHER INCOME				8,823					8,823
CHANGE IN NET ASSETS				**$ 186,285,504**	**$ 5,362,722**	**$ (1,432,086)**	**$ 3,918,084**	**$ (1,601)**	**$ 173,225,426**
BUDGETED CHANGE IN NET ASSETS				(62,762,174)	(4,128,099)	(900,420)	1,267,640	(56,977)	(58,246,697)
VARIANCE TO BUDGET - FAV (UNFAV)				$ 249,047,678	$ 9,490,821	$ (531,666)	$ 2,650,444	$ 55,376	$ 231,472,123

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Balance Sheet: As of April 2022

ASSETS		LIABILITIES & NET POSITION	
Current Assets		**Current Liabilities**	
Operating Cash	$715,670,672	Accounts Payable	$27,014,466
Short-term Investments	1,024,936,250	Medical Claims liability	817,912,791
Capitation receivable	149,990,359	Accrued Payroll Liabilities	15,988,232
Receivables - Other	47,843,685	Deferred Revenue	34,205,718
Prepaid expenses	13,245,411	Deferred Lease Obligations	98,147
		Capitation and Withholds	179,741,452
Total Current Assets	**1,951,686,378**	**Total Current Liabilities**	**1,074,960,806**
Capital Assets			
Furniture & Equipment	46,311,601		
Building/Leasehold Improvements	9,372,830		
505 City Parkway West	52,236,708		
	107,921,138		
Less: accumulated depreciation	(63,128,460)		
Capital assets, net	44,792,678	Other (than pensions) post employment benefits liability	32,060,789
Other Assets		Net Pension Liabilities	30,592,204
Restricted Deposit & Other	300,000	Bldg 505 Development Rights	-
Homeless Health Reserve	41,336,739		
Board-designated assets:		**TOTAL LIABILITIES**	**1,137,613,799**
Cash and Cash Equivalents	673,169		
Investments	570,201,900	**Deferred Inflows**	
Total Board-designated Assets	570,875,068	Excess Earnings	344,198
		OPEB 75 Difference in Experience	536,000
Total Other Assets	612,511,807	Change in Assumptions	2,709,945
		OPEB Changes in Assumptions	773,000
TOTAL ASSETS	**2,608,990,864**	**Net Position**	
		TNE	104,291,452
Deferred Outflows		Funds in Excess of TNE	1,377,714,766
Contributions	1,508,025	**TOTAL NET POSITION**	1,482,006,219
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	**2,623,983,161**	**TOTAL LIABILITIES, DEFERRED INFLOWS & NET POSITION**	**2,623,983,161**

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Board Designated Reserve and TNE Analysis: As of April 2022

Type	Reserve Name	Market Value	Benchmark		Variance	
			Low	High	Mkt - Low	Mkt - High
	Tier 1 - Payden & Rygel	232,241,723				
	Tier 1 - MetLife	230,771,229				
Board-designated Reserve		463,012,952	377,150,951	583,483,410	85,862,001	(120,470,457)
	Tier 2 - Payden & Rygel	54,051,285				
	Tier 2 - MetLife	53,810,831				
TNE Requirement		107,862,116	104,291,452	104,291,452	3,570,664	3,570,664
	Consolidated:	**570,875,068**	**481,442,403**	**687,774,862**	**89,432,665**	**(116,899,794)**
	Current reserve level	*1.66*	*1.40*	*2.00*		

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Net Assets Analysis: As of April 2022

Category	Item Description	Resource Committed	Amount (millions)	%
	Total Net Position @ 04/30/2022:		**$ 1,482.0**	**100.0%**
Resources Assigned	Board Designated Reserve		**$ 570.9**	**38.5%**
	Capital Assets, net of depreciation		**$ 44.8**	**3.0%**
Resources Allocated, not yet Spent	Homeless Health Initiative*	100.0	26.3	1.8%
	Intergovernmental Transfers (IGT)	80.8	24.4	1.6%
	Mind OC Grant	1.0	-	0.0%
	CalFresh Outreach Strategy	2.0	2.0	0.1%
	Digital Transformation and Workplace Modernization	100.0	100.0	6.7%
	Coalition of Orange County Community Health Centers Grant	50.0	50.0	3.4%
	Subtotal:	**333.8**	**$ 202.7**	**13.7%**
Resources Available for New Initiatives	Homeless Health Initiative		41.3	
	Intergovernmental Transfers (IGT)		26.7	
	Unallocated/Unassigned		595.6	
	Subtotal:		**$ 663.6**	**44.8%**

*See Summary of Homeless Health Initiatives and Allocated Funds for list of Board approved initiatives

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Homeless Health Initiative and Allocated Funds: As of April 2022

			Amount
Program Commitment		**$**	**100,000,000**
Funds Allocation, approved initiatives:			
Enhanced Medi-Cal Services at the Be Well OC Regional Mental Health and Wellness Campus	11,400,000		
Recuperative Care	8,250,000		
Medical Respite	250,000		
Day Habilitation (County for HomeKey)	2,500,000		
Clinical Field Team Start-up & Federal Qualified Health Center (FQHC)	1,600,000		
CalOptima Homeless Response Team	6,000,000		
Homeless Coordination at Hospitals	10,000,000		
CalOptima Days & QI Program - Homeless Clinic Access Program or HCAP	1,693,261		
FQHC (Community Health Center) Expansion and HHI Support	570,000		
HCAP Expansion for Telehealth and CFT On Call Days	1,000,000		
Vaccination Intervention and Member Incentive Strategy	400,000		
Street Medicine	8,000,000		
Outreach and Engagement Team	7,000,000		
Funds Allocation Total		**$**	**58,663,261**
Program Commitment Balance, available for new initiatives*		**$**	**41,336,739**

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

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Our Mission

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

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UNAUDITED FINANCIAL STATEMENTS

April 2022

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CalOptima - Consolidated
Financial Highlights
For the Ten Months Ended April 30, 2022

Month-to-Date					Year-to-Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
891,610	836,436	55,174	6.6%	Member Months	8,694,703	8,413,003	281,700	3.3%
328,069,578	277,987,245	50,082,333	18.0%	Revenues	3,712,079,190	3,103,154,066	608,925,124	19.6%
277,692,040	268,508,729	(9,183,311)	(3.4%)	Medical Expenses	3,395,510,836	3,021,240,058	(374,270,778)	(12.4%)
15,664,544	15,404,362	(260,182)	(1.7%)	Administrative Expenses	124,964,727	148,494,038	23,529,311	15.8%
34,712,994	**(5,925,846)**	**40,638,840**	**685.8%**	**Operating Margin**	**191,603,627**	**(66,580,030)**	**258,183,657**	**387.8%**
(1,999,049)	833,333	(2,832,382)	(339.9%)	Non Operating Income (Loss)	(18,378,201)	8,333,333	(26,711,534)	(320.5%)
32,713,946	**(5,092,513)**	**37,806,459**	**742.4%**	**Change in Net Assets**	**173,225,426**	**(58,246,697)**	**231,472,123**	**397.4%**
84.6%	96.6%	(11.9%)		Medical Loss Ratio	91.5%	97.4%	(5.9%)	
4.8%	5.5%	0.8%		Administrative Loss Ratio	3.4%	4.8%	1.4%	
10.6%	(2.1%)	12.7%		Operating Margin Ratio	5.2%	(2.1%)	7.3%	
100.0%	100.0%			Total Operating	100.0%	100.0%		
84.6%	96.6%	(11.9%)		*MLR (excluding Directed Payments)	90.8%	97.4%	(6.6%)	
4.8%	5.5%	0.8%		*ALR (excluding Directed Payments)	3.6%	4.8%	1.2%	

*CalOptima updated the category of Directed Payments per Department of Health Care Services instructions

CalOptima
Financial Dashboard
For the Ten Months Ended April 30, 2022

MONTH - TO - DATE

Enrollment

	Actual	Budget	Fav / (Unfav)	
Medi-Cal	874,172	819,060	55,112	6.7%
OneCare Connect	14,490	15,154	(664)	(4.4%)
OneCare	2,531	1,794	737	41.1%
PACE	417	428	(11)	(2.6%)
MSSP	457	625	(168)	(26.9%)
Total*	891,610	836,436	55,174	6.6%

Change in Net Assets (000)

	Actual	Budget	Fav / (Unfav)	
Medi-Cal	$ 36,028	$ (5,482)	$ 41,510	757.2%
OneCare Connect	(993)	(435)	(558)	(128.3%)
OneCare	238	(50)	288	576.0%
PACE	578	55	523	950.9%
MSSP	(1)	(13)	12	92.3%
505 Bldg.	-	-	-	0.0%
Investment Income	(3,137)	833	(3,970)	(476.6%)
Total	$ 32,713	$ (5,092)	$ 37,805	742.4%

MLR

	Actual	Budget	% Point Var
Medi-Cal	83.5%	96.9%	(13.5)
OneCare Connect	98.3%	94.8%	3.5
OneCare	86.0%	94.1%	(8.1)

Administrative Cost (000)

	Actual	Budget	Fav / (Unfav)	
Medi-Cal	$ 13,754	$ 12,920	$ (833)	(6.5%)
OneCare Connect	1,455	1,951	496	25.4%
OneCare	212	180	(32)	(17.6%)
PACE	187	262	75	28.5%
MSSP	57	91	34	37.2%
Total	$ 15,665	$ 15,404	$ (260)	(1.7%)

Total FTE's Month

	Actual	Budget	Fav / (Unfav)
Medi-Cal	1,158	1,205	47
OneCare Connect	180	210	29
OneCare	10	9	(1)
PACE	93	117	24
MSSP	16	18	2
Total	1,457	1,558	101

MM per FTE

	Actual	Budget	Fav / (Unfav)
Medi-Cal	755	680	(75)
OneCare Connect	80	72	(8)
OneCare	244	193	(51)
PACE	4	4	(1)
MSSP	29	35	5
Consolidated	612	537	(75)

YEAR - TO - DATE

Year To Date Enrollment

	Actual	Budget	Fav / (Unfav)	
Medi-Cal	8,520,425	8,239,993	280,432	3.4%
OneCare Connect	147,309	151,145	(3,836)	(2.5%)
OneCare	22,823	17,786	5,037	28.3%
PACE	4,146	4,079	67	1.6%
MSSP	1,825	2,160	(335)	(15.5%)
Total*	8,694,703	8,413,003	281,700	3.3%

Change in Net Assets (000)

	Actual	Budget	Fav / (Unfav)	
Medi-Cal	$ 186,286	$ (62,762)	$ 249,048	396.8%
OneCare Connect	5,363	(4,128)	9,491	229.9%
OneCare	(1,432)	(900)	(532)	(59.1%)
PACE	3,918	1,268	2,650	209.0%
MSSP	(2)	(57)	55	96.5%
505 Bldg.	-	-	-	0.0%
Investment Income	(20,907)	8,333	(29,240)	(350.9%)
Total	$ 173,226	$ (58,246)	$ 231,472	397.4%

MLR

	Actual	Budget	% Point Var
Medi-Cal	91.4%	97.8%	(6.4)
OneCare Connect	92.6%	94.8%	(2.1)
OneCare	98.4%	95.7%	2.7

Administrative Cost (000)

	Actual	Budget	Fav / (Unfav)	
Medi-Cal	$ 106,267	$ 125,193	$ 18,925	15.1%
OneCare Connect	14,883	18,833	3,949	21.0%
OneCare	1,898	1,796	(102)	(5.7%)
PACE	1,664	2,346	681	29.0%
MSSP	252	327	75	22.9%
Total	$ 124,965	$ 148,494	$ 23,529	15.8%

Total FTE's YTD

	Actual	Budget	Fav / (Unfav)
Medi-Cal	10,872	12,125	1,253
OneCare Connect	1,846	2,096	249
OneCare	100	93	(7)
PACE	918	1,144	226
MSSP	65	72	7
Total	13,801	15,530	1,728

MM per FTE

	Actual	Budget	Fav / (Unfav)
Medi-Cal	784	680	(104)
OneCare Connect	80	72	(8)
OneCare	229	191	(38)
PACE	5	4	(1)
MSSP	28	30	2
Consolidated	**630**	**542**	(88)

Note:* Total membership does not include MSSP

CalOptima - Consolidated
Statement of Revenues and Expenses
For the One Month Ended April 30, 2022

	Actual		Budget		Variance	
	$	PMPM	$	PMPM	$	PMPM
MEMBER MONTHS	891,610		836,436		55,174	
REVENUE						
Medi-Cal	$ 294,505,116	$ 336.90	$ 243,059,893	$ 296.75	$ 51,445,223	$ 40.15
OneCare Connect	26,601,752	1,835.87	28,955,578	1,910.75	(2,353,826)	(74.88)
OneCare	3,214,422	1,270.02	2,201,901	1,227.37	1,012,521	42.65
PACE	3,530,199	8,465.71	3,491,142	8,156.87	39,057	308.84
MSSP	218,089	477.22	278,731	445.97	(60,642)	31.25
Total Operating Revenue	328,069,578	367.95	277,987,245	332.35	50,082,333	35.60
MEDICAL EXPENSES						
Medi-Cal	245,860,881	281.25	235,621,805	287.67	(10,239,076)	6.42
OneCare Connect	26,140,079	1,804.01	27,439,865	1,810.73	1,299,786	6.72
OneCare	2,764,874	1,092.40	2,072,257	1,155.10	(692,617)	62.70
PACE	2,764,672	6,629.91	3,174,501	7,417.06	409,829	787.15
MSSP	161,534	353.47	200,301	320.48	38,767	(32.99)
Total Medical Expenses	277,692,040	311.45	268,508,729	321.02	(9,183,311)	9.57
GROSS MARGIN	50,377,538	56.50	9,478,516	11.33	40,899,022	45.17
ADMINISTRATIVE EXPENSES						
Salaries and benefits	11,298,127	12.67	9,576,413	11.45	(1,721,714)	(1.22)
Professional fees	398,087	0.45	881,646	1.05	483,559	0.60
Purchased services	1,066,165	1.20	1,215,789	1.45	149,624	0.25
Printing & Postage	536,091	0.60	639,498	0.76	103,407	0.16
Depreciation & Amortization	330,053	0.37	492,900	0.59	162,847	0.22
Other expenses	1,613,308	1.81	2,127,932	2.54	514,624	0.73
Indirect cost allocation & Occupancy expense	422,713	0.47	470,184	0.56	47,471	0.09
Total Administrative Expenses	15,664,544	17.57	15,404,362	18.42	(260,182)	0.85
INCOME (LOSS) FROM OPERATIONS	34,712,994	38.93	(5,925,846)	(7.08)	40,638,840	46.01
INVESTMENT INCOME						
Interest income	1,017,465	1.14	833,333	1.00	184,132	0.14
Realized gain/(loss) on investments	(161,537)	(0.18)	-	-	(161,537)	(0.18)
Unrealized gain/(loss) on investments	(3,992,987)	(4.48)	-	-	(3,992,987)	(4.48)
Total Investment Income	(3,137,059)	(3.52)	833,333	1.00	(3,970,392)	(4.52)
TOTAL MCO TAX	1,168,299	1.31	-	-	1,168,299	1.31
TOTAL GRANT INCOME	(30,303)	(0.03)	-	-	(30,303)	(0.03)
OTHER INCOME	15	-	-	-	15	-
CHANGE IN NET ASSETS	**32,713,946**	**36.69**	**(5,092,513)**	**(6.09)**	**37,806,459**	**42.78**
MEDICAL LOSS RATIO	**84.6%**		**96.6%**		**(11.9%)**	
ADMINISTRATIVE LOSS RATIO	**4.8%**		**5.5%**		**0.8%**	

CalOptima - Consolidated
Statement of Revenues and Expenses
For the Ten Months Ended April 30, 2022

	Actual		Budget		Variance	
	$	PMPM	$	PMPM	$	PMPM
MEMBER MONTHS	8,694,703		8,413,003		281,700	
REVENUE						
Medi-Cal	$ 3,373,138,113	$ 395.89	$ 2,766,200,411	$ 335.70	$ 606,937,702	$ 60.19
OneCare Connect	275,320,034	1,869.00	281,843,889	1,864.73	(6,523,855)	4.27
OneCare	28,912,846	1,266.83	21,000,004	1,180.70	7,912,842	86.13
PACE	33,869,927	8,169.30	33,146,120	8,126.04	723,807	43.26
MSSP	838,270	459.33	963,642	446.13	(125,372)	13.20
Total Operating Revenue	3,712,079,190	426.94	3,103,154,066	368.85	608,925,124	58.09
MEDICAL EXPENSES						
Medi-Cal	3,083,114,445	361.85	2,703,769,693	328.13	(379,344,752)	(33.72)
OneCare Connect	255,073,846	1,731.56	267,139,067	1,767.44	12,065,221	35.88
OneCare	28,446,909	1,246.41	20,104,748	1,130.37	(8,342,161)	(116.04)
PACE	28,287,542	6,822.85	29,532,836	7,240.21	1,245,294	417.36
MSSP	588,094	322.24	693,714	321.16	105,620	(1.08)
Total Medical Expenses	3,395,510,836	390.53	3,021,240,058	359.12	(374,270,778)	(31.41)
GROSS MARGIN	316,568,354	36.41	81,914,008	9.73	234,654,346	26.68
ADMINISTRATIVE EXPENSES						
Salaries and benefits	82,576,373	9.50	94,012,086	11.17	11,435,713	1.67
Professional fees	3,417,367	0.39	7,312,972	0.87	3,895,605	0.48
Purchased services	11,081,623	1.27	12,646,425	1.50	1,564,802	0.23
Printing & Postage	4,329,601	0.50	5,734,980	0.68	1,405,379	0.18
Depreciation & Amortization	3,689,293	0.42	4,929,000	0.59	1,239,707	0.17
Other expenses	16,030,192	1.84	19,406,735	2.31	3,376,543	0.47
Indirect cost allocation & Occupancy expense	3,840,276	0.44	4,451,840	0.53	611,564	0.09
Total Administrative Expenses	124,964,727	14.37	148,494,038	17.65	23,529,311	3.28
INCOME (LOSS) FROM OPERATIONS	191,603,627	22.04	(66,580,030)	(7.91)	258,183,657	29.95
INVESTMENT INCOME						
Interest income	6,845,415	0.79	8,333,333	0.99	(1,487,918)	(0.20)
Realized gain/(loss) on investments	(1,233,021)	(0.14)	-	-	(1,233,021)	(0.14)
Unrealized gain/(loss) on investments	(26,519,591)	(3.05)	-	-	(26,519,591)	(3.05)
Total Investment Income	(20,907,197)	(2.40)	8,333,333	0.99	(29,240,530)	(3.39)
TOTAL MCO TAX	2,580,779	0.30	-	-	2,580,779	0.30
TOTAL GRANT INCOME	(60,606)	(0.01)	-	-	(60,606)	(0.01)
OTHER INCOME	8,823	-	-	-	8,823	-
CHANGE IN NET ASSETS	**173,225,426**	**19.92**	**(58,246,697)**	**(6.92)**	**231,472,123**	**26.84**
MEDICAL LOSS RATIO	**91.5%**		**97.4%**		**(5.9%)**	
ADMINISTRATIVE LOSS RATIO	**3.4%**		**4.8%**		**1.4%**	

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CalOptima - Consolidated - Month to Date
Statement of Revenues and Expenses by LOB
For the One Month Ended April 30, 2022

	Medi-Cal Classic	Medi-Cal Expansion	Whole Child Model	Total Medi-Cal	OneCare Connect	OneCare	PACE	MSSP	Consolidated
MEMBER MONTHS	545,960	316,531	11,681	874,172	14,490	2,531	417	457	891,610
REVENUES									
Capitation Revenue	153,225,622	$ 120,028,867	$ 21,250,627	$ 294,505,116	$ 26,601,752	$ 3,214,422	$ 3,530,199	$ 218,089	$ 328,069,578
Total Operating Revenue	153,225,622	120,028,867	21,250,627	294,505,116	26,601,752	3,214,422	3,530,199	218,089	328,069,578
MEDICAL EXPENSES									
Provider Capitation	47,858,553	50,985,827	7,980,333	106,824,714	11,115,014	850,551			118,790,279
Facilities	25,441,150	25,775,537	6,345,350	57,562,037	4,274,500	777,673	798,081		63,412,291
Professional Claims	19,908,827	10,274,357	732,168	30,915,352	1,228,861	85,197	572,617		32,802,027
Prescription Drugs	(178,618)	(208,773)	(86,562)	(473,953)	6,459,392	1,023,182	321,449		7,330,069
MLTSS	34,824,927	3,928,008	1,695,952	40,448,888	1,351,662	(17,735)	83,470	28,686	41,894,971
Medical Management	2,786,940	1,924,906	368,269	5,080,115	1,283,296	43,231	847,001	132,848	7,386,491
Quality Incentives	2,767,079	816,598	224,521	3,808,198	213,585		5,213		4,026,996
Reinsurance & Other	1,080,820	605,681	9,030	1,695,531	213,768	2,775	136,842		2,048,916
Total Medical Expenses	134,489,679	94,102,141	17,269,061	245,860,881	26,140,079	2,764,874	2,764,672	161,534	277,692,040
Medical Loss Ratio	87.8%	78.4%	81.3%	83.5%	98.3%	86.0%	78.3%	74.1%	84.6%
GROSS MARGIN	**18,735,943**	**25,926,725**	**3,981,566**	**48,644,235**	**461,673**	**449,548**	**765,527**	**56,555**	**50,377,538**
ADMINISTRATIVE EXPENSES									
Salaries & Benefits	10,367,112	673,271	98,300	112,508	46,937	11,298,127			
Professional fees	355,031	11,623	29,227		2,207	398,087			
Purchased services	858,757	138,762	17,885	50,760		1,066,165			
Printing & Postage	473,581	49,717	6,371	6,422		536,091			
Depreciation & Amortization	329,683			370		330,053			
Other expenses	1,600,949	2,992	-	5,476	3,891	1,613,308			
Indirect cost allocation & Occupancy	(231,252)	578,216	59,743	11,733	4,273	422,713			
Total Administrative Expenses	13,753,862	1,454,580	211,526	187,269	57,307	15,664,544			
Admin Loss Ratio	4.7%	5.5%	6.6%	5.3%	26.3%	4.8%			
INCOME (LOSS) FROM OPERATIONS	34,890,373	(992,907)	238,022	578,259	(752)	34,712,994			
INVESTMENT INCOME						(3,137,059)			
TOTAL MCO TAX	1,168,299					1,168,299			
TOTAL GRANT INCOME	(30,303)					(30,303)			
OTHER INCOME	15					15			
CHANGE IN NET ASSETS	**$ 36,028,383**	**$ (992,907)**	**$ 238,022**	**$ 578,259**	**$ (752)**	**$ 32,713,946**			
BUDGETED CHANGE IN NET ASSETS	(5,482,356)	(435,095)	(50,229)	54,602	(12,768)	(5,092,513)			
VARIANCE TO BUDGET - FAV (UNFAV)	$ 41,510,739	$ (557,812)	$ 288,251	$ 523,657	$ 12,016	$ 37,806,459			

Note:* Total membership does not include MSSP

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CalOptima - Consolidated - Year to Date
Statement of Revenues and Expenses by LOB
For the Ten Months Ended April 30, 2022

	Medi-Cal Classic	Medi-Cal Expansion	Whole Child Model	Total MC	OneCare Connect	OneCare	PACE	MSSP	Consolidated
MEMBER MONTHS	5,370,244	3,031,994	118,187	8,520,425	147,309	22,823	4,146	1,825	8,694,703
REVENUES									
Capitation Revenue	1,722,405,584	$ 1,401,674,237	$ 249,058,292	3,373,138,113	$ 275,320,034	$ 28,912,846	$ 33,869,927	838,270	$ 3,712,079,190
Other Income	-	-	-	-	-	-	-	-	-
Total Operating Revenue	1,722,405,584	1,401,674,237	249,058,292	3,373,138,113	275,320,034	28,912,846	33,869,927	838,270	3,712,079,190
MEDICAL EXPENSES									
Provider Capitation	460,137,487	496,604,505	89,118,637	1,045,860,628	109,998,162	7,933,925		-	1,163,792,715
Facilities	252,511,223	253,024,594	57,110,498	562,646,315	41,375,728	8,923,476	7,351,260	-	620,296,779
Professional Claims	215,645,208	111,942,231	13,498,733	341,086,172	11,279,447	1,023,524	7,692,238	-	361,081,381
Prescription Drugs	128,435,528	175,097,755	40,417,337	343,950,620	63,410,056	9,655,312	3,244,601	-	420,260,589
MLTSS	366,351,702	40,129,639	17,646,288	424,127,629	14,344,627	506,577	452,739	120,624	439,552,196
Medical Management	25,444,698	15,582,268	3,292,916	44,319,882	10,585,801	370,977	8,337,493	467,469	64,081,622
Quality Incentives	17,556,821	9,292,641	818,034	27,667,496	2,216,400		(32,534)	-	29,851,362
Reinsurance & Other	172,517,679	111,027,435	9,910,589	293,455,703	1,863,626	33,119	1,241,746	-	296,594,193
Total Medical Expenses	1,638,600,346	1,212,701,067	231,813,032	3,083,114,445	255,073,846	28,446,909	28,287,542	588,094	3,395,510,836
Medical Loss Ratio	95.1%	86.5%	93.1%	91.4%	92.6%	98.4%	83.5%	70.2%	91.5%
GROSS MARGIN	**83,805,238**	**188,973,170**	**17,245,260**	**290,023,668**	**20,246,188**	**465,937**	**5,582,385**	**250,176**	**316,568,354**
ADMINISTRATIVE EXPENSES									
Salaries & Benefits	73,553,403	6,954,635	790,425	1,071,426	206,483	82,576,373			
Professional fees	2,934,503	169,851	298,432	7,251	7,330	3,417,367			
Purchased services	9,577,407	1,116,389	120,258	267,570	-	11,081,623			
Printing & Postage	3,255,126	848,470	90,400	135,606	-	4,329,601			
Depreciation & Amortization	3,681,781			7,513	-	3,689,293			
Other expenses	15,924,685	11,963	1,076	72,516	19,952	16,030,192			
Indirect cost allocation & Occupancy	(2,659,746)	5,782,159	597,432	102,418	18,013	3,840,276			
Total Administrative Expenses	106,267,160	14,883,466	1,898,023	1,664,301	251,778	124,964,727			
Admin Loss Ratio	3.2%	5.4%	6.6%	4.9%	30.0%	3.4%			
INCOME (LOSS) FROM OPERATIONS	183,756,508	5,362,722	(1,432,086)	3,918,084	(1,601)	191,603,627			
INVESTMENT INCOME						(20,907,197)			
TOTAL MCO TAX	2,580,779					2,580,779			
TOTAL GRANT INCOME	(60,606)					(60,606)			
OTHER INCOME	8,823					8,823			
CHANGE IN NET ASSETS	**$ 186,285,504**	**$ 5,362,722**	**$ (1,432,086)**	**$ 3,918,084**	**$ (1,601)**	**$ 173,225,426**			
BUDGETED CHANGE IN NET ASSETS	(62,762,174)	(4,128,099)	(900,420)	1,267,640	(56,977)	(58,246,697)			
VARIANCE TO BUDGET - FAV (UNFAV)	$ 249,047,678	$ 9,490,821	$ (531,666)	$ 2,650,444	$ 55,376	$ 231,472,123			

Note:* Total membership does not include MSSP

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April 30, 2022 Unaudited Financial Statements

SUMMARY MONTHLY RESULTS:

- Change in Net Assets is $32.7 million, $37.8 million favorable to budget
- Operating surplus is $34.7 million, with a deficit in non-operating income of $2.0 million

YEAR TO DATE RESULTS:

- Change in Net Assets is $173.2 million, $231.5 million favorable to budget
- Operating surplus is $191.6 million, with a deficit in non-operating income of $18.4 million

Change in Net Assets by Line of Business (LOB) ($ millions):

April				July-April		
Actual	Budget	Variance		Actual	Budget	Variance
34.9	(5.5)	40.4	Medi-Cal	183.8	(62.8)	246.5
(1.0)	(0.4)	(0.6)	OCC	5.4	(4.1)	9.5
0.2	(0.1)	0.3	OneCare	(1.4)	(0.9)	(0.5)
0.6	0.1	0.5	PACE	3.9	1.3	2.7
(0.0)	(0.0)	0.0	MSSP	(0.0)	(0.1)	0.1
34.7	**(5.9)**	**40.6**	**Operating**	**191.6**	**(66.6)**	**258.2**
(2.0)	0.8	(2.8)	Inv./Rental Inc, MCO tax	(18.4)	8.3	(26.7)
(2.0)	**0.8**	**(2.8)**	**Non-Operating**	**(18.4)**	**8.3**	**(26.7)**
32.7	**(5.1)**	**37.8**	**TOTAL**	**173.2**	**(58.2)**	**231.5**

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CalOptima - Consolidated
Enrollment Summary
For the Ten Months Ended April 30, 2022

Month-to-Date Actual	Budget	$ Variance	% Variance	Enrollment (by Aid Category)	Year-to-Date Actual	Budget	$ Variance	% Variance
120,319	117,823	2,496	2.1%	SPD	1,191,325	1,173,587	17,738	1.5%
303,183	293,103	10,080	3.4%	TANF Child	3,008,451	2,960,321	48,130	1.6%
119,304	105,870	13,434	12.7%	TANF Adult	1,139,114	1,066,675	72,439	6.8%
3,154	3,191	(37)	(1.2%)	LTC	31,354	31,910	(556)	(1.7%)
316,531	287,914	28,617	9.9%	MCE	3,031,994	2,895,910	136,084	4.7%
11,681	11,159	522	4.7%	WCM	118,187	111,590	6,597	5.9%
874,172	**819,060**	**55,112**	**6.7%**	**Medi-Cal Total**	**8,520,425**	**8,239,993**	**280,432**	**3.4%**
14,490	**15,154**	**(664)**	**(4.4%)**	**OneCare Connect**	**147,309**	**151,145**	**(3,836)**	**(2.5%)**
2,531	**1,794**	**737**	**41.1%**	**OneCare**	**22,823**	**17,786**	**5,037**	**28.3%**
417	**428**	**(11)**	**(2.6%)**	**PACE**	**4,146**	**4,079**	**67**	**1.6%**
457	**625**	**(168)**	**(26.9%)**	**MSSP***	**1,825**	**2,160**	**(335)**	**(15.5%)**
891,610	**836,436**	**55,174**	**6.6%**	**CalOptima Total**	**8,694,703**	**8,413,003**	**281,700**	**3.3%**

				Enrollment (by Network)				
204,523	190,183	14,340	7.5%	HMO	1,984,606	1,910,466	74,140	3.9%
233,291	225,039	8,252	3.7%	PHC	2,302,677	2,271,409	31,268	1.4%
214,491	200,482	14,009	7.0%	Shared Risk Group	2,084,407	2,023,606	60,801	3.0%
221,867	203,356	18,511	9.1%	Fee for Service	2,148,735	2,034,512	114,223	5.6%
874,172	**819,060**	**55,112**	**6.7%**	**Medi-Cal Total**	**8,520,425**	**8,239,993**	**280,432**	**3.4%**
14,490	**15,154**	**(664)**	**(4.4%)**	**OneCare Connect**	**147,309**	**151,145**	**(3,836)**	**(2.5%)**
2,531	**1,794**	**737**	**41.1%**	**OneCare**	**22,823**	**17,786**	**5,037**	**28.3%**
417	**428**	**(11)**	**(2.6%)**	**PACE**	**4,146**	**4,079**	**67**	**1.6%**
457	**625**	**(168)**	**-26.9%**	**MSSP**	**1,825**	**2,160**	**(335)**	**-15.5%**
891,610	**836,436**	**55,174**	**6.6%**	**CalOptima Total**	**8,694,703**	**8,413,003**	**281,700**	**3.3%**

*Note: CalOptima Total does not include MSSP

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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	10,796	10,750	10,821	10,837	10,841	10,887	10,843	10,879			108,185	108,109	76
TANF Child	57,684	57,453	57,592	57,944	58,108	58,236	58,526	58,795	58,905	59,086			582,329	568,714	13,615
TANF Adult	33,827	34,099	34,339	34,622	35,046	35,411	35,758	36,052	36,426	36,751			352,331	331,038	21,293
LTC		1	3	1		1	1		2	2			11		11
MCE	88,797	89,334	90,159	91,017	91,516	92,159	93,225	93,841	94,771	95,797			920,616	882,505	38,111
WCM	2,114	2,193	2,177	2,133	2,130	2,143	2,103	1,986	2,147	2,008			21,134	20,100	1,034
Total	**193,181**	**193,852**	**195,066**	**196,467**	**197,621**	**198,787**	**200,454**	**201,561**	**203,094**	**204,523**			**1,984,606**	**1,910,466**	**74,140**
PHCs															
SPD	6,896	6,819	6,942	6,915	6,953	6,926	6,861	6,880	6,894	6,846			68,932	71,206	(2,274)
TANF Child	155,214	154,985	155,440	155,771	156,156	156,251	156,692	157,039	156,984	157,528			1,562,060	1,542,781	19,279
TANF Adult	14,006	14,054	14,197	14,390	14,667	14,851	14,985	15,115	15,270	15,437			146,972	137,810	9,162
LTC		2	1			1							4		4
MCE	44,256	44,359	44,580	44,754	44,973	45,241	45,668	45,753	46,013	46,253			451,850	450,892	958
WCM	7,304	7,368	7,236	7,322	7,178	7,262	7,246	7,037	7,679	7,227			72,859	68,720	4,139
Total	**227,676**	**227,587**	**228,396**	**229,152**	**229,927**	**230,532**	**231,452**	**231,824**	**232,840**	**233,291**			**2,302,677**	**2,271,409**	**31,268**
Shared Risk Groups															
SPD	10,063	10,104	10,074	10,003	10,122	10,095	10,096	10,086	10,077	10,099			100,819	103,307	(2,488)
TANF Child	59,085	58,837	58,641	58,541	58,523	58,347	58,363	58,200	58,279	58,269			585,085	594,012	(8,927)
TANF Adult	33,013	33,123	33,374	33,745	34,109	34,482	34,824	35,120	35,551	35,818			343,159	330,812	12,347
LTC	1	1	1		1			1		3			8		8
MCE	99,994	100,643	101,666	102,780	103,620	104,418	105,563	106,367	107,480	108,934			1,041,465	981,315	60,150
WCM	1,373	1,368	1,394	1,400	1,395	1,394	1,423	1,363	1,393	1,368			13,871	14,160	(289)
Total	**203,529**	**204,076**	**205,150**	**206,469**	**207,770**	**208,736**	**210,269**	**211,137**	**212,780**	**214,491**			**2,084,407**	**2,023,606**	**60,801**
Fee for Service (Dual)															
SPD	79,829	80,117	80,139	80,438	80,738	80,494	81,326	81,148	81,219	81,291			806,739	787,074	19,665
TANF Child	1	1	1	1	1	1	1	1	1	1			10		10
TANF Adult	1,318	1,351	1,392	1,408	1,435	1,465	1,529	1,568	1,563	1,582			14,611	11,587	3,024
LTC	2,788	2,778	2,806	2,847	2,864	2,870	2,914	2,624	2,846	2,819			28,156	28,870	(714)
MCE	3,612	3,813	4,013	4,268	4,489	4,889	4,982	5,145	5,468	5,693			46,372	26,018	20,354
WCM	16	16	18	20	15	18	16	16	19	18			172	150	22
Total	**87,564**	**88,076**	**88,369**	**88,982**	**89,542**	**89,737**	**90,768**	**90,502**	**91,116**	**91,404**			**896,060**	**853,699**	**42,361**
Fee for Service (Non-Dual - Total)															
SPD	10,163	10,047	10,616	10,358	10,832	10,708	10,937	10,763	11,022	11,204			106,650	103,891	2,759
TANF Child	26,720	26,952	27,715	28,188	27,730	27,774	28,746	28,788	28,055	28,299			278,967	254,814	24,153
TANF Adult	26,224	26,653	27,382	27,916	28,150	28,339	29,265	29,129	29,267	29,716			282,041	255,428	26,613
LTC	309	314	305	316	321	332	292	332	324	330			3,175	3,040	135
MCE	53,947	54,384	55,449	56,467	56,714	56,885	58,967	59,675	59,349	59,854			571,691	555,180	16,511
WCM	993	962	999	1,030	1,009	975	1,053	898	1,172	1,060			10,151	8,460	1,691
Total	**118,356**	**119,312**	**122,466**	**124,275**	**124,756**	**125,013**	**129,260**	**129,585**	**129,189**	**130,463**			**1,252,675**	**1,180,813**	**71,862**
SPD	117,710	117,859	118,567	118,464	119,466	119,060	120,061	119,764	120,055	120,319			1,191,325	1,173,587	17,738
TANF Child	298,704	298,228	299,389	300,445	300,518	300,609	302,328	302,823	302,224	303,183			3,008,451	2,960,321	48,130
TANF Adult	108,388	109,280	110,684	112,081	113,407	114,548	116,361	116,984	118,077	119,304			1,139,114	1,066,675	72,439
LTC	3,098	3,096	3,116	3,164	3,186	3,204	3,207	2,957	3,172	3,154			31,354	31,910	(556)
MCE	290,606	292,533	295,867	299,286	301,312	303,592	308,405	310,781	313,081	316,531			3,031,994	2,895,910	136,084
WCM	11,800	11,907	11,824	11,905	11,727	11,792	11,841	11,300	12,410	11,681			118,187	111,590	6,597
Total Medi-Cal MM	**830,306**	**832,903**	**839,447**	**845,345**	**849,616**	**852,805**	**862,203**	**864,609**	**869,019**	**874,172**			**8,520,425**	**8,239,993**	**280,432**
OneCare Connect	**14,688**	**14,819**	**14,817**	**14,833**	**14,877**	**14,933**	**14,686**	**14,579**	**14,587**	**14,490**			**147,309**	**151,145**	**(3,836)**
OneCare	**2,019**	**2,110**	**2,152**	**2,232**	**2,274**	**2,330**	**2,319**	**2,395**	**2,461**	**2,531**			**22,823**	**17,786**	**5,037**
PACE	**401**	**407**	**409**	**418**	**415**	**421**	**427**	**418**	**413**	**417**			**4,146**	**4,079**	**67**
MSSP							**452**	**457**	**459**	**457**			**1,825**	**2,160**	**(335)**
Grand Total	**847,414**	**850,239**	**856,825**	**862,828**	**867,182**	**870,489**	**879,635**	**882,001**	**886,480**	**891,610**			**8,694,703**	**8,413,003**	**281,700**

ENROLLMENT:

Overall, April enrollment was 891,610

- Favorable to budget 55,174 or 6.6%
- Increased 5,130 or 0.6% from Prior Month (PM) (March 2022)
- Increased 57,762 or 6.9% from Prior Year (PY) (April 2021)

Medi-Cal enrollment was 874,172

- Favorable to budget 55,112 or 6.7%
  - Medi-Cal Expansion (MCE) favorable 28,617
  - Temporary Assistance for Needy Families (TANF) favorable 23,514
  - Seniors and Persons with Disabilities (SPD) favorable 2,496
  - Whole Child Model (WCM) favorable 522
  - Long-Term Care (LTC) unfavorable 37
- Increased 5,153 from PM

OneCare Connect enrollment was 14,490

- Unfavorable to budget 664 or 4.4%
- Decreased 97 from PM

OneCare enrollment was 2,531

- Favorable to budget 737 or 41.1%
- Increased 70 from PM

PACE enrollment was 417

- Unfavorable to budget 11 or 2.6%
- Decreased 4 from PM

MSSP enrollment was 457

- Unfavorable to budget 168 or 26.9% due to MSSP currently being under-staffed. There is a staff to member ratio that must be met
- Decreased 2 from PM

CalOptima
Medi-Cal Total
Statement of Revenues and Expenses
For the Ten Months Ending April 30, 2022

Month					Year to Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
874,172	**819,060**	**55,112**	**6.7%**	**Member Months**	**8,520,425**	**8,239,993**	**280,432**	**3.4%**
				Revenues				
294,505,116	243,059,893	51,445,223	21.2%	Capitation Revenue	3,373,138,113	2,766,200,411	606,937,702	21.9%
-	-	-	0.0%	Other Income	-	-	-	0.0%
294,505,116	**243,059,893**	**51,445,223**	**21.2%**	**Total Operating Revenue**	**3,373,138,113**	**2,766,200,411**	**606,937,702**	**21.9%**
				Medical Expenses				
110,632,912	88,993,871	(21,639,041)	(24.3%)	Provider Capitation	1,073,528,125	912,571,177	(160,956,948)	(17.6%)
57,562,037	64,587,365	7,025,328	10.9%	Facilities Claims	562,646,315	640,821,299	78,174,984	12.2%
30,915,352	31,039,178	123,826	0.4%	Professional Claims	341,086,172	312,003,563	(29,082,609)	(9.3%)
(473,953)	-	473,953	0.0%	Prescription Drugs	343,950,620	345,521,586	1,570,966	0.5%
40,448,888	41,997,870	1,548,982	3.7%	MLTSS	424,127,629	421,407,547	(2,720,082)	(0.6%)
5,080,115	5,689,426	609,311	10.7%	Medical Management	44,319,882	54,035,158	9,715,276	18.0%
1,695,531	3,314,095	1,618,564	48.8%	Reinsurance & Other	293,455,703	17,409,363	(276,046,340)	(1585.6%)
245,860,881	**235,621,805**	**(10,239,076)**	**(4.3%)**	**Total Medical Expenses**	**3,083,114,445**	**2,703,769,693**	**(379,344,752)**	**(14.0%)**
48,644,235	**7,438,088**	**41,206,147**	**554.0%**	**Gross Margin**	**290,023,668**	**62,430,718**	**227,592,950**	**364.6%**
				Administrative Expenses				
10,367,112	8,378,071	(1,989,041)	(23.7%)	Salaries, Wages & Employee Benefits	73,553,403	82,668,942	9,115,539	11.0%
355,031	746,868	391,837	52.5%	Professional Fees	2,934,503	6,509,792	3,575,289	54.9%
858,757	1,045,945	187,188	17.9%	Purchased Services	9,577,407	11,003,700	1,426,293	13.0%
473,581	466,328	(7,253)	(1.6%)	Printing and Postage	3,255,126	4,003,280	748,154	18.7%
329,683	492,500	162,817	33.1%	Depreciation & Amortization	3,681,781	4,925,000	1,243,219	25.2%
1,600,949	2,061,353	460,404	22.3%	Other Operating Expenses	15,924,685	19,009,084	3,084,399	16.2%
(231,252)	(270,621)	(39,369)	(14.5%)	Indirect Cost Allocation, Occupancy Expense	(2,659,746)	(2,926,906)	(267,160)	(9.1%)
13,753,862	**12,920,444**	**(833,418)**	**(6.5%)**	**Total Administrative Expenses**	**106,267,160**	**125,192,892**	**18,925,732**	**15.1%**
				Operating Tax				
15,612,835	13,792,976	1,819,859	13.2%	Tax Revenue	147,026,142	138,761,478	8,264,664	6.0%
14,444,536	13,792,976	(651,560)	(4.7%)	Premium Tax Expense	144,445,363	138,761,478	(5,683,885)	(4.1%)
-	-	-	0.0%	Sales Tax Expense	-	-	-	0.0%
1,168,299	-	1,168,299	**0.0%**	**Total Net Operating Tax**	2,580,779	-	2,580,779	**0.0%**
				Grant Income				
-	-	-	0.0%	Grant Revenue	-	-	-	0.0%
30,303	-	(30,303)	0.0%	Grant Expense	60,606	-	(60,606)	0.0%
(30,303)	-	(30,303)	**0.0%**	**Total Grant Income**	(60,606)	-	(60,606)	**0.0%**
-	**-**	**-**	**0.0%**	**QAF and IGT - Net**	**(0)**	**-**	**0**	**0.0%**
15	**-**	**15**	**0.0%**	**Other income**	**8,823**	**-**	**8,823**	**0.0%**
36,028,383	**(5,482,356)**	**41,510,739**	**757.2%**	**Change in Net Assets**	**186,285,504**	**(62,762,174)**	**249,047,678**	**396.8%**
83.5%	***96.9%***	***(13.5%)***		***Medical Loss Ratio***	***91.4%***	***97.7%***	***(6.3%)***	
4.7%	***5.3%***	***0.6%***		***Admin Loss Ratio***	***3.2%***	***4.5%***	***1.4%***	

MEDI-CAL INCOME STATEMENT– APRIL MONTH:

REVENUES of $294.5 million are favorable to budget $51.4 million driven by:

- Favorable volume related variance of $16.4 million
- Favorable price related variance of $35.1 million
  - $35.2 million due to favorable revenue rates and Proposition 56 risk corridor estimates

MEDICAL EXPENSES of $245.9 million are unfavorable to budget $10.2 million driven by:

- Unfavorable volume related variance of $15.9 million
- Favorable price related variance of $5.6 million
  - Facilities Claims expense favorable variance of $11.4 million due to low utilization
  - Managed Long-Term Services and Supports (MLTSS) expense favorable variance of $4.4 million due to Incurred But Not Reported (IBNR) claims
  - Professional Claims expense favorable variance of $2.2 million due to IBNR claims
  - Reinsurance & Other expense favorable variance of $1.8 million
  - Offset by:
    - Provider Capitation expense unfavorable variance of $15.7 million due primarily to the extension of Proposition 56 and short-term supplemental rate increase due to COVID-19

ADMINISTRATIVE EXPENSES of $13.8 million are unfavorable to budget $0.8 million driven by:

- Salaries & Benefit expense unfavorable to budget $2.0 million
- Other Non-Salary expense favorable to budget $1.2 million

CHANGE IN NET ASSETS is $36.0 million, favorable to budget $41.5 million

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CalOptima
OneCare Connect Total
Statement of Revenue and Expenses
For the Ten Months Ending April 30, 2022

Month					Year to Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
14,490	**15,154**	**(664)**	**(4.4%)**	**Member Months**	**147,309**	**151,145**	**(3,836)**	**(2.5%)**
				Revenues				
2,649,375	2,790,167	(140,792)	(5.0%)	Medi-Cal Capitation Revenue	27,058,416	28,042,287	(983,871)	(3.5%)
17,539,861	20,361,708	(2,821,847)	(13.9%)	Medicare Capitation Revenue Part C	188,249,520	196,273,787	(8,024,267)	(4.1%)
6,412,516	5,803,703	608,813	10.5%	Medicare Capitation Revenue Part D	60,012,098	57,527,815	2,484,283	4.3%
-	-	-	0.0%	Other Income	-	-	-	0.0%
26,601,752	**28,955,578**	**(2,353,826)**	**(8.1%)**	**Total Operating Revenue**	**275,320,034**	**281,843,889**	**(6,523,855)**	**(2.3%)**
				Medical Expenses				
11,328,599	12,465,190	1,136,591	9.1%	Provider Capitation	112,214,562	118,925,117	6,710,555	5.6%
4,274,500	4,463,186	188,686	4.2%	Facilities Claims	41,375,728	43,766,143	2,390,415	5.5%
1,228,861	1,053,860	(175,001)	(16.6%)	Ancillary	11,279,447	10,449,055	(830,392)	(7.9%)
1,351,662	1,375,010	23,348	1.7%	MLTSS	14,344,627	14,212,832	(131,795)	(0.9%)
6,459,392	6,669,370	209,978	3.1%	Prescription Drugs	63,410,056	65,708,625	2,298,569	3.5%
1,283,296	1,235,094	(48,202)	(3.9%)	Medical Management	10,585,801	12,304,281	1,718,480	14.0%
213,768	178,155	(35,613)	(20.0%)	Other Medical Expenses	1,863,626	1,773,014	(90,612)	(5.1%)
26,140,079	**27,439,865**	**1,299,786**	**4.7%**	**Total Medical Expenses**	**255,073,846**	**267,139,067**	**12,065,221**	**4.5%**
461,673	**1,515,713**	**(1,054,040)**	**(69.5%)**	**Gross Margin**	**20,246,188**	**14,704,822**	**5,541,366**	**37.7%**
				Administrative Expenses				
673,271	887,499	214,228	24.1%	Salaries, Wages & Employee Benefits	6,954,635	8,793,396	1,838,761	20.9%
11,623	104,320	92,697	88.9%	Professional Fees	169,851	505,350	335,499	66.4%
138,762	119,752	(19,010)	(15.9%)	Purchased Services	1,116,389	1,141,805	25,416	2.2%
49,717	138,109	88,392	64.0%	Printing and Postage	848,470	1,381,090	532,620	38.6%
-	-	-	0.0%	Depreciation & Amortization	-	-	-	0.0%
2,992	21,075	18,083	85.8%	Other Operating Expenses	11,963	210,750	198,787	94.3%
578,216	680,053	101,837	15.0%	Indirect Cost Allocation	5,782,159	6,800,530	1,018,371	15.0%
1,454,580	**1,950,808**	**496,228**	**25.4%**	**Total Administrative Expenses**	**14,883,466**	**18,832,921**	**3,949,455**	**21.0%**
(992,907)	**(435,095)**	**(557,812)**	**(128.2%)**	**Change in Net Assets**	**5,362,722**	**(4,128,099)**	**9,490,821**	**229.9%**
98.3%	***94.8%***	***3.5%***		***Medical Loss Ratio***	***92.6%***	***94.8%***	***(2.1%)***	
5.5%	***6.7%***	***1.3%***		***Admin Loss Ratio***	***5.4%***	***6.7%***	***1.3%***	

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ONECARE CONNECT INCOME STATEMENT– APRIL MONTH:

REVENUES of $26.6 million are unfavorable to budget $2.4 million driven by:

- Unfavorable volume related variance of $1.3 million
- Unfavorable price related variance of $1.1 million

MEDICAL EXPENSES of $26.1 million are favorable to budget $1.3 million driven by:

- Favorable volume related variance of $1.2 million
- Favorable price related variance of $0.1 million
  - Provider Capitation expense favorable variance of $0.6 million
  - Offset by all other expenses unfavorable variance of $0.5 million

ADMINISTRATIVE EXPENSES of $1.5 million are favorable to budget $0.5 million

CHANGE IN NET ASSETS is ($1.0) million, unfavorable to budget $0.6 million

CalOptima
OneCare
Statement of Revenues and Expenses
For the Ten Months Ending April 30, 2022

Month					Year to Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
2,531	**1,794**	**737**	**41.1%**	**Member Months**	**22,823**	**17,786**	**5,037**	**28.3%**
				Revenues				
2,107,587	1,481,698	625,889	42.2%	Medicare Part C revenue	19,609,928	14,305,511	5,304,417	37.1%
1,106,835	720,203	386,632	53.7%	Medicare Part D revenue	9,302,919	6,694,493	2,608,426	39.0%
3,214,422	**2,201,901**	**1,012,521**	**46.0%**	**Total Operating Revenue**	**28,912,846**	**21,000,004**	**7,912,842**	**37.7%**
				Medical Expenses				
850,551	587,057	(263,494)	(44.9%)	Provider Capitation	7,933,925	5,602,163	(2,331,762)	(41.6%)
777,673	637,236	(140,437)	(22.0%)	Inpatient	8,923,476	6,147,854	(2,775,622)	(45.1%)
85,197	74,684	(10,513)	(14.1%)	Ancillary	1,023,524	728,774	(294,750)	(40.4%)
(17,735)	28,748	46,483	161.7%	Skilled Nursing Facilities	506,577	292,162	(214,415)	(73.4%)
1,023,182	691,264	(331,918)	(48.0%)	Prescription Drugs	9,655,312	6,809,177	(2,846,135)	(41.8%)
43,231	51,940	8,709	16.8%	Medical Management	370,977	511,457	140,480	27.5%
2,775	1,328	(1,447)	(109.0%)	Other Medical Expenses	33,119	13,161	(19,958)	(151.6%)
2,764,874	**2,072,257**	**(692,617)**	**(33.4%)**	**Total Medical Expenses**	**28,446,909**	**20,104,748**	**(8,342,161)**	**(41.5%)**
449,548	**129,644**	**319,904**	**246.8%**	**Gross Margin**	**465,937**	**895,256**	**(429,319)**	**(48.0%)**
				Administrative Expenses				
98,300	73,764	(24,536)	(33.3%)	Salaries, wages & employee benefits	790,425	734,586	(55,839)	(7.6%)
29,227	29,166	(61)	(0.2%)	Professional fees	298,432	291,660	(6,772)	(2.3%)
17,885	9,167	(8,718)	(95.1%)	Purchased services	120,258	91,670	(28,588)	(31.2%)
6,371	15,823	9,452	59.7%	Printing and postage	90,400	158,230	67,830	42.9%
-	1,029	1,029	100.0%	Other operating expenses	1,076	10,290	9,214	89.5%
59,743	50,924	(8,819)	(17.3%)	Indirect cost allocation, occupancy expense	597,432	509,240	(88,192)	(17.3%)
211,526	**179,873**	**(31,653)**	**(17.6%)**	**Total Administrative Expenses**	**1,898,023**	**1,795,676**	**(102,347)**	**(5.7%)**
238,022	**(50,229)**	**288,251**	**573.9%**	**Change in Net Assets**	**(1,432,086)**	**(900,420)**	**(531,666)**	**(59.0%)**
86.0%	***94.1%***	***(8.1%)***		***Medical Loss Ratio***	***98.4%***	***95.7%***	***2.7%***	
6.6%	***8.2%***	***1.6%***		***Admin Loss Ratio***	***6.6%***	***8.6%***	***2.0%***	

CalOptima
PACE
Statement of Revenues and Expenses
For the Ten Months Ending April 30, 2022

Month					Year to Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
417	**428**	**(11)**	**(2.6%)**	**Member Months**	**4,146**	**4,079**	**67**	**1.6%**
				Revenues				
2,636,073	2,640,560	(4,487)	(0.2%)	Medi-Cal Capitation Revenue	25,750,942	25,278,233	472,709	1.9%
682,029	696,040	(14,011)	(2.0%)	Medicare Part C Revenue	6,152,146	6,387,470	(235,324)	(3.7%)
212,097	154,542	57,555	37.2%	Medicare Part D Revenue	1,966,840	1,480,417	486,423	32.9%
3,530,199	**3,491,142**	**39,057**	**1.1%**	**Total Operating Revenue**	**33,869,927**	**33,146,120**	**723,807**	**2.2%**
				Medical Expenses				
847,001	1,060,576	213,575	20.1%	Medical Management	8,337,493	10,107,680	1,770,187	17.5%
798,081	766,513	(31,568)	(4.1%)	Facilities Claims	7,351,260	7,350,485	(775)	(0.0%)
572,617	712,461	139,844	19.6%	Professional Claims	7,692,238	6,704,973	(987,265)	(14.7%)
136,842	220,014	83,172	37.8%	Patient Transportation	1,241,746	1,601,354	359,608	22.5%
321,449	348,350	26,901	7.7%	Prescription Drugs	3,244,601	3,264,406	19,805	0.6%
83,470	61,368	(22,102)	(36.0%)	MLTSS	452,739	453,549	810	0.2%
5,213	5,219	7	0.1%	Other Expenses	(32,534)	50,389	82,923	164.6%
5,213	5,219			Other Expenses	(32,534)	50,389		
2,764,672	**3,174,501**	**409,829**	**12.9%**	**Total Medical Expenses**	**28,287,542**	**29,532,836**	**1,245,294**	**4.2%**
765,527	**316,641**	**448,886**	**141.8%**	**Gross Margin**	**5,582,385**	**3,613,284**	**1,969,101**	**54.5%**
				Administrative Expenses				
112,508	159,199	46,691	29.3%	Salaries, wages & employee benefits	1,071,426	1,541,529	470,103	30.5%
-	167	167	100.0%	Professional fees	7,251	1,670	(5,581)	(334.2%)
50,760	40,925	(9,835)	(24.0%)	Purchased services	267,570	409,250	141,680	34.6%
6,422	19,238	12,816	66.6%	Printing and postage	135,606	192,380	56,774	29.5%
370	400	30	7.6%	Depreciation & amortization	7,513	4,000	(3,513)	(87.8%)
5,476	37,166	31,690	85.3%	Other operating expenses	72,516	147,375	74,859	50.8%
11,733	4,944	(6,789)	(137.3%)	Indirect Cost Allocation, Occupancy Expense	102,418	49,440	(52,978)	(107.2%)
187,269	**262,039**	**74,770**	**28.5%**	**Total Administrative Expenses**	**1,664,301**	**2,345,644**	**681,343**	**29.0%**
				Operating Tax				
6,188	-	6,188	0.0%	Tax Revenue	61,527	-	61,527	0.0%
6,188	-	(6,188)	0.0%	Premium Tax Expense	61,527	-	(61,527)	0.0%
-	**-**	**-**	**0.0%**	**Total Net Operating Tax**	**-**	**-**	**-**	**0.0%**
578,259	**54,602**	**523,657**	**959.0%**	**Change in Net Assets**	**3,918,084**	**1,267,640**	**2,650,444**	**209.1%**
78.3%	***90.9%***	***(12.6%)***		***Medical Loss Ratio***	***83.5%***	***89.1%***	***(5.6%)***	
5.3%	***7.5%***	***2.2%***		***Admin Loss Ratio***	***4.9%***	***7.1%***	***2.2%***	

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CalOptima
Multipurpose Senior Services Program
Statement of Revenues and Expenses
For the Ten Months Ending April 30, 2022

Month					Year to Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
457	**625**	**(168)**	**(26.9%)**	**Member Months**	**1,825**	**2,160**	**(335)**	**(15.5%)**
				Revenues				
218,089	278,731	(60,642)	(21.8%)	Capitation Revenue	838,270	963,642	(125,372)	(13.0%)
218,089	**278,731**	**(60,642)**	**(21.8%)**	**Total Operating Revenue**	**838,270**	**963,642**	**(125,372)**	**(13.0%)**
				Medical Expenses				
132,848	164,061	31,213	19.0%	Medical Management	467,469	568,435	100,966	17.8%
				Waived Services				
-	165	165	100.0%	Minor home repairs	457	570	113	19.8%
6,974	10,301	3,327	32.3%	Non-medical home equipment	27,020	35,611	8,591	24.1%
5,394	4,189	(1,205)	(28.8%)	Chores	17,440	14,481	(2,959)	(20.4%)
3,088	3,590	502	14.0%	Personal care	14,259	12,409	(1,850)	(14.9%)
400	549	149	27.1%	In-home respite	1,297	1,898	601	31.7%
694	884	190	21.5%	Transportation	1,773	3,056	1,283	42.0%
645	1,319	674	51.1%	Home delivered meals	2,198	4,560	2,362	51.8%
4	209	205	97.9%	Food	94	722	628	87.0%
9,201	13,888	4,687	33.8%	Communications	37,887	48,010	10,123	21.1%
46	1,146	1,100	96.0%	Non-Covered Services	138	3,962	3,824	96.5%
2,239	-	(2,239)	0.0%	Protective Services	18,060	-	(18,060)	0.0%
132,848	164,061	31,213	19.0%	Total Medical Management	467,469	568,435	100,966	17.8%
28,686	36,240	7,554	20.8%	Other Medical Expenses	120,624	125,279	4,655	3.7%
161,534	**200,301**	**38,767**	**19.4%**	**Total Program Expenses**	**588,094**	**693,714**	**105,620**	**15.2%**
56,555	**78,430**	**(21,875)**	**(27.9%)**	**Gross Margin**	**250,176**	**269,928**	**(19,752)**	**(7.3%)**
				Administrative Expenses				
46,937	77,880	30,943	39.7%	Salaries, wages & employee benefits	206,483	273,633	67,150	24.5%
2,207	1,125	(1,082)	(96.2%)	Professional fees	7,330	4,500	(2,830)	(62.9%)
3,891	7,309	3,418	46.8%	Other operating expenses	19,952	29,236	9,284	31.8%
4,273	4,884	611	12.5%	Indirect Cost Allocation	18,013	19,536	1,523	7.8%
57,307	**91,198**	**33,891**	**37.2%**	**Total Administrative Expenses**	**251,778**	**326,905**	**75,127**	**23.0%**
(752)	**(12,768)**	**12,016**	**94.1%**	**Change in Net Assets**	**(1,601)**	**(56,977)**	**55,376**	**97.2%**
74.1%	***71.9%***	***2.2%***		***Medical Loss Ratio***	***70.2%***	***72.0%***	***(1.8%)***	
26.3%	***32.7%***	***6.4%***		***Admin Loss Ratio***	***30.0%***	***33.9%***	***3.9%***	

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CalOptima
Building 505 - City Parkway
Statement of Revenues and Expenses
For the Ten Months Ending April 30, 2022

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				
38,239	54,250	16,011	29.5%	Purchase services	377,154	542,500	165,346	30.5%
177,043	206,000	28,957	14.1%	Depreciation & amortization	1,734,931	2,060,000	325,069	15.8%
20,875	19,750	(1,125)	(5.7%)	Insurance expense	196,958	197,500	542	0.3%
172,233	162,833	(9,400)	(5.8%)	Repair and maintenance	1,172,741	1,378,330	205,589	14.9%
36,815	43,000	6,185	14.4%	Other Operating Expense	484,568	430,000	(54,568)	(12.7%)
(445,205)	(485,833)	(40,628)	(8.4%)	Indirect allocation, Occupancy	(3,966,353)	(4,608,330)	(641,977)	(13.9%)
-	-	-	**0.0%**	**Total Administrative Expenses**	-	-	-	**0.0%**
-	-	-	**0.0%**	**Change in Net Assets**	-	-	-	**0.0%**

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OTHER INCOME STATEMENTS – APRIL MONTH:

ONECARE INCOME STATEMENT

CHANGE IN NET ASSETS is $0.2 million, favorable to budget $0.3 million

PACE INCOME STATEMENT

CHANGE IN NET ASSETS is $0.6 million, favorable to budget $0.5 million

MSSP INCOME STATEMENT

CHANGE IN NET ASSETS is ($752), favorable to budget $12,016

- Carved out of Medi-Cal effective January 1, 2022

NET INVESTMENT INCOME

- Unfavorable variance of $3.1 million is primarily due unrealized losses in treasuries, corporate bonds and municipals due to continued increases to interest rates and the Federal Reserve's responses to inflation

CalOptima
Balance Sheet
April 30, 2022

ASSETS			**LIABILITIES & NET POSITION**		
Current Assets			Current Liabilities		
	Operating Cash	$715,670,672		Accounts Payable	$27,014,466
	Short-term Investments	1,024,936,250		Medical Claims liability	817,912,791
	Capitation receivable	149,990,359		Accrued Payroll Liabilities	15,988,232
	Receivables - Other	47,843,685		Deferred Revenue	34,205,718
	Prepaid expenses	13,245,411		Deferred Lease Obligations	98,147
				Capitation and Withholds	179,741,452
	Total Current Assets	**1,951,686,378**		**Total Current Liabilities**	**1,074,960,806**
Capital Assets					
	Furniture & Equipment	46,311,601			
	Building/Leasehold Improvements	9,372,830			
	505 City Parkway West	52,236,708			
		107,921,138			
	Less: accumulated depreciation	(63,128,460)			
	Capital assets, net	44,792,678	Other (than pensions) post		
				employment benefits liability	32,060,789
Other Assets			Net Pension Liabilities		30,592,204
	Restricted Deposit & Other	300,000	Bldg 505 Development Rights		-
	Homeless Health Reserve	41,336,739			
	Board-designated assets:				
	Cash and Cash Equivalents	673,169	**TOTAL LIABILITIES**		**1,137,613,799**
	Investments	570,201,900	Deferred Inflows		
	Total Board-designated Assets	570,875,068		Excess Earnings	344,198
				OPEB 75 Difference in Experience	536,000
	Total Other Assets	612,511,807		Change in Assumptions	2,709,945
				OPEB Changes in Assumptions	773,000
			Net Position		
TOTAL ASSETS		**2,608,990,864**		TNE	104,291,452
				Funds in Excess of TNE	1,377,714,766
Deferred Outflows			**TOTAL NET POSITION**		1,482,006,219
	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	**2,623,983,161**		**TOTAL LIABILITIES, DEFERRED INFLOWS & NET POSITION**	**2,623,983,161**

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CalOptima
Board Designated Reserve and TNE Analysis
as of April 30, 2022

Type	Reserve Name	Market Value	Benchmark		Variance	
			Low	High	Mkt - Low	Mkt - High
	Tier 1 - Payden & Rygel	232,241,723				
	Tier 1 - MetLife	230,771,229				
Board-designated Reserve		463,012,952	377,150,951	583,483,410	85,862,001	(120,470,457)
	Tier 2 - Payden & Rygel	54,051,285				
	Tier 2 - MetLife	53,810,831				
TNE Requirement		107,862,116	104,291,452	104,291,452	3,570,664	3,570,664
	Consolidated:	**570,875,068**	**481,442,403**	**687,774,862**	**89,432,665**	**(116,899,794)**
	Current reserve level	*1.66*	*1.40*	*2.00*		

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CalOptima
Statement of Cash Flows
April 30, 2022

	Month Ended	Year-To-Date
CASH FLOWS FROM OPERATING ACTIVITIES:		
Change in net assets	32,713,946	173,225,426
Adjustments to reconcile change in net assets		
to net cash provided by operating activities		
Depreciation and amortization	507,096	5,424,224
Changes in assets and liabilities:		
Prepaid expenses and other	(1,043,435)	(1,266,800)
Catastrophic reserves		
Capitation receivable	10,418,609	277,061,974
Medical claims liability	(150,178,608)	(126,406,157)
Deferred revenue	23,946,621	20,618,892
Payable to health networks	(3,917,909)	34,961,663
Accounts payable	(26,601,627)	(19,399,954)
Accrued payroll	3,580,615	194,300
Other accrued liabilities	(2,970)	(29,181)
Net cash provided by/(used in) operating activities	(110,577,662)	364,384,386
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	(48,634,104)	40,473,556
Change in Property and Equipment	(128,449)	(4,489,027)
Change in Board designated reserves	3,014,028	18,005,084
Change in Homeless Health Reserve	7,462,174	15,462,174
Net cash provided by/(used in) investing activities	(38,286,351)	69,451,787
NET INCREASE/(DECREASE) IN CASH & CASH EQUIVALENTS	(148,864,013)	433,836,174
CASH AND CASH EQUIVALENTS, beginning of period	$864,534,685	281,834,499
CASH AND CASH EQUIVALENTS, end of period	**715,670,672**	**715,670,672**

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BALANCE SHEET – APRIL MONTH:

ASSETS of $2.6 billion decreased $120.5 million from March or 4.4%

- Operating Cash and Short-term Investments net decrease of $100.2 million due primarily to the payout of hospital Directed Payments (DP) of $138.7 million to providers
  - Operating cash decreased $148.9 million
  - Short-term Investments increased $48.6 million
- Capitation Receivables decreased $12.9 million due to the timing of cash receipts
- Homeless Health Reserve decreased $7.0 million due to approved initiative for Outreach and Engagement Team

LIABILITIES of $1.1 billion decreased $153.2 million from March or 11.9%

- Claims Liabilities decreased $150.2 million due to disbursement of hospital DP
- Accounts Payable decreased $26.6 million due to the timing of accruals for the quarterly premium tax payment
- Deferred Revenue increased $23.9 million due to timing of capitation payments from Centers for Medicare & Medicaid Services (CMS)

NET ASSETS of $1.5 billion, increased $32.7 million from March or 2.3%

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CalOptima - Consolidated
Net Assets Analysis
For the Ten Months Ended April 30, 2022

Category	Item Description	Resource Committed	Amount (millions)	%
	Total Net Position @ 04/30/2022:		**$ 1,482.0**	**100.0%**
Resources Assigned	Board Designated Reserve		**$ 570.9**	**38.5%**
	Capital Assets, net of depreciation		**$ 44.8**	**3.0%**
Resources Allocated, not yet Spent	Homeless Health Initiative*	100.0	26.3	1.8%
	Intergovernmental Transfers (IGT)	80.8	24.4	1.6%
	Mind OC Grant	1.0	-	0.0%
	CalFresh Outreach Strategy	2.0	2.0	0.1%
	Digital Transformation and Workplace Modernization	100.0	100.0	6.7%
	Coalition of Orange County Community Health Centers Grant	50.0	50.0	3.4%
	Subtotal:	**333.8**	**$ 202.7**	**13.7%**
Resources Available for New Initiatives	Homeless Health Initiative		41.3	
	Intergovernmental Transfers (IGT)		26.7	
	Unallocated/Unassigned		595.6	
	Subtotal:		**$ 663.6**	**44.8%**

*See Summary of Homeless Health Initiatives and Allocated Funds for list of Board approved initiatives

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Summary of Homeless Health Initiatives and Allocated Funds
As of April 30, 2022

			Amount
Program Commitment		**$**	**100,000,000**
Funds Allocation, approved initiatives:			
Enhanced Medi-Cal Services at the Be Well OC Regional Mental Health and Wellness Campus	11,400,000		
Recuperative Care	8,250,000		
Medical Respite	250,000		
Day Habilitation (County for HomeKey)	2,500,000		
Clinical Field Team Start-up & Federal Qualified Health Center (FQHC)	1,600,000		
CalOptima Homeless Response Team	6,000,000		
Homeless Coordination at Hospitals	10,000,000		
CalOptima Days & QI Program - Homeless Clinic Access Program or HCAP	1,693,261		
FQHC (Community Health Center) Expansion and HHI Support	570,000		
HCAP Expansion for Telehealth and CFT On Call Days	1,000,000		
Vaccination Intervention and Member Incentive Strategy	400,000		
Street Medicine	8,000,000		
Outreach and Engagement Team	7,000,000		
Funds Allocation Total		**$**	**58,663,261**
Program Commitment Balance, available for new initiatives*		**$**	**41,336,739**

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

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Budget Allocation Changes
Reporting Changes for April 2022

Transfer Month	Line of Business	From	To	Amount	Expense Description	Fiscal Year
August	Medi-Cal	Ground Floor Corridor Heating and Cooling Boxes Replacement	Multiple Bathroom Upgrades (Original Bathrooms on 2nd and 4th Floors)	$25,800	To transfer funds from capital project Ground Floor Corridor Heating and Cooling Boxes Replacement to capital project Multiple Bathroom Upgrades (Original Bathrooms on the 2nd and 4th Floors) to fund the final bathroom change order.	2020-21
November	Medi-Cal	Upgrade the System Backup Application Disk Storage - Hardware	Upgrade the Citrix Virtual Servers to Support Version - Hardware	$24,000	To transfer funds from capital project Upgrade the System Backup Application Disk Storage to capital project Upgrade the Citrix Virtual Servers to Support Version to provide additional funds for hardware purchases.	2021-22
November	Medi-Cal	Upgrade the System Backup Application Disk Storage - Hardware	Upgrade the Database Disk Storage Equipment - Hardware	$51,000	To transfer funds from capital project Upgrade the System Backup Application Disk Storage to capital project Upgrade the Database Disk Storage Equipment to provide additional funds for hardware purchases.	2021-22
December	Medi-Cal	Maintenance HW/SW - BMC	Maintenance HW/SW – SolarWinds	$10,500	To repurpose funds from BMC to SolarWinds to provide additional funds for maintenance contract renewal.	2021-22
December	Medi-Cal	Upgrade the Citrix Virtual Servers to Support Version - Hardware	Upgrade the Database Disk Storage Equipment - Hardware	$13,500	To transfer funds from capital project Upgrade the Citrix Virtual Servers to Support Version to capital project Upgrade the Database Disk Storage Equipment to provide additional funds for hardware purchases.	2021-22
December	Medi-Cal	Maintenance HW/SW – Optum/Ingenix ICD 10	Maintenance HW/SW – Smart Communications	$14,000	To repurpose funds from Optum/Ingenix ICD10 to Smart Communications to provide additional funds for maintenance contract renewal.	2021-22
December	Medi-Cal	Maintenance HW/SW – Microsoft True-Up	Maintenance HW/SW – Extreme Networks	$24,000	To repurpose funds from Microsoft True-UP to Extreme Networks to provide additional funds for maintenance contract renewal.	2021-22
January	Medi-Cal	Professional Fees – Citrix Pro Fees	Professional Fees – HIPPA Compliance (Risk Assessment & Network Penetration)	$10,500	To repurpose funds from Citrix professional fees to HIPPAA Compliance professional fees to provide additional funds.	2021-22
January	Medi-Cal	Maintenance HW/SW – Microsoft True-Up	Maintenance HW/SW – SSL Certs for Production Applications	$12,000	To repurpose funds from Microsoft True-UP to SSL Certs for Production Applications to provide additional funds for maintenance contract renewal.	2021-22
January	Medi-Cal	Purchased Services – Executive Coaching	Purchased Services – Concentra	$18,000	To reallocate funding from Executive Coaching to Concentra for additional funds needed.	2021-22
February	Medi-Cal	Purchased Services – Disaster Recovery Technology Services	Purchased Services – Offsite Backup Tape Storage and Services	$25,000	To repurpose funds from Purchased Services - Disaster Recovery Technology Services to Purchased Services - Offsite Backup Tape Storage and Services to provide additional funds.	2021-22
March	Medi-Cal	Cert/Cont. Education - Leadership Series Quarterly	Training & Seminar	$28,000	To reallocate funding from Cert/Cont. Education Leadership Series to Training & Seminar for the funding of company-wide training from Dale Carnegie	2021-22
April	Medi-Cal	Purchased Services - Executive Coaching	Purchased Services - Concentra	$15,000	To reallocate funding from Executive Coaching to Concentra for additional funds needed.	2021-22

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.

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Board of Directors Meeting
June 2, 2022

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

- 2022 Medicare Parts C and D Data Validation Audit (*applicable to OneCare and OneCare Connect*):

  On an annual basis, CalOptima is required to engage an independent auditor to validate all Medicare Parts C and D data reported for the prior calendar year. The validation audit includes a webinar validation and source documentation review for various Medicare Parts C and D measures.

  CalOptima completed submission of reports to CMS ahead of February 7, 2022, and February 28, 2022 deadlines. RAC worked with the business owners to complete the Organization Assessment Instrument, Measure Overviews and additional supporting documents.

  On March 29, 2022, CMS notified CalOptima that potential data issues with the OC Special Needs Plan (SNP), Coverage Determinations and Redeterminations (CDR) and Medication Therapy Management Program (MTMP) files and OCC CDR and MTMP files have been identified. Responses to the potential issues have been submitted to CMS; all data were accurate as submitted.

  The webinar validation with Advent took place on April 7, 2022 and April 13, 2022. Following the webinar validations, Advent began providing data file findings reports for each of the measures and source document request.

  The data elements for the Grievances C & D, CDR, and SNP measures have all received 100% accuracy rates. CalOptima is still pending results for the Organization Determinations and Reconsiderations (ODR), MTMP and Improving Drug Utilization Review Control (IDURC) measures.

  CalOptima is working to collect the documents requested for submission ahead of the submission deadline.

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- 2021 CMS Program Audit/Independent Validation Audit (applicable to OneCare and OneCare Connect):

  CMS conducted a program audit on both OneCare and OneCare Connect. CMS released the preliminary draft audit report on 8/6/21 and completed the exit conference. On October 21, 2021, CMS issued the Draft Audit Report, which noted a total of 11 observations, 8 Corrective Action Required (CARs), and one ICAR. (The ICAR issued on August 27th and the CAP was accepted by CMS on 9/13/21.) As there were no comments/rebuttals to the Draft Audit Report, CMS released the Final Audit Report, with no changes to the findings, on 11/5/21.

  CalOptima submitted the corrective action plans (CAPs) for the non-ICAR condition on 12/9/21. On 1/5/22, CMS informed CalOptima that the CAPs submitted for the SNP, CCQIPE and FA program areas have been accepted. CMS has provided a deadline of 7/5/2022 for CalOptima to complete the independent validation audit (IVA).

  CalOptima has chosen Integritas Medicare to conduct the IVA and will be working with BluePeak to conduct a mock validation audit ahead of the IVA. On April 5, 2022, CalOptima received approval from CMS on the IVA Work Plan.

  On March 1, 2022, CalOptima in collaboration with BluePeak, held a mock IVA webinar for the FA program area. No issues were identified during the session.

  On April 14, 2022, CalOptima participated in a kick-off call with Integritas to review the audit scope and document requests for the FA webinar. On April 20, 2022, CalOptima participated in the FA IVA webinar session with Integritas. Integritas is reviewing additional supporting documents submitted to them following the webinar session.

  On April 18, 2022, CalOptima participated in a mock IVA session with BluePeak for the ODAG data integrity review. No issues were identified during the session. On April 27, 2022, CalOptima participated in the ODAG Data Integrity Review IVA webinar session with Integritas. The universe passed the data integrity and timeliness test.

  Webinar sessions for the SNP and CCQIPE program areas will be completed by July 2022.

2. Medi-Cal

- 2021 DHCS Medical Audit:

  On October 7, 2021, DHCS formally engaged CalOptima for its annual medical audit. The audit covered CalOptima's provision of Medi-Cal services to its non-Seniors and Persons with Disabilities (non-SPD) and SPD members. The review period extended from February 1, 2020 through December 31, 2021 and assessed CalOptima's compliance with its Medi-Cal contract and regulations in the areas of utilization management, case management and coordination of care, member's rights, quality management, access & availability, and administrative and organizational capacity. DHCS selected Kaiser, Prospect, and FCMG to participate in various capacities.

DHCS hosted its audit via webinar from January 24, 2022 through February 4, 2022. The Entrance Conference was held on January 24, 2022. On February 4, 2022, the DHCS concluded its staff interviews and hosted a close-out meeting with the Office of Compliance to discuss preliminary observations.

CalOptima is currently awaiting its draft findings report. Once DHCS finalizes its draft report, a formal Exit Conference will be scheduled to review CalOptima's draft audit findings. CalOptima will have fifteen (15) calendar days to review and confirm or rebut the draft findings. DHCS will provide CalOptima with a final audit report and formal request for corrective action, thirty (30) calendar days from the Exit Conference.

- 2022 Managed Care Entity (MCE) Program Integrity Review:

  On April 13, 2022, the DHCS notified CalOptima that it had been selected to provide feedback to the Centers for Medicare and Medicaid Services (CMS) in respect to CalOptima's internal Program Integrity (PI) efforts that are in place to ensure adequate oversight as well as to deter and address fraud, waste, and abuse (FWA). The review period for the MCE PI review covers the preceding 3 Federal Fiscal Year (FFYs) and focuses on CalOptima's Medi-Cal program. While the focus is largely on FWA, various internal stakeholders were also impacted.

  DHCS requested that CalOptima respond to a series of questions within the CMS Template and submit responses and supporting documentation to DHCS, for subsequent submission to CMS. On May 4, 2022, CalOptima provided its timely response to DHCS. Following CalOptima's submission, there may be additional questions or need for clarification, at which time, DHCS will contact CalOptima for any follow-up information. At this time, Health Networks are not expected to participate.

- 2022 Department of Managed Care (DMHC) Routine Examination:

  On February 9, 2022, the DMHC engaged CalOptima for the 2022 DMHC Routine Examination. This examination is routine and occurs every three (3) years. The examination will review CalOptima's fiscal and administrative affairs and includes an examination of CalOptima's financial reports.

  On April 5, 2022, CalOptima completed its submission of pre-audit deliverables; this submission was provided ahead of schedule. DMHC has scheduled an entrance conference for May 16, 2022, at 10:00am via webinar. As part of the entrance conference, DMHC will provide a brief overview of the examination process and CalOptima will present a description of its operations and administrative arrangements. The formal examination will begin on May 16, 2022 and will be conducted remotely. CalOptima delegates are not expected to participate.

B. Regulatory Notices of Non-Compliance

- CalOptima did not receive any notices of non-compliance from its regulators for the month of April 2022.

C. Updates on Internal and Health Network Monitoring and Audits

- No significant issues to report related to the monthly self-reported Key Performance Indicators (KPI).

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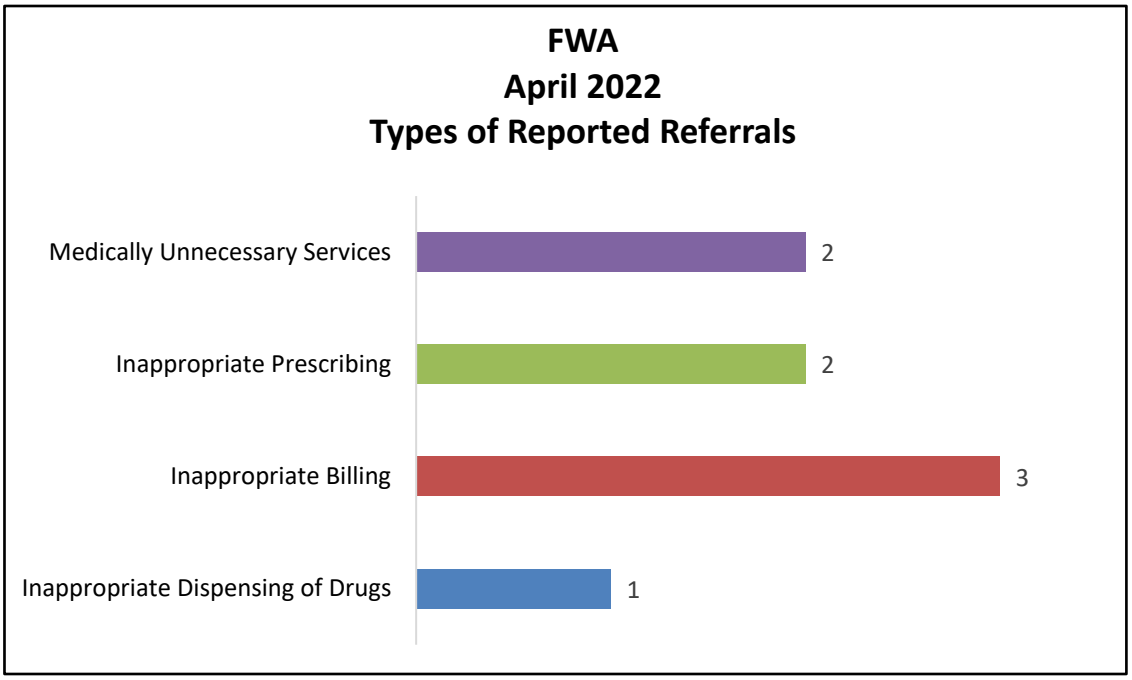
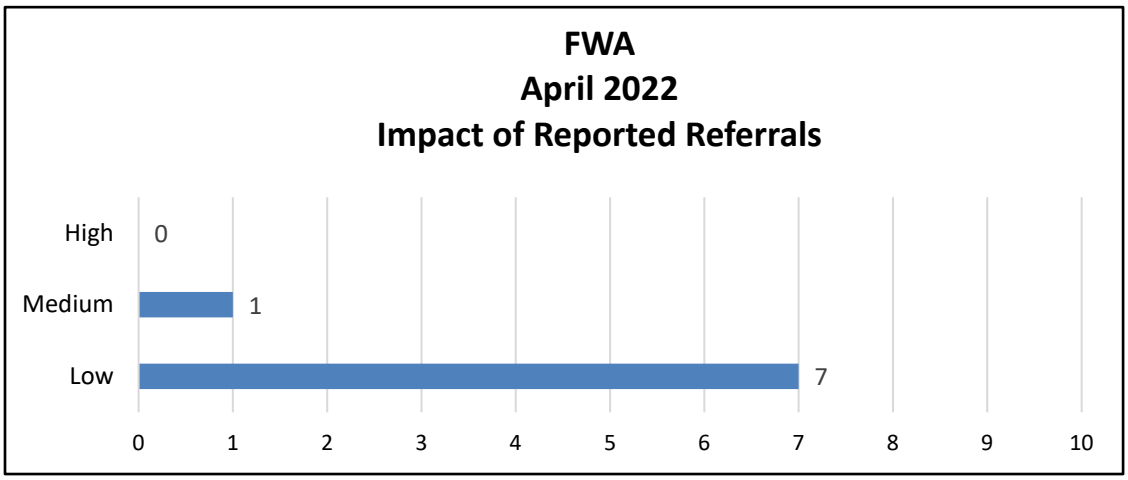
D. Fraud, Waste & Abuse (FWA) Investigations

Types of FWA Cases: (April 2022)





Total Number of New Cases Referred to DHCS (State)	8
Total Number of New Cases Referred to DHCS and CMS*	4

*Effective January 1, 2022, CMS implemented a new portal to report suspicious FWA. Any potential FWA *with impact to Medicare* is reported to both DHCS and CMS at the start of an investigation.

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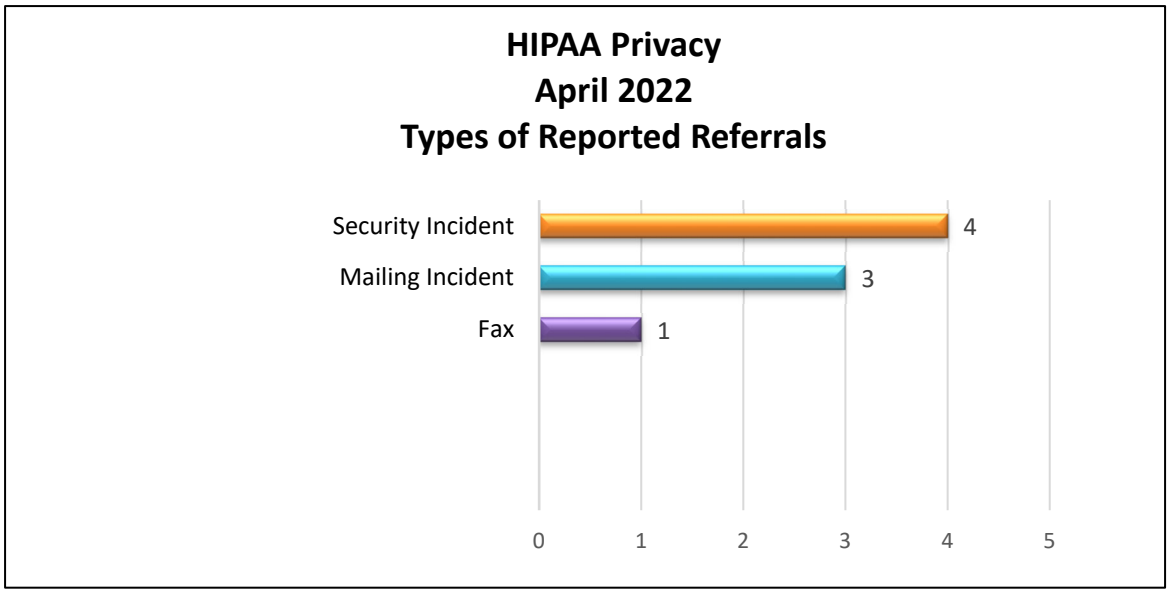
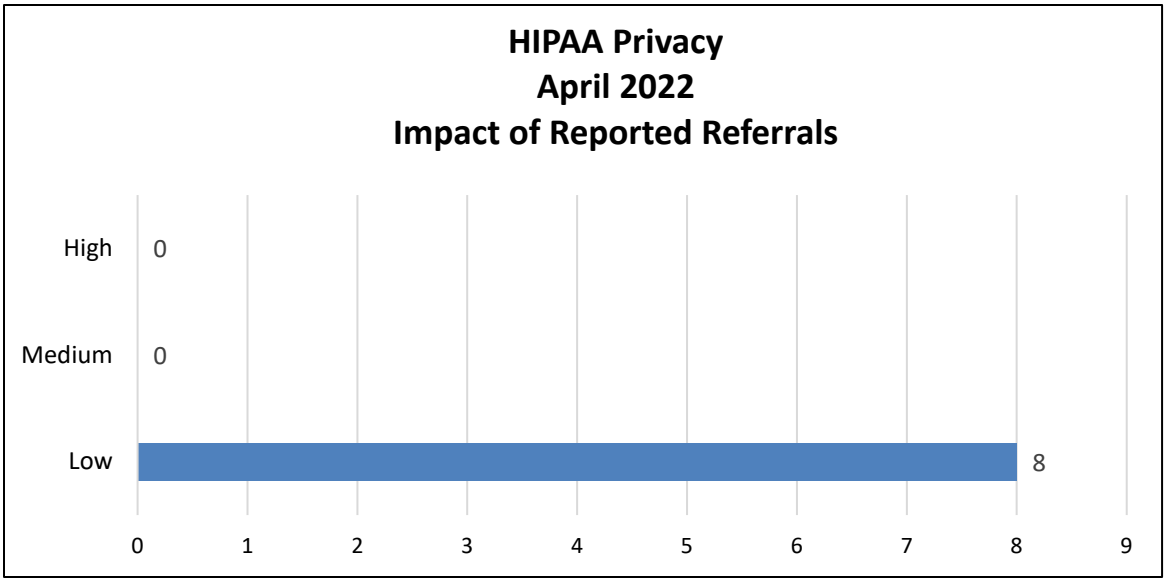
E. Privacy Update: (April 2022)





Total Number of Referrals Reported to DHCS (State)	8
Total Number of Referrals / Breaches Reported to DHCS and Office for Civil Rights (OCR)	0

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POTOMAC PARTNERS DC

STRATEGIC HEALTH CARE

MEMORANDUM

May 6, 2022

To: CalOptima

From: Potomac Partners DC & Strategic Health Care

Re: May Board of Directors Report

FISCAL YEAR 2023 APPROPRIATIONS & CONGRESSIONALLY DIRECTED SPENDING

Leaders of the House and Senate Appropriations Committees met at the end of April to discuss the Fiscal Year 2023 (FY23) appropriations process, the discretionary spending cap for FY23, and top-level spending limits for defense and non-defense discretionary appropriations. The House Appropriations Committee is still tentatively planning to begin marking up their proposed appropriations bills in mid-to-late June, with a plan for floor votes in July, with the Senate aiming for a somewhat similar timeline (albeit likely at least a few weeks behind).

Separately, Congress is still considering an additional COVID-19 package aimed at providing relief to struggling restaurants and small businesses and procuring key supplies, including (but not limited to) antivirals and vaccines. Attempts to pass this type of targeted COVID-19 relief funding prior to the April recess were unsuccessful. Senate Republicans sought to include language to prevent the Biden Administration from ending the "Title 42 Public Health Directive" that allowed the Department of Homeland Security to prevent asylum-seeking migrants from entering the United States.

MEDICARE ADVANTAGE

A coalition of 46 mental and behavioral health groups have sent a letter to Congress in support of a bipartisan bill aimed at reforming the use of prior authorization under Medicare Advantage plans. The coalition, led by the Mental Health Liaison Group, says that given the mental health and substance abuse crisis in the country, the delays that prior authorization creates put patients at risk. "Delays and denials of care can have serious and sometimes devastating effects on patients in need of mental health/substance use treatment and services," the letter states. For the letter, click here.

This month, CMS released the Calendar Year (CY) 2023 Medicare Advantage Capitation Rates and Part C and Part D Payment Policies. The year-to-year percentage change in payment did change in several categories including the expected average change in revenue, which is 8.50

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percent. This is one of the largest increases ever provided to MA plans. Click here for the announcement. Despite the recent release, some groups are already expressing concern over the changes, as seen here.

Medicare Part D beneficiaries who have low incomes and receive government subsidies were nearly twice as likely to fill a prescription for a high-priced medicine for cancer or other illnesses compared with Americans who don't receive such support, according to a new study in *Health Affairs* available here.

Federal Judge Halts Mask Mandate on Public Transportation

On Monday, April 18th, U.S. District Judge Kathryn Kimball Mizelle issued a ruling (found here) concluding that the Centers for Disease Control and Prevention (CDC) exceeded their legal authority by imposing mask mandates on public transportation. The ruling reached the same conclusion as the court in the National Eviction Moratorium, which was overturned late last year, which found that the 1944 statute being used by the CDC does not apply to masks because the law only grants legal authority for quarantining, sanitizing, and destruction of infected farm animals, and the government too broadly applied the meaning of the word "sanitizing" by applying it to wearing masks. The Judge also stated that the CDC overstepped their authority by not having a public comment period before imposing the mask mandate and, although the CDC was pursuing the public's interest in combatting the spread of COVID-19, "our system does not permit agencies to act unlawfully even in pursuit of desirable ends."

Surprise Billing

The Department of Justice plans to appeal a federal court ruling on the surprise billing law that sided with providers who said HHS' rule conflicts with the No Surprises Act passed by Congress as it unfairly tips the scales in favor of insurers under the arbitration rules. A federal judge in Texas sided with providers saying the rule conflicts with the law Congress passed, forcing regulators to remove the presumption language in recently released revised guidance for arbiters. The guidance can be found here. A FAQ from the administration clarifying how health plans and other insurers should report certain in-network payment arrangements under the Transparency in Coverage rule's requirements that most health plans disclose can be found here.

Public Health Emergency Extended for 90 Days

The Biden Administration extended the Public Health Emergency (PHE) for another 90 days, effective April 16th through July 15th. So long as the PHE remains in place, a number of emergency programs and regulation waivers will continue to function without interruption, such as telehealth flexibilities. Congress has expressed concerns with ending the PHE abruptly and has asked the White House to give significant notice for ending the designation to allow states, local governments, hospitals, and other entities time to adjust their operations when the PHE ends. In

the meantime, Congress is looking for ways to permanently keep some of the regulatory rollbacks that have proven to be extremely effective in streamlining some public services.

ROE V. WADE AND CONGRESS

On May 2nd, a Majority Opinion draft of the Supreme Court's apparent decision to strike down Roe v. Wade was leaked to the press and confirmed by Chief Justice Roberts. The draft, which does not necessarily represent the Court's final view, can be found here. In response, Senate Majority Leader Chuck Schumer (D-NY) announced plans for a floor vote on legislation that would codify Roe v. Wade on the week of May 9th, which is unlikely to pass. Should Roe v. Wade be overturned in the Supreme Court, the legal status of abortion will be determined by the states. 17 states have already codified abortion as a right, including California.

EDELSTEIN GILBERT ROBSON & SMITH LLC

Donald B. Gilbert Michael R. Robson Trent E. Smith Jason D. Ikerd Associate Bridget E. McGowan Associate

May 23, 2022

LEGISLATIVE UPDATE
Edelstein Gilbert Robson & Smith LLC

General Update

The Legislature passed a critical legislative milestone on April 29 – the policy committee deadline. The Legislature will now turn to the fiscal committee deadline, a point in the legislative process where we see a narrowing of the number of active bills continuing to advance. This is due to the Appropriations Suspense hearing, where the Senate and Assembly Appropriations Committees will hear and decide the fate of hundreds of bills.

After the fiscal committee deadline, each house will have until May 27 to pass bills off the floor and out of the house they were introduced in.

Meanwhile, the Governor released his revised budget proposal on May 13, beginning a month-long sprint to pass the State Budget by the June 15 constitutional deadline. The Governor's Budget exceeds $300 billion in proposed state spending, including $97.5 billion in surplus revenue. The State's surplus is more than double what was estimated in January. For perspective, only a handful of states have a total operating budget greater than $97 billion.

The Legislature has its priorities for how to spend the surplus and negotiating with the Governor will start immediately. One of the biggest points of contention is the Governor's rebate proposal to offset record high gas prices. The Governor is proposing each vehicle owner receive a $400 rebate check from the state. The Legislature wants to provide rebates only to those making less than $125,000 annually.

The Governor is proposing health care workers receive $1,500 apiece in "hero pay" bonuses that labor tried to win last year.

Below are some important figures related to the Governor's revised budget proposal.

- **$49.2 billion:** Amount of the surplus that is discretionary (rest is obligated to education)
- **94 percent:** Share of that excess cash that would go to one-time allocations.
- **$37.1 billion:** Total reserves, including $23.3 billion in the Rainy Day fund.
- **$65 million:** Bonus to courts to implement "Care Court" plan providing homeless people with — and compelling them into — treatment.
- **$9.5 billion:** Extra money to fight climate change over the next four years, including $5.2 billion to keep the lights on and nearly $1 billion for residential solar.
- **$1.6 billion:** Additional drought relief outlay

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Other Bills and Topics of Interest

SB 1342 (Bates) - Older Adult Care Coordination. This bill would authorize counties to create a Multi-Disciplinary Team (MDT) for older adults that would allow county departments and aging services providers to exchange information to improve interagency care coordination and service delivery for older adults and their caregivers.

The bill is on the Senate Floor.

CalOptima submitted a support letter for the bill.

AB 2724 (Arambula)/Trailer Bill - Kaiser Medi-Cal Contract. We continue to lobby legislators asking that they support amendments to exclude CalOptima and other County Organized Health Systems (COHS) from the Governor's no-bid contract with Kaiser to provide direct Med-Cal services. The proposal was amended into AB 2724 heard in the Assembly Health Committee in April. Most of the Health Committee members were deferential to the author, Kaiser, and the Governor – or some combination of the three. However, the proposal had a much tougher review in a Senate informational hearing on May 4. Senators asked DHCS and Kaiser many questions indicating some skepticism about the proposal. While the committee did not vote on the proposal, the hearing did provide some hope that Senators could force some amendments to gain their support.

The bill passed out of the Assembly Appropriations Committee on May 19 and is headed for a vote on the Assembly Floor by May 27.

We still expect this matter to be resolved in a budget trailer bill, presuming the Governor gets his way. This means the issue could be resolved at the state level in less than a month. The Department of Finance released new trailer bill language last week. However, the new language does little to improve the bill. In fact, the new language does not reflect many of the changes DHCS has presented in their background documents and testimony. It is unclear why they did not change the language to reflect what they testified is their intent. It is important to note that their proposed changes, even if amended into the trailer bill, would not address the concerns of LHPC or CalOptima.

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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 (IA) **S. 2493 Bennet (CO)**	**Provider Relief Fund Deadline Extension Act:** Would delay the deadline by which providers must spend any funds received from the Provider Relief Fund (PRF) — created in response to the COVID-19 pandemic — until the end of 2021 or the end of the COVID-19 public health emergency (PHE), 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
H.R. 5963 Spanberger (VA) **S. 3611 Shaheen (NH)**	**Provider Relief Fund Improvement Act:** Would delay the deadline by which providers must spend any funds received from the PRF until the end of the COVID-19 PHE. Would also direct HHS to distribute any funds remaining in the PRF by March 31, 2022. Finally, would allow workplace safety improvements as an allowable use of PRF dollars. ***Potential CalOptima Impact:*** *Increased financial stability for CalOptima's contracted providers.*	**11/12/2021** Introduced; referred to committees	CalOptima: Watch

BEHAVIORAL HEALTH

Bill Number Author	Bill Summary	Bill Status	Position/Notes
H.R. 1368 Porter (CA) **S. 515 Warren (MA)**	**Mental Health Justice Act:** Would require HHS to award grants to states and local governments to hire, train and dispatch mental health professionals instead of law enforcement personnel to respond to behavioral health crises. ***Potential CalOptima Impact:*** *Increased access to behavioral health services for CalOptima members; decreased rates of arrest and incarceration.*	**02/25/2021** Introduced; referred to committees	CalOptima: Watch County of Orange: Support
H.R. 1914 DeFazio (OR) **S. 764 Wyden (OR)**	**Crisis Assistance Helping Out On The Streets (CAHOOTS) Act:** Would increase the Federal Medical Assistance Percentage (FMAP) for states to cover 24/7 community-based mobile crisis intervention services for those experiencing a mental health or substance use disorder (SUD) crisis from 85% to 95% for three years. Would also require HHS to issue an additional $25 million in planning and evaluation grants to states. ***Potential CalOptima Impact:*** *Increased behavioral health and SUD services to CalOptima Medi-Cal members.*	**03/16/2021** Introduced; referred to committees	**08/05/2021** CalOptima: Support

Bill Number Author	Bill Summary	Bill Status	Position/Notes
AB 552 **Quirk-Silva**	**Integrated School-Based Behavioral Health Partnership Program:** Would establish the Integrated School-Based Behavioral Health Partnership Program to expand prevention and early intervention behavioral health services for students. This would allow a county mental health agency and local education agency to develop a formal partnership whereby county mental health professionals would deliver brief school-based services to any student who has, or is at risk of developing, a behavioral health condition or SUD. ***Potential CalOptima Impact:*** *Increased coordination with the Orange County Health Care Agency and school districts to ensure non-duplication of other school-based behavioral health services and initiatives.*	**01/31/2022** Passed Assembly floor; referred to Senate	CalOptima: Watch
SB 1019 **Gonzalez**	**Mental Health Benefit Outreach and Education:** Would require a Medi-Cal managed care plan (MCP) to conduct annual outreach and education to beneficiaries and primary care physicians regarding covered mental health benefits while incorporating best practices in stigma reduction. DHCS must conduct an annual assessment of Medi-Cal beneficiaries' experience with mental health services, which an MCP must supplement through regional surveys or listening sessions. ***Potential CalOptima Impact:*** *Additional member and provider outreach activities by CalOptima staff.*	**04/06/2022** Passed Senate Health Committee; referred to Senate Appropriations Committee	CalOptima: Watch
SB 1338 **Umberg**	**Community Assistance, Recovery, and Empowerment (CARE) Court Program:** Would establish the CARE Court Program to facilitate delivery of mental health and SUD services to individuals with schizophrenia spectrum or other psychotic disorders who lack medical decision-making capabilities. The program would connect a person in crisis with a court-ordered care plan for up to 12 months, with the option to extend an additional 12 months as a diversion from homelessness, incarceration or conservatorship. Care plans could include court-ordered stabilization medications, wellness and recovery supports, and connection to social services and a housing plan. Eligible individuals may be referred by family members, counties, behavioral health providers or first responders among others. ***Potential CalOptima Impact:*** *Increased behavioral health and SUD services for eligible CalOptima members.*	**04/27/2022** Passed Senate Health Committee; referred to Senate Appropriations Committee **04/26/2022** Passed Senate Judiciary Committee	CalOptima: Watch CAHP: Concern
RN 22 06818 **Trailer Bill**	**Qualifying Community-Based Mobile Crisis Intervention Services:** No sooner than January 1, 2023, and through March 31, 2027, would add 24/7 community-based mobile crisis intervention services as a covered Medi-Cal benefit for beneficiaries experiencing a mental health or SUD crisis. Services would be provided through county behavioral health systems. ***Potential CalOptima Impact:*** *Increased coordination with the Orange County Health Care Agency for behavioral health services; increased follow-up care by CalOptima and its contracted behavioral health providers.*	**03/03/2022** Published by the Department of Finance	CalOptima: Watch

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BUDGET

Bill Number Author	Bill Summary	Bill Status	Position/Notes
H.R. 2471 DeLauro (CT)	**Consolidated Appropriations Act, 2022:** Appropriates $1.5 trillion to fund the federal government through September 30, 2022, including earmarks for the following projects in Orange County: ■ Children's Hospital of Orange County: $325,000 to expand capacity for mental health treatment services and programs in response to the COVID-19 pandemic ■ City of Huntington Beach: $500,000 to establish a mobile crisis response program ■ County of Orange: $2 million to develop a second Be Well Orange County campus in the City of Irvine ■ County of Orange: $5 million to develop a Coordinated Reentry Center to help justice-involved individuals with mental health conditions or SUDs reintegrate into the community ■ North Orange County Public Safety Task Force: $5 million to expand homeless outreach and housing placement services In addition, extends all current telehealth flexibilities in the Medicare program until approximately five months following the termination of the COVID-19 PHE. ***Potential CalOptima Impact:*** *Increased coordination with the County of Orange and other community partners to support implementation of projects that benefit CalOptima members; continuation of all current telehealth flexibilities for CalOptima OneCare, OneCare Connect and Program of All-Inclusive Care for the Elderly (PACE).*	**03/15/2022** Signed into law	CalOptima: Watch

COVERED BENEFITS

Bill Number Author	Bill Summary	Bill Status	Position/Notes
H.R. 56 Biggs (AZ)	**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 (MI)	**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 PACE.*	**02/18/2021** Introduced; referred to committees	CalOptima: Watch

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Bill Number Author	Bill Summary	Bill Status	Position/Notes
H.R. 4187 **Schrier (WA)**	**Medicare Vision Act of 2021:** Effective January 1, 2024, would require Medicare Part B coverage of vision services, including eyeglasses, contact lenses, routine eye examinations and fittings. ***Potential CalOptima Impact:*** *New covered benefits for CalOptima OneCare and PACE.*	**06/25/2021** Introduced; referred to committees	CalOptima: Watch
H.R. 4311 **Doggett (TX)** **S. 2618** **Casey (PA)**	**Medicare Dental, Vision, and Hearing Benefit Act of 2021:** Effective no sooner than January 1, 2022, would require Medicare Part B coverage of the following benefits: ■ Dental: Routine dental cleanings and examinations, basic and major dental services, emergency dental care, and dentures ■ Vision: Routine eye examinations, eyeglasses, contact lenses and low vision devices ■ Hearing: Routine hearing examinations, hearing aids and related examinations The Senate version would also increase the Medicaid FMAP for hearing, vision and dental services to 90%. ***Potential CalOptima Impact:*** *New covered benefits for CalOptima OneCare, OneCare Connect and PACE; higher federal funding rate for current Medi-Cal benefits.*	**07/01/2021** Introduced; referred to committees	CalOptima: Watch
H.R. 4650 **Kelly (IL)**	**Medicare Dental Coverage Act of 2021:** Effective January 1, 2025, would require Medicare Part B coverage of dental and oral health services, including routine dental cleanings and examinations, basic and major dental treatments, and dentures. ***Potential CalOptima Impact:*** *New covered benefits for CalOptima OneCare and PACE.*	**07/22/2021** Introduced; referred to committees	CalOptima: Watch
AB 1929 **Gabriel**	**Violence Preventive Services:** Would add violence preventive services as a covered Medi-Cal benefit for beneficiaries who have experienced, are at risk of experiencing or have been chronically exposed to community violence, including gunshot wounds, stabbing injuries and other violent harms. DHCS would approve training and certification programs for qualified violence prevention professionals, who would be designated as community health workers (CHWs). ***Potential CalOptima Impact:*** *New covered benefit for CalOptima Medi-Cal members; additional credentialing and contracting for a new provider type.*	**04/05/2022** Passed Assembly Health Committee; referred to Assembly Appropriations Committee	CalOptima: Watch
AB 1930 **Arambula**	**Perinatal Services:** Would require Medi-Cal coverage of additional perinatal assessments and services as developed by the California Department of Public Health and additional stakeholders for beneficiaries up to one year postpartum. A nonlicensed perinatal worker could deliver such services if supervised by an enrolled Medi-Cal provider or a non-enrolled community-based organization (CBO) if a Medi-Cal provider is available for billing. ***Potential CalOptima Impact:*** *New covered benefit for CalOptima Medi-Cal members up to one-year postpartum.*	**04/26/2022** Passed Assembly Health Committee; referred to Assembly Appropriations Committee	CalOptima: Watch

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Bill Number Author	Bill Summary	Bill Status	Position/Notes
AB 2697 Aguiar-Curry	**Community Health Workers and Promotores:** Would add preventive services provided by CHWs and promotores as a Medi-Cal covered benefit. Services include health education and navigation for individuals who have or are at risk of a chronic condition or injury and are unable to prevent or manage such condition. Upon implementation, Medi-Cal MCPs would conduct annual benefit education to beneficiaries and providers as well as complete an annual assessment of CHW and promotores capacity and need. ***Potential CalOptima Impact:*** *New covered benefit for CalOptima Medi-Cal members; additional member and provider outreach activities; additional network adequacy analyses.*	**04/26/2022** Passed Assembly Health Committee; referred to Assembly Appropriations Committee	CalOptima: Watch
SB 245 Gonzalez	**Abortion Services:** Would prohibit a health plan from imposing Medi-Cal cost-sharing on all abortion services, including any pre-abortion or follow-up care, no sooner than January 1, 2023. In addition, a health plan and its delegated entities may not require a prior authorization or impose an annual or lifetime limit on such coverage. ***Potential CalOptima Impact:*** *Modified Utilization Management (UM) procedures for a covered Medi-Cal benefit.*	**03/22/2022** Signed into law	CalOptima: Watch CAHP: Oppose
SB 912 Limón	**Biomarker Testing:** No later than July 1, 2023, would add biomarker testing, including whole genome sequencing, as a Medi-Cal covered benefit to diagnose, treat or monitor a disease. ***Potential CalOptima Impact:*** *New covered benefit for CalOptima Medi-Cal members.*	**04/20/2022** Passed Senate Health Committee; referred to Senate Appropriations Committee	CalOptima: Watch CAHP: Oppose

MEDI-CAL ELIGIBILITY AND ENROLLMENT

Bill Number Author	Bill Summary	Bill Status	Position/Notes
H.R. 1738 Dingell (MI) **S. 646 Brown (OH)**	**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 Medi-Cal members.*	**03/10/2021** Introduced; referred to committees	CalOptima: Watch ACAP: Support
H.R. 5610 Bera (CA) **S. 3001 Van Hollen (MD)**	**Easy Enrollment in Health Care Act:** To streamline and increase enrollment into public health insurance programs, would allow taxpayers to request their federal income tax returns include a determination of eligibility for Medicaid, CHIP or advance premium tax credits to purchase insurance through a health plan exchange. Taxpayers could also consent to be automatically enrolled into any such program or plan if they would be subject to a zero net premium. ***Potential CalOptima Impact:*** *Increased number of CalOptima Medi-Cal members.*	**10/19/2021** Introduced; referred to committees	CalOptima: Watch ACAP: Support

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Bill Number Author	Bill Summary	Bill Status	Position/Notes
H.R. 6636 **Trone (MD)** **S. 2697** **Cassidy (LA)**	**Due Process Continuity of Care Act:** Would allow states to extend Medicaid coverage to inmates who are awaiting trial and have not been convicted of a crime. ***Potential CalOptima Impact:*** *If DHCS exercises option and requires enrollment into managed care, increased number of CalOptima Medi-Cal members.*	**08/10/2021** Introduced; referred to committees	CalOptima: Watch
AB 2402 **Rubio, B.**	**Medi-Cal Continuous Eligibility for Children:** Would allow Medi-Cal beneficiaries under five years of age to remain continuously eligible for Medi-Cal regardless of income changes. ***Potential CalOptima Impact:*** *Increased number of CalOptima Medi-Cal members.*	**03/29/2022** Passed Assembly Health Committee; referred to Assembly Appropriations Committee	CalOptima: Watch LHPC: Support
AB 2680 **Arambula**	**Community Health Navigator Program:** Would require DHCS to create the Community Health Navigator Program to issue direct grants to qualified CBOs to conduct targeted outreach, enrollment and access activities for Medi-Cal-eligible individuals and families. ***Potential CalOptima Impact:*** *Increased number of CalOptima Medi-Cal members.*	**04/26/2022** Passed Assembly Health Committee; referred to Assembly Appropriations Committee	CalOptima: Watch
RN 22 07748 **Trailer Bill**	**Extend the Duration of Suspension of Medi-Cal Benefits for Adult Incarcerated Individuals:** Would require that Medi-Cal benefits are paused for the entire duration of incarceration without any termination of Medi-Cal eligibility. Current law requires that Medi-Cal benefits are paused for adult inmates for only one year before termination. ***Potential CalOptima Impact:*** *Increased number of CalOptima Medi-Cal members who are recently released from incarceration; improved continuity of care and health outcomes for such members.*	**02/10/2022** Published by the Department of Finance	CalOptima: Watch
RN 22 08022 **Trailer Bill**	**Expansion of Full Scope Medi-Cal Coverage to Individuals 26 to 49 Years of Age, Regardless of Immigration Status:** No sooner than January 1, 2024, would expand eligibility for full-scope Medi-Cal benefits to include individuals ages 26 to 49 years, regardless of immigration status. With previous legislative action extending such eligibility to those under 26 years and over 50 years, this would provide Medi-Cal coverage for all ages regardless of immigration status. ***Potential CalOptima Impact:*** *Increased number of CalOptima Medi-Cal members.*	**02/01/2022** Published by the Department of Finance	CalOptima: Watch

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MEDI-CAL OPERATIONS AND ADMINISTRATION

Bill Number Author	Bill Summary	Bill Status	Position/Notes
AB 1355 **Levine**	**Medi-Cal Independent Medical Review (IMR) System:** Would require DHCS to establish an IMR system, effective January 1, 2023, for Medi-Cal services provided through the following: ■ County Drug Medi-Cal Organized Delivery Systems ■ County Mental Health Plans ■ Medi-Cal fee-for-service (FFS) ■ Medi-Cal MCPs without a Knox-Keene license from the California Department of Managed Health Care (DMHC) ■ PACE The proposed DHCS IMR would closely mirror the current DMHC IMR process for Knox-Keene licensed health plans. As a result, the bill would provide every Medi-Cal beneficiary with access to an IMR. ***Potential CalOptima Impact:*** *Implementation of an additional Grievance and Appeals process for CalOptima Medi-Cal and PACE.*	**01/27/2022** Passed Assembly floor; referred to Senate	CalOptima: Watch
AB 1400 **Kalra, Lee, Santiago**	**California Guaranteed Health Care for All:** Would create the California Guaranteed Health Care for All program (CalCare) to provide a comprehensive universal single-payer health care benefit for all California residents. Would require CalCare cover a wide range of medical benefits and other services and would incorporate the health care benefits and standards of CHIP, Medi-Cal, Medicare, the Knox-Keene Act, and ancillary health care or social services covered by regional centers for people with developmental disabilities. ***Potential CalOptima Impact:*** *Unknown but potentially significant impacts to the Medi-Cal delivery system and MCPs, including changes to administration, covered benefits, eligibility, enrollment, financing and organization.*	**01/31/2022** Died on Assembly floor	CalOptima: Watch CAHP: Oppose
AB 1937 **Patterson**	**Out-of-Pocket Pregnancy Costs:** No later than July 1, 2023, would require DHCS to reimburse pregnant Medi-Cal beneficiaries up to $1,250 for out-of-pocket pregnancy costs, including birth and infant care classes, midwife and doula services, lactation support, prenatal vitamins, lab tests or screenings, prenatal acupuncture or acupressure, and medical transportation. ***Potential CalOptima Impact:*** *Increased financial stability for CalOptima Medi-Cal members who are currently or were recently pregnant.*	**04/29/2022** Died in Assembly Health Committee	CalOptima: Watch

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Bill Number Author	Bill Summary	Bill Status	Position/Notes
AB 1944 **Lee**	**Brown Act Flexibilities:** Would extend certain Brown Act flexibilities, temporarily enacted in response to the COVID-19 PHE, until January 1, 2030, regardless of the existence of a PHE. Specifically, teleconferencing locations for any members of a legislative body would not need to be identified or publicly accessible. If exercising these flexibilities, a legislative body must comply with the following requirements: ■ The agenda must identify which members are teleconferencing. ■ Members of the public must have access to a video stream of the primary meeting location. ■ Members of the public must be able to provide public comment via in-person, audio-visual or call-in options. ***Potential CalOptima Impact:*** *Continued ability for members of CalOptima's Board of Directors and advisory committees to participate in meetings by teleconference; modified posting and noticing requirements for the Clerk of the Board.*	**05/04/2022** Passed Assembly Local Government Committee; referred to Assembly floor	CalOptima: Watch LHPC: Support
AB 1995 **Arambula**	**Medi-Cal Premium and Copayment Elimination:** Would eliminate Medi-Cal premiums for low-income children whose family income exceeds 160% federal poverty level (FPL), working disabled persons with incomes less than 250% FPL and pregnant women and infants enrolled in the Medi-Cal Access Program. Would also eliminate copayments for all Medi-Cal beneficiaries. ***Potential CalOptima Impact:*** *Increased financial stability for CalOptima Medi-Cal members.*	**03/22/2022** Passed Assembly Health Committee; referred to Assembly Appropriations Committee	CalOptima: Watch LHPC: Support
AB 2077 **Calderon**	**Medi-Cal Personal Needs Allowance:** Would increase the monthly income that a Medi-Cal beneficiary residing in a long-term care (LTC) facility or receiving PACE services is allowed to retain from $35 to $80. Beneficiaries must contribute remaining income as a share of cost to the facility before Medi-Cal pays remaining expenses. ***Potential CalOptima Impact:*** *Increased financial stability for CalOptima PACE participants and CalOptima Medi-Cal members residing in LTC facilities with a share of cost.*	**03/22/2022** Passed Assembly Health Committee; referred to Assembly Appropriations Committee	CalOptima: Watch CalPACE: Support LHPC: Support

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Bill Number Author	Bill Summary	Bill Status	Position/Notes
AB 2449 **Rubio, B.**	**Brown Act Flexibilities:** Would permanently extend certain Brown Act flexibilities, temporarily enacted in response to the COVID-19 PHE, regardless of the existence of a PHE. Specifically, teleconferencing locations for any members of a legislative body would not need to be identified or publicly accessible. If exercising these flexibilities, a legislative body must comply with the following requirements: ■ A quorum of members must participate in-person at a single location identified on the agenda and publicly accessible. ■ Teleconferencing members must participate through audio and visual technology. ■ Members of the public must be able to provide public comment via in-person, call-in or internet-based options. ***Potential CalOptima Impact:*** *Continued ability for members of CalOptima's Board of Directors and advisory committees to participate in meetings by teleconference; modified posting and noticing requirements for the Clerk of the Board.*	**05/04/2022** Passed Assembly Local Government Committee; referred to Assembly floor	CalOptima: Watch
AB 2724 **Arambula** **RN 22 08897** **Trailer Bill**	**Alternate Health Care Service Plan:** No sooner than January 1, 2024, would authorize DHCS to contract directly with an Alternate Health Care Service Plan (AHCSP) as a Medi-Cal MCP in any region. An AHCSP is a nonprofit health plan with at least four million enrollees statewide that owns or operates pharmacies and provides medical services through an exclusive contract with a single medical group in each region. Enrollment into an AHCSP would be limited to the following Medi-Cal beneficiaries: ■ Previous AHCSP enrollees and their immediate family members ■ Dually eligible for Medi-Cal and Medicare benefits ■ Foster youth ***Potential CalOptima Impact:*** *Additional Medi-Cal MCP in Orange County; decreased number of CalOptima Medi-Cal members; increased percentage of CalOptima members who are high-risk.*	**04/19/2022** Passed Assembly Health Committee; referred to Assembly Appropriations Committee	**04/07/2022** CalOptima: Oppose Unless Amended LHPC: Oppose
SB 858 **Wiener**	**Health Plan Civil Penalties:** Would increase the civil penalty amount that DMHC could levy on a health plan from no more than $2,500 per violation to no less than $25,000 per violation per impacted beneficiary per day. The penalty amount would be adjusted annually, beginning January 1, 2024. ***Potential CalOptima Impact:*** *Increased financial penalties for CalOptima OneCare, OneCare Connect and PACE.*	**04/26/2022** Passed Senate Judiciary Committee; referred to Senate Appropriations Committee **04/20/2022** Passed Senate Health Committee	CalOptima: Watch CAHP: Oppose

Bill Number Author	Bill Summary	Bill Status	Position/Notes
SB 923 **Wiener**	**TGI Inclusive Care Act:** No later than January 1, 2024, would require Medi-Cal MCP and PACE organization staff in direct contact with beneficiaries to complete cultural competency training to help provide inclusive health care services for individuals who identify as transgender, gender nonconforming or intersex (TGI). In addition, no later than July 31, 2023, would require a Medi-Cal MCP and PACE organization to include in its provider directory any in-network providers who offer gender-affirming services. Finally, no later than January 1, 2025, would require the California Health and Human Services Agency to implement a quality standard that measures patient experience with TGI cultural competency. ***Potential CalOptima Impact:*** *Additional training requirement for member-facing CalOptima employees; additional requirement for provider directory publication.*	**04/06/2021** Passed Senate Health Committee; referred to Senate Appropriations Committee	CalOptima: Watch CAHP: Oppose Unless Amended
RN 22 08129 **Trailer Bill**	**Copayments in the Medi-Cal Program:** Effective July 1, 2022, would allow DHCS to eliminate copayments for all Medi-Cal beneficiaries. Currently, providers may impose the following copayments on Medi-Cal beneficiaries, except children, foster youth and women receiving pregnancy or postpartum care: ■ $5 copayment for nonemergency services in an emergency department ■ $1 copayment for most outpatient and dental services, except preventive and family planning services ***Potential CalOptima Impact:*** *Increased financial stability for CalOptima Medi-Cal members.*	**02/17/2022** Published by the Department of Finance	CalOptima: Watch
RN 22 10705 **Trailer Bill**	**Reducing Premiums for the Optional Targeted Low-Income Children's Program (OTLICP), 250 Percent Working Disabled Program (WDP), and Children's Health Insurance Program (CHIP):** Effective July 1, 2022, would allow DHCS to eliminate Medi-Cal premiums for low-income children whose family income exceeds 160% FPL, working disabled persons with incomes less than 250% FPL and pregnant women and infants enrolled in the Medi-Cal Access Program. ***Potential CalOptima Impact:*** *Increased financial stability for CalOptima Medi-Cal members in certain aid code categories.*	**03/03/2022** Published by the Department of Finance	CalOptima: Watch

OLDER ADULT SERVICES

Bill Number Author	Bill Summary	Bill Status	Position/Notes
H.R. 3173 **DelBene (WA)** **S. 3018** **Marshall (KS)**	**Improving Seniors' Timely Access to Care Act:** Would require Medicare Advantage (MA) plans to issue real-time decisions for routine prior authorization requests. HHS would determine and biannually update the definitions of "real-time" and "routine." In addition, HHS would establish electronic prior authorization transmission standards for MA plans. ***Potential CalOptima Impact:*** *Modified UM procedures and timelines for CalOptima OneCare.*	**05/13/2021** Introduced; referred to committees	CalOptima: Watch

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Bill Number Author	Bill Summary	Bill Status	Position/Notes
H.R. 4131 **Dingell (MI)** **S. 2210** **Casey (PA)**	**Better Care Better Jobs Act:** Would make permanent the enhanced 10% FMAP for Medicaid home- and community-based services (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 (OR)**	**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
H.R. 6770 **Dingell (MI)** **S. 1162** **Casey (PA)**	**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 size and/or service area of a current PACE center or to establish a new PACE center(s).*	**04/15/2021** Introduced; referred to committees	CalOptima: Watch NPA: Support
H.R. 6823 **Brownley (CA)** **S. 3854** **Moran (KS)**	**Elizabeth Dole Home and Community Based Services for Veterans and Caregivers Act:** Would require Veterans Affairs (VA) medical centers to establish partnerships with PACE organizations to enable veterans to access PACE services through their VA benefits. ***Potential CalOptima Impact:*** *Increased number of CalOptima PACE participants; increased care coordination for CalOptima PACE participants who are veterans.*	**02/25/2022** Introduced; referred to committees	CalOptima: Watch NPA: Support

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Bill Number Author	Bill Summary	Bill Status	Position/Notes
S. 3626 Casey	**PACE Expanded Act:** To increase access to and the affordability of PACE, would allow PACE organizations to set premiums individually for Medicare-only beneficiaries consistent with their health status. Would also allow individuals to enroll in PACE at any time during the month. In addition, would simplify and expedite the process for organizations to apply for the following: ■ New PACE program ■ New centers for an existing PACE program ■ Expanded service area for an existing PACE center Finally, would allow pilot programs to test the PACE model of care with new populations not currently eligible to participate in PACE. ***Potential CalOptima Impact:*** *Increased number of CalOptima PACE participants; expanded eligibility criteria; new premium development procedure; simplified process to establish new PACE centers.*	**02/10/2022** Introduced; referred to committee	CalOptima: Watch NPA: Support
SB 1342 Bates	**Older Adult Care Coordination:** Would allow a county and/or an Area Agency on Aging to create a multi-disciplinary team (MDT) for county departments and aging service providers to exchange information about older adults to better address their health and social needs. By eliminating data silos, MDTs could develop coordinated case plans for wraparound services, provide support to caregivers and improve service delivery. ***Potential CalOptima Impact:*** *Participation in Orange County's MDT; improved care coordination for CalOptima's older adult members.*	**04/26/2022** Passed Senate Judiciary Committee; referred to Senate Appropriations Committee **04/05/2022** Passed Senate Human Services Committee	**03/29/2022** CalOptima: Support County of Orange: Sponsor

PHARMACY

Bill Number Author	Bill Summary	Bill Status	Position/Notes
SB 853 Wiener	**Medication Access Act:** Effective January 1, 2023, would require a health plan to cover a prescribed medication for the duration of utilization review and any appeals if the drug was previously covered for the beneficiary by any health plan. Would prohibit a plan from seeking reimbursement from a beneficiary if a denial is sustained. ***Potential CalOptima Impact:*** *Modified UM and Grievance and Appeals requirements for prescribed drugs covered by CalOptima; increased CalOptima costs for drug coverage.*	**04/20/2022** Passed Senate Health Committee; referred to Senate Appropriations Committee	CalOptima: Watch CAHP: Oppose
SB 958 Limón	**Medication and Patient Safety Act of 2022:** Would prohibit health plans from arranging for "brown bagging" or "white bagging," as follows, except under certain limited conditions: ■ "Brown bagging" involves specialty pharmacies dispensing an infused or injected medication directly to a patient who transports it to a provider for administration. ■ "White bagging" involves specialty pharmacies distributing such medications to a provider ahead of a patient's visit. ***Potential CalOptima Impact:*** *Increased CalOptima costs and decreased member access for certain physician-administered drugs covered by CalOptima.*	**04/18/2022** Rereferred to Senate Appropriations Committee **04/06/2022** Passed Senate Health Committee; referred to Senate Judiciary Committee	CalOptima: Watch CAHP: Oppose LHPC: Oppose Unless Amended

PROVIDERS

Bill Number Author	Bill Summary	Bill Status	Position/Notes
AB 2581 Salas	**Behavioral Health Provider Credentialing:** Effective January 1, 2023, would require health plans to process credentialing applications from mental health and SUD providers within 60 days of receipt. ***Potential CalOptima Impact:*** *Modified provider credentialing processes for Quality Improvement staff.*	**04/26/2022** Passed Assembly Health Committee; referred to Assembly Appropriations Committee	CalOptima: Watch
AB 2659 Patterson	**Midwife Access:** Would require a Medi-Cal MCP to include at least one licensed midwife (LM), certified-nurse midwife (CNM) and alternative birth center specialty clinic in each county within its provider network. An MCP would be exempt if such providers or centers are not located within the county or do not accept Medi-Cal payments. An MCP must reimburse an out-of-network provider who accepts the Medi-Cal FFS rate. ***Potential CalOptima Impact:*** *Additional provider contracting and credentialing; increased access to midwifery services for CalOptima Medi-Cal members.*	**04/29/2022** Died in Assembly Health Committee	CalOptima: Watch
SB 966 Limón	**Clinic Providers:** Effective 60 days following the termination of the COVID-19 PHE, would allow Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) to be reimbursed for visits with an associate clinical social worker or associate marriage and family therapist when supervised by a licensed behavioral health practitioner. ***Potential CalOptima Impact:*** *Increased member access to behavioral health providers at contracted FQHCs.*	**03/23/2022** Passed Senate Health Committee; referred to Senate Appropriations Committee	CalOptima: Watch LHPC: Support
SB 987 Portantino	**California Cancer Care Equity Act:** Would require a Medi-Cal MCP to contract directly with at least one National Cancer Institute Designated Cancer Center in each county — where one exists — within the MCP's service area. In addition, an MCP must refer a beneficiary to a Cancer Center within 15 business days of a complex cancer diagnosis, subject to expedited appeals and authorization timelines. ***Potential CalOptima Impact:*** *Modified UM procedures for CalOptima Medi-Cal members referred to the UCI Health Chao Family Comprehensive Cancer Center; increased access to cancer care.*	**04/20/2022** Passed Senate Health Committee; referred to Senate Appropriations Committee	CalOptima: Watch CAHP: Oppose LHPC: Oppose

REIMBURSEMENT RATES

Bill Number Author	Bill Summary	Bill Status	Position/Notes
AB 1892 Flora	**California Orthotic and Prosthetic Patient Access and Fairness Act:** Would require reimbursement for prosthetic and orthotic appliances and durable medical equipment (DME) to be at least 80% of the lowest maximum allowance for California established by the federal Medicare program. ***Potential CalOptima Impact:*** *Increased cost to CalOptima Medi-Cal due to higher reimbursement to DME providers; adjustment to DHCS capitation rates.*	**04/05/2022** Passed Assembly Health Committee; referred to Assembly Appropriations Committee	CalOptima: Watch

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Bill Number Author	Bill Summary	Bill Status	Position/Notes
AB 2458 **Weber**	**Whole Child Model (WCM) Reimbursement Rates:** Effective January 1, 2023, would increase provider reimbursement rates for WCM services by 25% if provided at a medical practice in which at least 30% of pediatric patients are Medi-Cal beneficiaries. ***Potential CalOptima Impact:*** *Increased cost to CalOptima Medi-Cal due to higher reimbursement to WCM providers; adjustment to DHCS capitation rates.*	**03/22/2022** Passed Assembly Health Committee; referred to Assembly Appropriations Committee	CalOptima: Watch
RN 22 08446 **Trailer Bill**	**FQHC Alternative Payment Methodology (APM) Project:** No sooner than January 1, 2024, would authorize DHCS to permanently implement an APM option for FQHCs to receive value-based payments instead of volume-based payments. Specifically, Medi-Cal MCPs would pay an FQHC a per-member-per-month rate, based on historic utilization, which would be no less than the current amount paid through its Prospective Payment System rate. ***Potential CalOptima Impact:*** *New rate structure and modified contracts for CalOptima's contracted FQHCs who participate in the APM project; increased reporting requirements to DHCS.*	**03/07/2022** Published by the Department of Finance	CalOptima: Watch

SOCIAL DETERMINANTS OF HEALTH

Bill Number Author	Bill Summary	Bill Status	Position/Notes
H.R. 379 **Barragan (CA)** **S. 104** **Smith (MN)**	**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 (GA)** **S. 851** **Blumenthal (CT)**	**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 (IL) **S. 3039 Young (IN)**	**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 (House version) or $10 million (Senate version) 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 (DE)	**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.*	**12/08/2021** Passed House floor; referred to Senate Committee on Finance	CalOptima: Watch
H.R. 4026 Burgess (TX)	**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.*	**11/30/2021** Passed House floor; referred to Senate Committee on Health, Education, Labor, and Pensions	CalOptima: Watch

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 PHE 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

Bill Number Author	Bill Summary	Bill Status	Position/Notes
H.R. 1332 **Carter (GA)** **S. 368** **Scott (SC)**	**Telehealth Modernization Act of 2021:** Would permanently extend certain current telehealth flexibilities in the Medicare program, enacted temporarily in response to the COVID-19 pandemic. Specifically, would permanently allow the following: ■ FQHCs and RHCs may serve as the site of a telehealth provider ■ Beneficiaries may receive all telehealth services at any location, including their own homes ■ CMS may retain and expand the list of covered telehealth services ■ CMS may expand the types of providers eligible to provide telehealth services ***Potential CalOptima Impact:*** *Continuation of certain telehealth flexibilities allowed during the COVID-19 pandemic for CalOptima OneCare, OneCare Connect and PACE.*	**02/23/2021** Introduced; referred to committees	CalOptima: Watch
H.R. 2166 **Sewell (AL)**	**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 MA and PACE plans during the COVID-19 PHE. ***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 (HI)**	**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 PHE: ■ Medicare providers may be reimbursed for providing certain services via audio-only telehealth, including evaluation and management, behavioral health and SUD 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

Bill Number Author	Bill Summary	Bill Status	Position/Notes
H.R. 4058 **Matsui (CA)** **S. 2061** **Cassidy (LA)**	**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
H.R. 7573 **Axne (IA)** **S. 3593** **Cortez Masto (NV)**	**Telehealth Extension and Evaluation Act:** Would extend current Medicare telehealth payments authorized temporarily in response to the COVID-19 pandemic for two additional years following the termination of the PHE. Would require HHS to study the impact of telehealth flexibilities and report its recommendations for permanent telehealth policies to Congress. ***Potential CalOptima Impact:*** *Continuation of telehealth flexibilities for CalOptima OneCare, OneCare Connect and PACE.*	**02/08/2022** Introduced; referred to committee	CalOptima: Watch
S. 150 **Cortez Masto (NV)**	**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 PHE. ***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
RN 22 09807 **Trailer Bill**	**Medi-Cal Telehealth Services:** Would permanently extend or modify certain Medi-Cal telehealth flexibilities currently authorized during the COVID-19 pandemic as follows: ■ DHCS must specify the Medi-Cal covered benefits that may be delivered via telehealth as well as the telehealth provider types allowed in addition to FQHCs and RHCs. ■ Telehealth services may be delivered via video, audio only, remote patient monitoring and other virtual modalities. ■ Video and audio-only telehealth services must be reimbursed at the same rate as in-person services, while remote patient monitoring and other modalities may be reimbursed at different rates. ■ Medi-Cal providers, including FQHCs and RHCs, may establish a new Medi-Cal patient using video telehealth but not audio-only telehealth or other virtual modalities. Finally, would allow Medi-Cal MCPs to include video telehealth encounters when determining compliance with network adequacy requirements. ***Potential CalOptima Impact:*** *Continuation and modification of certain telehealth flexibilities for CalOptima Medi-Cal.*	**03/08/2022** Published by the Department of Finance	CalOptima: Watch

YOUTH SERVICES

Bill Number Author	Bill Summary	Bill Status	Position/Notes
H.R. 66 **Buchanan (FL)**	**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 Medi-Cal members eligible under CHIP.*	**01/04/2021** Introduced; referred to committee	CalOptima: Watch
H.R. 1390 **Wild (PA)** **S. 453** **Casey (PA)**	**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 PHE. ***Potential CalOptima Impact:*** *Increased federal funds for CalOptima Medi-Cal members eligible under CHIP.*	**02/25/2021** Introduced; referred to committees	CalOptima: Watch

Two-Year Bills

The following bills did not meet the deadline to be passed by both houses of the State Legislature in 2021 but are still eligible for reconsideration in 2022:

- AB 4 (Arambula)
- AB 32 (Aguiar-Curry)
- AB 114 (Maienschein)
- AB 470 (Carrillo)
- AB 540 (Petrie-Norris)
- AB 563 (Berman)
- AB 586 (O'Donnell)
- AB 1132 (Wood)
- SB 17 (Pan)
- SB 56 (Pan)
- SB 250 (Pan)
- SB 256 (Pan)
- SB 293 (Limón)
- SB 316 (Eggman)
- SB 371 (Caballero)
- SB 523 (Leyva)
- SB 562 (Portantino)
- SB 773 (Roth)

2021 Signed Bills

- H.R. 1868 (Yarmuth [KY])
- AB 128 (Ting)
- AB 133 (Committee on Budget)
- AB 161 (Ting)
- AB 164 (Ting)
- AB 361 (Rivas)
- AB 1082 (Waldron)
- SB 48 (Limón)
- SB 65 (Skinner)
- SB 129 (Skinner)
- SB 171 (Committee on Budget and Fiscal Review)
- SB 221 (Wiener)
- SB 306 (Pan)
- SB 510 (Pan)

2021 Vetoed Bills

- AB 369 (Kamlager)
- AB 523 (Nazarian)
- SB 365 (Caballero)
- SB 682 (Rubio)

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

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2022 Federal Legislative Dates

January 3	117th Congress, Second Session convenes
April 11–22	Spring recess
August 1–12	Summer recess for House
August 8–September 5	Summer recess for Senate
December 10	Second Session adjourns

2022 State Legislative Dates

January 3	Legislature reconvenes
January 14	Last day for policy committees to hear and report to fiscal committees any fiscal bills introduced in that house in 2021
January 21	Last day for any committee to hear and report to the floor any bill introduced in that house in 2021
January 31	Last day for each house to pass bills introduced in that house in 2021
February 18	Last day for legislation to be introduced
April 7–18	Spring recess
April 29	Last day for policy committees to hear and report to fiscal committees any fiscal bills introduced in that house in 2022
May 6	Last day for policy committees to hear and report to the floor any non-fiscal bills introduced in that house in 2022
May 20	Last day for fiscal committees to hear and report to the floor any bills introduced in that house in 2022
May 23–27	Floor session only
May 27	Last day for each house to pass bills introduced in that house in 2022
June 15	Budget bill must be passed by midnight
July 1	Last day for policy committees to hear and report bills in their second house to fiscal committees or the floor
July 1–August 1	Summer recess
August 12	Last day for fiscal committees to report bills in their second house to the floor
August 15–31	Floor session only
August 25	Last day to amend bills on the floor
August 31	Last day for each house to pass bills; final recess begins upon adjournment
September 30	Last day for Governor to sign or veto bills passed by the Legislature

Source: 2022 State Legislative Deadlines, California State Assembly: http://assembly.ca.gov/legislativedeadlines

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Board of Directors Meeting
June 2, 2022

CalOptima Community Outreach Summary — May and June 2022

Background

CalOptima is committed to serving the community by sharing information with current and potential members and strengthening relationships with community partners. To do so, CalOptima attends community coalitions, collaborative meetings and advisory groups, and supports our community partners' public activities.

CalOptima's participation in public activities promotes:

- Member interaction/enrollment in a CalOptima program
- Community awareness of CalOptima
- Partnerships that increase positive visibility and relationships with community organizations

CalOptima continues to participate in public activities virtually in most instances with some limited in-person attendance. Participation includes providing CalOptima Medi-Cal educational materials and, if criteria are met, financial support and/or CalOptima-branded items.

Community Outreach Highlight

CalOptima launched the CalFresh Outreach Strategy to address food insecurity for our members by increasing awareness and enrollment into the CalFresh program. This comprehensive strategy includes a text message campaign; warmline transfer from CalOptima to CalFresh; direct mailer; staff, member and community stakeholder presentations; CalFresh enrollment events; and a robust marketing campaign. The goal is to enroll 100,000 members in CalFresh by the end of 2022. As part of this strategy, CalOptima is hosting a series of CalFresh Enrollment events to increase visibility and access to CalFresh. The first event took place on Friday, May 6 at the Delhi Center in Santa Ana with the County of Orange Social Services Agency onsite to enroll members into CalFresh and educate the community about the program. The event also had a resource fair component to provide information for basic needs, mental health, early education and more. There was food distribution along with free bike helmets, school supplies and diapers while supplies lasted. This event was designed to celebrate health and wellness and included family activities, such as a magic show, face painting and balloon artists. Additional CalFresh Enrollment Events are scheduled for Ponderosa Park Family Resource Center in Anaheim on June 11 and La Habra City Hall on June 18.

Summary of Public Activities

As of April 27, CalOptima plans to participate in, organize or convene 52 public activities in May and June. In May, there will be 28 public activities that include 12 virtual community/collaborative meetings, 15 community events and one Health Network Forum. In June, there will be 24 public activities that include 14 virtual community/collaborative meetings, 8 community events, one Cafecito meeting and one Health Network Forum. CalOptima's participation in community events throughout Orange County can be found in the attachment.

Endorsements

CalOptima provided zero endorsements since the last reporting period (e.g., letters of support, program/public activity events with support or use of name/logo). Endorsement requests must 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 policy requirements can be found at: https://www.caloptima.org/en/About/CommunityRelations/CommunityOutreach.aspx.

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For additional information or questions, contact CalOptima Community Relations Manager Tiffany Kaaiakamanu at 657-235-6872 or tkaaiakamanu@caloptima.org.

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List of community events hosted by community partners and CalOptima-hosted events in May and June 2022:

May 2022			
5/1 9 a m.–5 p m.	**Aging and Disability Resource Fair hosted by St. Norbert Catholic Church†** St. Norbert Catholic Church 300 E. Taft Ave, Orange	At least one staff member attended (in-person).	• Health/resource fair • Open to the public
5/1 10 a m.–2 p m	**Health and Wellness Fair hosted by the Anaheim Family YMCA†** Anaheim YMCA Community Complex 1422 W. Broadway, Anaheim	At least two staff members attended (in-person).	• Health/resource fair • Open to the public
5/4 10:30 a.m.–Noon	**Resource Wednesdays hosted by Irvine Unified School District Early Learning Education Center†** Early Childhood Learning Center 1 Smoketree, Irvine	At least one staff member attended (in-person).	• Health/resource fair • Open to the public
5/6 3–7 p.m.	**CalFresh Enrollment Event and Resource Fair*** Delhi Center 505 E. Central Ave., Santa Ana	At least 10 staff members attended (in-person).	• Health/resource fair • Open to the public
5/7 9 a m.–Noon	**Collaboration with SSA and the OC Labor Federation on Medi-Cal Expansion†** Ehler's Event Center 8150 Knott Ave., Buena Park	At least two staff members to attend (in-person).	• Health/resource fair • Open to the public
5/09 4:30–5:30 p m.	**Choose Wellness Resource Fair hosted by Garden Grove Unified School District†** Bolsa Grande High School 9401 Westminster Blvd., Garden Grove	At least one staff member attended (in-person).	• Health/resource fair • Open to the public
5/10–5/12 8 a m.–1:30 p m.	**Health Literacy Virtual Conference hosted by the Institute for Healthcare Advancement†** Virtual	At least three staff members attended. Sponsorship fee: $1,000; included 30-second video, one digital tote bag flyer, logo placement on sponsor page, one banner ad and logo placement on conference emails.	• Forum • Open to community stakeholders; register prior to event
5/12 1–2:30 p m.	**InfoSeries: Medi-Cal Expansion*** Virtual	At least three staff members attended.	• Forum • Open to community stakeholders; register prior to event
5/12 4–6 p.m.	**Open House hosted by Anaheim Elementary School District†** Patrick Henry Elementary School 1123 W. Romneya Dr., Anaheim	At least one staff attended (in-person).	• Health/resource fair • Open to the public
5/14 9–11 a m.	**Health and Wellness Resource Fair hosted by OASIS Senior Center†**	At least three staff members attended (in-person).	• Health/resource fair • Open to the public

* CalOptima Hosted
† Exhibitor/Attendee

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	Oasis Senior Center 801 Narcissus Ave., Corona Del Mar		
5/14 9 a m.–1 p m.	**Spring Health & Resource Fair hosted by the City of Anaheim Active Older Adult Program**† Downtown Anaheim Community Center 250 E. Center St., Anaheim	At least one staff member attended (in-person). Registration fee: $100; included resource table at event.	• Health/resource fair • Open to the public
5/15 10 a m.–4 p m.	**Peace of Mind: A Family Wellness Event hosted by Access California Services**† Delhi Center 505 E. Central Ave., Santa Ana	At least one staff member attended (in-person). Sponsorship fee: $2,000; included logo on marketing materials, acknowledgment on day of the event, virtual background with sponsor logo and resource table at event.	• Conference • Open to the public
5/19 9 a m.–Noon	**Senior Resource Fair hosted by City of Stanton**† Stanton City Hall 7800 Katella Ave., Stanton	At least one staff member attended (in-person).	• Health/resource fair • Open to the public
5/19 8 a m.–4:30 p m.	**FaCT Annual Conference hosted by Families and Communities Together**† Great Wolf Lodge 12681 Harbor Blvd., Garden Grove	At least 10 staff members attended (in-person). Sponsorship fee: $1,000; included group recognition at conference, five event tickets and resource table at event.	• Forum • Open to community stakeholders; registration required
5/19 9–11 a m.	**Health Network Forum*** Virtual	At least 10 staff members attended.	• Forum • Open to health and human service providers
5/22 9 a m.–2 p m.	**Health Fair hosted by St. Joachim Catholic Church**† Saint Joachim Catholic Church & School 1964 Orange Ave., Costa Mesa	At least one staff member attended.	• Health/resource fair • Open to the public
June 2022			
6/1 10 a m.–3 p m.	**Benefit Enrollment and Resource Fair hosted by Social Services Agency**† St. Nicholas Church 24252 El Toro Rd., Laguna Woods	At least one staff member to attend (in-person).	• Health/resource fair • Open to the public
6/7 9–10 a m.	**CalOptima Virtual Community Resource Fair — Resources to Address Food Insecurity in Orange County: Families and Children*** Virtual	At least four staff members to attend.	• Health/resource fair • Open to community stakeholders; registration required
6/11 10 a m.–2 p m.	**CalFresh Enrollment Event and Resource Fair*** Ponderosa Park Family Resource Center	At least 10 staff members to attend (in-person).	• Health/resource fair • Open to the public

* CalOptima Hosted
† Exhibitor/Attendee

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	320 E. Orangewood Ave., Anaheim		
6/15 2–3 p.m.	**CalOptima Virtual Community Resource Fair — Resources to Address Food Insecurity in Orange County: Older Adults*** Virtual	At least four staff members to attend.	• Health/resource fair • Open to community stakeholders; registration required
6/16 9–11 a m.	**Health Network Forum*** Virtual	At least 10 staff members to attend.	• Forum • Open to health and human service providers
6/18 10 a m.–2 p m.	**CalFresh Enrollment Event and Resource Fair*** La Habra City Hall Atrium 110 E. La Habra Blvd., La Habra	At least 10 staff members to attend (in-person).	• Health/resource fair • Open to the public
6/23 11 a m.–Noon	**CalOptima Virtual Community Resource Fair: Resources to Address Food Insecurity in Orange County: Food Distribution in the Community*** Virtual	At least four staff members to attend.	• Health/resource fair • Open to community stakeholders; registration required
6/24 9 a m.–Noon	**Community Resource Fair hosted by the City of Cypress†** Cypress Senior Center 9031 Grindlay St., Cypress	At least one staff member to attend (in-person). Registration fee: $64; includes resource table at event.	• Health/resource fair • Open to the public
6/28 9–10:30 a m.	**Cafecito Meeting*** Virtual	At least four staff members to attend.	• Steering committee meeting • Open to collaborative members
6/30 9:30 a.m.–Noon	**Senior Expo hosted by City of Fountain Valley†** The Center at Founders Village Senior & Community Center 17967 Bushard St., Fountain Valley	At least one staff member to attend (in-person). Sponsorship fee: $1,000; includes resource table at the event, placement of the agency logo on the event banner, agency name listed on the website and social media, and announcement of sponsorship during the event..	• Health/resource fair • Open to the public

These sponsorship request(s) and community event(s) met the requirements of CalOptima Policy AA.1223: Participation in Community Events Involving External Entities. More information about policy requirements can be found at: https://www.caloptima.org/en/About/CommunityRelations/CommunityOutreach.aspx.

* CalOptima Hosted
† Exhibitor/Attendee

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken June 2, 2022
Regular Meeting of the CalOptima Board of Directors

Report Item
16. Approve the CalOptima Fiscal Year 2022-23 Operating Budget

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

Recommended Actions
1. Approve the CalOptima Fiscal Year (FY) 2022-23 Operating Budget, as reflected in Attachment A: Fiscal Year 2022-23 Operating Budget for all Lines of Business; and
2. Authorize the expenditures and appropriate the funds for the items listed in Attachment B: Administrative Budget Details and Attachment B1: Digital Transformation Administrative Budget Details, which shall be procured in accordance with CalOptima Policy GA.5002: Purchasing Policy.

Background
The CalOptima FY 2022-23 Operating Budget provides revenues and appropriations for the period of July 1, 2022, through June 30, 2023, and includes the following budget categories:

- Lines of Business:
  - Medi-Cal
  - OneCare Connect
  - OneCare
  - Program for All-Inclusive Care for the Elderly (PACE)
  - Multipurpose Senior Services Program (MSSP)
  - Facilities (505 Building)

- Non-Operating:
  - 500 Building
  - Investment Income

- Budget to Support New Initiative: Digital Transformation Strategy

Staff is submitting a complete and balanced budget for all lines of business for approval, using assumptions based on the best available information to date. 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 for 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.

CalOptima's primary revenue source is the State of California. The Governor released the revised state budget (i.e., May Revise) on May 13, 2022. The May Revise includes several proposals that, if enacted, will have a direct or indirect impact on CalOptima's lines of business:

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- No sooner than January 1, 2024, expand Medi-Cal coverage to all income-eligible adults aged 26 through 49, regardless of immigration status;
- Continue CalAIM implementation;
- Continue Proposition 56 supplemental payments;
- Implement a Medi-Cal Direct contract with Kaiser Permanente effective no sooner than January 1, 2024;
- Reform Skilled Nursing Facility financing framework;
- No sooner than January 1, 2023, implement new Medi-Cal benefit for community-based mobile crisis services; and
- Eliminate certain Assembly Bill 97 Medi-Cal provider rate reductions from 2011.

The May Revise assumes redetermination activities will begin August 2022, with the first redeterminations completed in October 2022 and the first individuals no longer Medi-Cal eligible to leave the program in November 2022. The State projects Medi-Cal caseload will continue to grow through October 2022, peaking at 14.9 million enrollees. As of this writing, the COVID-19 Public Health Emergency (PHE) is extended through July 15, 2022. Management will communicate to the Board information, as it becomes available, on the end of the PHE, the unwinding of temporary flexibilities and resumption of normal Medi-Cal eligibility operations at the state and county levels, and the resulting impact on our members.

The State Legislature will finalize and pass a balanced budget by June 15, 2022. Staff will continue to monitor budget actions and return to the Board with further recommendations in the event additional resources are necessary beyond what was incorporated in this budget.

At its May 19, 2022 meeting, the CalOptima Finance and Audit Committee recommended that the Board approve the CalOptima FY 2022-23 Operating Budget. The proposed FY 2022-23 Consolidated Operating Budget reflects Management's efforts to balance state funding with ensuring members continue to have access to quality covered services.

Discussion

Management proposes an Operating Budget with a change in net assets of $35,581,185 for FY 2022-23 as summarized in the following table and details below:

FY 2022-23 Consolidated Operating Budget (in 000's except Enrollment)

	Medi-Cal	OneCare[1]	OneCare Connect[2]	PACE	MSSP*	FY 2022-23 Budget
Average Monthly Enrollment	891,950	9,772	7,324	477	568	909,523
Revenue	$3,595,160	$188,485	$167,628	$47,851	$3,042	$4,002,166
Medical Costs	$3,376,547	$180,552	$159,626	$44,495	$2,394	$3,763,614
Administrative Expenses	$167,093	$16,450	$11,184	$3,185	$1,172	$199,084
Operating Income/Loss	**$51,520**	**($8,517)**	**($3,181)**	**$171**	**($524)**	**$39,468**

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	Medi-Cal	OneCare[1]	OneCare Connect[2]	PACE	MSSP*	FY 2022-23 Budget
Investments, Net	--	--	--	--	--	$6,000
ITS Digital Transformation	--	--	--	--	--	($10,977)
New 500 Building	--	--	--	--	--	$1,090
Change in Net Assets						**$35,581**
Medical Loss Ratio (MLR)	93.92%	95.79%	95.23%	92.99%	78.69%	94.04%
Administrative Loss Ratio (ALR)	4.65%	8.73%	6.67%	6.66%	38.52%	4.97%

* MSSP enrollment included in Medi-Cal total
[1] OneCare Connect enrollment transitions to OneCare program on January 1, 2023
[2] OneCare Connect program sunsets on December 31, 2022. Six-month operating budget from July 1, 2022, through December 31, 2022. Budget includes expenses for run-out period.
Note: Totals may not add due to rounding

Operating Budget Analysis

Enrollment: There are two (2) significant changes in enrollment: (1) An increase in Medi-Cal enrollment effective May 1, 2022, from coverage expansion to older adults aged 50 and over; and (2) the sunsetting of the OneCare Connect program and resulting transition of OneCare Connect members to two (2) eligibility segments, Medi-Cal and OneCare. The budget assumes the end of the COVID-19 PHE in July 2022 and anticipates that a reduction in enrollment from Medi-Cal eligibility redetermination will begin September 2022.

Revenue: The budget projects revenue for each line of business based on the most recent capitation rates available from the California Department of Health Care Services (DHCS) and the Centers for Medicare & Medicaid Services (CMS). Staff made additional adjustments based on member acuity, and federal and state program and policy changes, and included trend assumptions based on CalOptima's Rate Development Template submission to the State. The FY 2022-23 Consolidated Budget is approximately 9.5% higher than the prior year budget.

Medical Cost: The budget proposes a 94.04% MLR. Major components are in provider capitation, claims payments and case management & other medical costs. The budget includes the following:

- Extend the temporary COVID supplemental payment to Medi-Cal direct fee-for-service providers and delegated health networks through June 30, 2023;
- Continue implementation of the CalAIM Enhanced Care Management benefit and expand Community Support services offerings;
- Sunset OneCare Connect effective December 31, 2022, and transition enrollment to OneCare D-SNP;
- Continue to absorb the 2% sequestration reduction in OneCare when CMS resumes the cut in July 2022, and implement OneCare rebased capitation rates effective January 1, 2023; and
- Assume PACE will return to pre-pandemic operations.

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The budget excludes the Medi-Cal pharmacy benefit beginning January 1, 2022. Budgeted costs for prescription drugs reflect this transition and is the primary driver for the negative prior year variance in claims payments.

Several methods were utilized to develop the medical cost forecasts. Predominantly, projections were based on trends calculated from historical experience. Historical experience included several years' worth of data to incorporate trends for both the pre- and post- COVID-19 PHE declaration. Staff assigned various credibility to the different time periods depending on how representative they were of future utilization. In addition, adjustments were applied to account for known changes to operations, program structure, benefits, and regulatory policies. For newly implemented programs, staff used historical data, proxy data and industry benchmarks, where available, and checked results for reasonability.

Administrative Expenses: The budget proposes a 4.97% ALR, which is higher than the prior year budgeted ALR of 4.89%. The budget includes the following changes approved through recent Board actions:

- Updates to the salary schedule;
- Cost of living adjustment; and
- Supplemental pay and holiday premium.

Staff prepared the General and Administrative budget using a "zero-based" budgeting methodology, which required departments to justify each expense before adding it to the budget. Attachment B: Administrative Budget Details provides additional information regarding all administrative expenses included in the FY 2022-23 Operating Budget.

Non-Operating
500 Building: Based on a market analysis prepared by CalOptima's real estate consultant dated December 2021, the budget projects an estimated net surplus of approximately $1.1 million.

Investment Income: The budget projects $6 million in investment income and is based on historical performance. This amount is lower than prior years based on current market conditions and projected return on investments in FY 2022-23.

Budget Highlights: Budget to Support New Initiatives
Digital Transformation Strategy: In March 2022, the Board authorized a three-year Digital Transformation and Workplace Modernization Strategy and created a $100 million restricted reserve to fund digital transformation efforts. Attachment B1: Digital Transformation Administrative Budget Details provides additional information regarding administrative expenses to implement initiatives in year one.

Fiscal Impact
As outlined above and described in Attachment A: Fiscal Year 2022-23 Operating Budget for all Lines of Business, the FY 2022-23 Operating Income shows a projected surplus of $39,468,298. Accounting for investment income, Digital Transformation Strategy costs and the 500 Building net surplus, the total change in net assets is forecasted to be $35,581,185.

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Rationale for Recommendation

Management submits the FY 2022-23 Operating Budget for all program areas using the best assumptions available to provide covered services to CalOptima's forecasted enrollment.

Concurrence

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

Attachments

1. Attachment A: Fiscal Year 2022-23 Operating Budget for all Lines of Business
2. Attachment B: Administrative Budget Details
3. Attachment B1: Digital Transformation Administrative Budget Details

/s/ Michael Hunn *05/27/2022*
Authorized Signature **Date**

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Attachment A

CalOptima Fiscal Year 2022-23 Budget
By Line of Business

	Medi-Cal	OCC	OneCare	PACE	MSSP	Facilities	Other	Consolidated
Member Months	10,703,401	87,887	117,263	5,728	6,816	-	-	**10,914,280**
Avg Members	891,950	7,324	9,772	477	568	-	-	**909,523**
Revenues								
Capitation revenue	$ 3,595,159,756	$ 167,628,058	$ 188,484,971	$ 47,851,218	$ 3,042,209	$ -	$ -	**$ 4,002,166,212**
Total	$ 3,595,159,756	$ 167,628,058	$ 188,484,971	$ 47,851,218	$ 3,042,209	$ -	$ -	**$ 4,002,166,212**
Medical Costs								
Provider capitation	$ 1,260,978,417	$ 70,623,820	$ 73,179,668	$ -	$ -	$ -	$ -	**$ 1,404,781,904**
Professional Facility & Ancillary	$ 1,185,211,585	$ 33,072,291	$ 44,387,911	$ 22,808,949	$ -	$ -	$ -	**$ 1,285,480,735**
LTC/Skilled Nursing Facilities	$ 612,794,229	$ 8,924,314	$ -	$ 847,445	$ 395,500	$ -	$ -	**$ 622,961,488**
Prescription Drugs	$ -	$ 38,194,494	$ 54,257,469	$ 4,892,869	$ -	$ -	$ -	**$ 97,344,832**
Case Mgmt & Oth Medical	$ 317,562,637	$ 8,810,763	$ 8,727,199	$ 15,945,857	$ 1,998,263	$ -	$ -	**$ 353,044,719**
Total	$ 3,376,546,867	$ 159,625,681	$ 180,552,247	$ 44,495,120	$ 2,393,763	$ -	$ -	**$ 3,763,613,678**
MLR	***93.92%***	***95.23%***	***95.79%***	***92.99%***	***78.69%***			***94.04%***
Gross Margin	$ 218,612,889	$ 8,002,377	$ 7,932,724	$ 3,356,098	$ 648,446	$ -	$ -	**$ 238,552,534**
Administrative Expenses								
Salaries, Wages, & Employee Benefits	$ 114,426,884	$ 5,626,427	$ 7,123,243	$ 2,126,441	$ 967,549	$ -	$ -	**$ 130,270,544**
Non-Salary Operating Expenses	$ 50,274,061	$ 1,224,285	$ 4,454,541	$ 892,798	$ 125,800	$ 3,183,720	$ -	**$ 60,155,204**
Depreciation & Amortization	$ 6,300,000	$ -	$ -	$ 10,800	$ -	$ 2,691,000	$ -	**$ 9,001,800**
Indirect Cost Allocation, Occupancy Expense	$ (3,907,922)	$ 4,333,100	$ 4,872,200	$ 155,430	$ 78,600	$ (5,874,720)	$ -	**$ (343,312)**
Total	$ 167,093,023	$ 11,183,812	$ 16,449,984	$ 3,185,468	$ 1,171,949	$ -	$ -	**$ 199,084,236**
ALR	***4.65%***	***6.67%***	***8.73%***	***6.66%***	***38.52%***			***4.97%***
Operating Income/(Loss)	$ 51,519,866	$ (3,181,434)	$ (8,517,260)	$ 170,629	$ (523,503)	$ -	$ -	**$ 39,468,298**
Investment Income							$ 6,000,000	$ 6,000,000
Digital Transformation Strategy							$ (10,977,113)	$ (10,977,113)
500 Building							$ 1,090,000	$ 1,090,000
CHANGE IN NET ASSETS	**$ 51,519,866**	**$ (3,181,434)**	**$ (8,517,260)**	**$ 170,629**	**$ (523,503)**	**$ -**	**$ (3,887,113)**	**$ 35,581,185**

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Attachment B: Administrative Budget Details

	Medi-Cal: Non-Salary Operating Expenses			
Specific Type	**Objective of the Item Proposed**	**Budget FY 2022-23 Input**	**Authorization**	**Appropriation**
Other Operating Expenses	Insurance Premiums - Errors and Omissions Professional Liability - General and Property Liabilities - Excess Liabilities - Commercial Auto - Directors and Officers (D&O) - Network/Privacy (Cyber), Crime, Employment Practices Liability (EPL) - Earthquake, Pollution and Umbrella - Wage and Hour Coverage	2,512,000	X	X
Other Operating Expenses	Telecommunications and Network Connectivity Expenses, Business Telephones and Accessories (Desk Phones, Headsets, Tablets and Accessories)	2,271,000	X	X
Other Operating Expenses	Network Connectivity Maintenance and Support for CalOptima Sites (Network Monitoring Tools, Web Filters, All Main Distribution Frame and Intermediate Distribution Frame Batteries, Internet Optimizers, Routers, Wireless Application Protocol Devices, Other Tools)	1,988,000	X	X
Other Operating Expenses	Facets Core System (Enrollment, Claims, Authorizations and Other Modules) License Renewal and Maintenance. Facets True-Up Membership	1,935,672	X	X
Other Operating Expenses	Corporate Software Maintenance (Provider Sanctioning and Analytics, Data Warehouse Cleansing, Analytics, Business Application Workflow, Website Content Management, Compliance and Other Corporate Applications)	1,635,506	X	X
Other Operating Expenses	Operating Systems and Office Software Suite License Costs to Support Entire Organization	1,500,000	X	X
Other Operating Expenses	Replacement Hardware for Operating System Upgrade, Desktop Software Licenses, and Other Minor Computer Equipment, Laptop and Desktop Replacements	1,458,000	X	X
Other Operating Expenses	User Licenses for Medicare Claims Pricing Software	1,371,000	X	X
Other Operating Expenses	Provider and Physician Credentialing System Maintenance and License Renewal	844,800	X	X
Other Operating Expenses	Information Security Data Loss Prevention Solution Annual Maintenance	839,800	X	X
Other Operating Expenses	Application Software Maintenance - IT Development Tools (Data Modeling, Architecture, Technical Libraries, Documentation, Technical Frameworks, Electronic Data Interchange, Software Development Testing)	747,328	X	X
Other Operating Expenses	Server Connectivity Maintenance and Support for Server Equipment (Servers, Storage, Virtual Machine Licenses, Backup Software)	719,000	X	X
Other Operating Expenses	Maintenance and Support Annual Renewal for the Telecommunications Network Systems	680,800	X	X
Other Operating Expenses	Training & Seminar - Professional Development and Education - System and Software Update Training - Process Improvement Training - Financial and Reporting Software Upgrade and Training - Training Classes for Facility Management, Environmental and Safety Issues - Training Classes for Professional Certifications and Continuing Legal Education	653,581	X	X

Attachment B: Administrative Budget Details

	Medi-Cal: Non-Salary Operating Expenses			
Specific Type	Objective of the Item Proposed	Budget FY 2022-23 Input	Authorization	Appropriation
Other Operating Expenses	Human Resources Corporate Application Software Maintenance (Training, Recruitment, Performance Evaluation, HR Benefits, Employee Time and Attendance and Payroll)	629,000	X	X
Other Operating Expenses	Association Membership Dues (Provide Advocacy, Program Support, Technical Support Regarding State and Federal Regulatory Issues)	606,125	X	X
Other Operating Expenses	Purchases and Installation of Office Furniture for Adds, Moves, Furniture, Fixture and Equipment, and Various Other Articles of Minor Equipment	435,000	X	X
Other Operating Expenses	Cloud Government/Storage Subscription	420,000	X	X
Other Operating Expenses	Maintenance of Desktop Application Software and Hardware	378,542	X	X
Other Operating Expenses	Healthcare Information Research and Analysis, Information Systems Audit and Control, Association Subscription Renewal	359,500	X	X
Other Operating Expenses	Contract Management System	354,900	X	X
Other Operating Expenses	Subscription Renewal for Standard Medical Coding Schedules and Multiple User Licenses	324,996	X	X
Other Operating Expenses	Tuition Reimbursement for Staff Development and Organizational Development Programs (CalOptima Special Speakers, Trainers, Computer Classes, Other Training Events)	269,270	X	X
Other Operating Expenses	Office Supplies (Paper, Toner, Batteries, Mouse Pads, Keyboards, Environmental Health and Safety, Disaster Recovery, Other Miscellaneous Items) for Company-Wide Usage	264,996	X	X
Other Operating Expenses	Additional Software License and Upgrade Costs for Operating Systems and Office Software Suite	200,000	X	X
Other Operating Expenses	24/7 Support to Assist CalOptima's Operating Systems and Office Software Suite Related Questions and Issues	200,000	X	X
Other Operating Expenses	Sponsorship, Registration Fees and Other Related Costs for New and Anticipated Community Events, Health Fairs, Venue Rental, Services and Supplies, Promotional Items	192,250	X	X
Other Operating Expenses	Maintenance for Windows and Carpet Cleaning, Furniture Repair, Doors, Audio Visual Equipment, Plumbing and Other General Maintenance Needs	192,000	X	X
Other Operating Expenses	Maintenance and Support for the Production/Development of Citrix Operating System/Software Environments	176,000	X	X
Other Operating Expenses	Travel - Conferences/Seminars and Meetings for Managers and Staff - State Meetings Related to Regulatory and Legislative Issues, Strategic Development - Association Meetings - Vendor Site Visits, Field Staff Visits - Mileage and Parking Reimbursement for Community Events and Presentations, Provider Offices and Member Enrollment	164,327	X	X
Other Operating Expenses	Employee Engagement Events and CalOptima Logo Apparel	164,000	X	X
Other Operating Expenses	Software to Generate and Interface with Facets Letters	158,796	X	X
Other Operating Expenses	Finance Corporate Applications Software Maintenance (Accounting, Finance and Procurement Systems)	157,208	X	X
Other Operating Expenses	Professional Dues and Member Fees for Various Professional Associations	150,073	X	X
Other Operating Expenses	Database Administrator License Renewals, Maintenance and Support	146,500	X	X

Attachment B: Administrative Budget Details

	Medi-Cal: Non-Salary Operating Expenses			
Specific Type	Objective of the Item Proposed	Budget FY 2022-23 Input	Authorization	Appropriation
Other Operating Expenses	Board Member Stipends, Memberships, Conferences, Training and Travel	99,314	X	X
Other Operating Expenses	Office Supplies for Various Departments' Needs for Everyday Operations	73,538	X	X
Other Operating Expenses	Employee Appreciation Events	63,380	X	X
Other Operating Expenses	Subscription Fees for Various Licenses, Literature and Organizations	51,342	X	X
Other Operating Expenses	Subscriptions for Existing Software and Databases	46,396	X	X
Other Operating Expenses	CMO Physician Advisory Committee Outreach	31,200	X	X
Other Operating Expenses	Food Services for CalOptima Informational Series, Legislative Luncheon Events, Member and Provider Meetings/Conferences, Board Meetings and Other Events	19,050	X	X
Other Operating Expenses	Subscription Fees for Electronic Surveys, Education Videos for Members and Associations	18,000	X	X
Other Operating Expenses	General Supplies for CalOptima Staff	15,000	X	X
Other Operating Expenses	Supplies and Costs Associated with Various Outreach, Community Events, Sponsorships and Health Fairs	14,104	X	X
Other Operating Expenses	Maintenance and Support for Printers	12,000	X	X
Other Operating Expenses	Medical Licenses and Required Certifications	12,000	X	X
Other Operating Expenses	Subscription Fees for Both Clinical and Programmatic Support, and Normal Maintenance of Certification Licensure	10,008	X	X
Other Operating Expenses	Food Services for Community Events and Supporting New Initiatives	10,000	X	X
Other Operating Expenses	Food Services Allowances, as Needed, for Sponsoring Member and Provider Meetings, Conferences, Department Meetings and Other Events	9,452	X	X
Other Operating Expenses	Promotional and Outreach Activities to Help Support CalOptima Programs and Initiatives. Branded Signage to Promote CalOptima's Medi-Cal Campaigns	9,000	X	X
Other Operating Expenses	Computer Software for Medical Coding and Design of Print Materials and Other Related Expenses	7,300	X	X
Other Operating Expenses	Incentives for Provider Recognition and Outreach	6,200	X	X
Other Operating Expenses	Food Services for Advisory Committees, Existing and New Collaboratives, Stakeholder Engagement For New Initiatives	3,600	X	X
Other Operating Expenses	Food Services for Provider Advisory Committee, CalOptima Community Network Lunch and Learn Events and CCN Anniversary Event	3,000	X	X
Other Operating Expenses	Food Services for Annual CalOptima Event to Promote Mental Health Awareness and Other Events	2,000	X	X
Other Operating Expenses	Maintenance and Renewal for Procurement Software	1,200	X	X
Printing & Postage	Postage for Maintenance of Business, Direct Mailer, ID Cards, and Community Supports Benefits Flier	1,571,111	X	X
Printing & Postage	Print and Fulfillment for Regular Mailings of Daily/Monthly Packets	1,541,808	X	X
Printing & Postage	General Postage for Outgoing Mail	642,000	X	X
Printing & Postage	Print and Fulfillment for Newsletters	476,937	X	X
Printing & Postage	California Advancing and Innovating Medi-Cal (CalAIM) Mailing, Community Supports Inserts, CalFresh Initiative, and New ID Cards	160,193	X	X

Attachment B: Administrative Budget Details

	Medi-Cal: Non-Salary Operating Expenses			
Specific Type	**Objective of the Item Proposed**	**Budget FY 2022-23 Input**	**Authorization**	**Appropriation**
Printing & Postage	Printing of the Annual Report to the Community, Holiday Cards, Provider Press Newsletter, Stock Photo Fees and Ad Hoc Collateral Materials	72,000	X	X
Printing & Postage	Mail Services Charges, Courier/Delivery of Print Materials	49,488	X	X
Printing & Postage	Provider Relations Provider Directory Validation Forms, Annual In-Service Letters and Attestation Forms, Access and Availability Required Mailings and Postage Required to Ensure Provider Training and Education Compliance	36,000	X	X
Printing & Postage	Miscellaneous Member Materials, Printing Expenses and Supplies for Various Departments	32,280	X	X
Printing & Postage	Printing Services for Facilities Projects and Events, Safety and Security, Other CalOptima Departments' Printing Needs	24,000	X	X
Professional Fees	General and Adversarial Legal Fees	3,200,000	X	X
Professional Fees	Internal Audit on Operations	400,000	X	X
Professional Fees	Employee Engagement and Feedback, Executive Recruiter Expenses, Leave and Accommodation and Ad Hoc Consulting	375,000	X	X
Professional Fees	Consultant for Medi-Cal Mock Audit and Other Required Audits	360,000	X	X
Professional Fees	Rebasing, Network Support and Other Related Actuarial Consulting Services	340,000	X	X
Professional Fees	Compensation and Job Classification Study	300,000	X	X
Professional Fees	Core Systems Upgrade Consultation, Technical Training and Other Core Application Support	292,992	X	X
Professional Fees	Government Affairs Contract and Management of State and Federal Lobbyists	265,000	X	X
Professional Fees	Consulting Fees for Organizational and Strategic Plan Support	260,000	X	X
Professional Fees	Medical Loss Ratio Audit	250,632	X	X
Professional Fees	Consulting Fees To Support Campaign Development and Advertising Strategy	240,000	X	X
Professional Fees	Financial Audit Annual Contract	216,000	X	X
Professional Fees	Consulting Fees To Support Program Outreach and Social Media Efforts, Acquiring Data for Strategic Direction	200,000	X	X
Professional Fees	Support for Implementation of Strategic Plan, Initiatives Aligned with Strategic Plan, Equity Initiative Activities, Duals Population Market Analysis and Network Model Change Evaluation	200,000	X	X
Professional Fees	Consulting Fees for Government Affairs Support	150,000	X	X
Professional Fees	Portal and Website Support for Enhancements of Software Development Tools and Frameworks	120,000	X	X
Professional Fees	Health Insurance Portability and Accountability Act (HIPAA) Security Compliance, including Risk Management, Assessment and Network Penetration	116,000	X	X
Professional Fees	External Peer Review and Compliance and Ethics Hotline	91,200	X	X
Professional Fees	Consulting Fees to Support CalAIM Implementation and Stakeholder Events	90,000	X	X
Professional Fees	Investment Advisory Support Services	90,000	X	X
Professional Fees	Software Upgrades and Transitions, Security Services and Miscellaneous Consulting/Professional Services	60,000	X	X
Professional Fees	Professional Fees for Budget and Procurement Support	40,200	X	X
Professional Fees	Chronic Illness and Disability Payment System (CDPS) Renormalization and Coefficient Development	40,000	X	X

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	Medi-Cal: Non-Salary Operating Expenses			
Specific Type	Objective of the Item Proposed	Budget FY 2022-23 Input	Authorization	Appropriation
Professional Fees	Space Planning Services	36,000	X	X
Professional Fees	Evaluation of End to End Workflow for System/Process Improvements	32,000	X	X
Professional Fees	Professional Fees for Other Post Employment Benefits (OPEB) and Various Accounting and Related Consulting Services	20,500	X	X
Professional Fees	Focus Group Support to Gather Consumer Feedback on Advertising Effort	20,000	X	X
Professional Fees	Annual IBNR Certification Review	19,500	X	X
Professional Fees	Professional Fees for External Peer Review	18,000	X	X
Professional Fees	Consulting Fees for Medical Necessity Support	10,008	X	X
Purchased Services	Claims Prepayment Editing Services	2,700,000	X	X
Purchased Services	Overpayment Identification Services	1,440,000	X	X
Purchased Services	Electronic Data Interchange Institutional Claims	1,104,000	X	X
Purchased Services	Coordination Of Benefits (COB) Project	900,000	X	X
Purchased Services	Face to Face Interpreter Services	730,512	X	X
Purchased Services	Radio, Television, Print, Outdoor, Digital Advertising and Other Media to Promote and Support Awareness Campaigns and Satellite Office Campaign	540,000	X	X
Purchased Services	Telephonic and Video Interpreter Services	473,592	X	X
Purchased Services	Business Bank Fees	408,000	X	X
Purchased Services	Third Party Check Printing and Mailing Fees	390,000	X	X
Purchased Services	Claims Imaging and Indexing Services	372,000	X	X
Purchased Services	Conversion of Temporary Assistance for Needy Families (TANF) to Supplemental Security Income (SSI)	370,128	X	X
Purchased Services	Long Term Care Rate Adjustments	350,400	X	X
Purchased Services	Translation Services for Threshold Languages, Translation Audit Review, Annual Translation Skills Assessment, New Hire Bilingual Testing and In-Design License	287,304	X	X
Purchased Services	Disaster Recovery Technology Services	240,000	X	X
Purchased Services	Radio, Television, Print, Outdoor, Digital Advertising Campaign to Encourage Use of CalOptima-Covered Preventative Services	150,000	X	X
Purchased Services	Recruitment Advertisement and Sourcing	145,000	X	X
Purchased Services	Offsite Backup Tape Storage and Services, Slotted Media Storage	130,140	X	X
Purchased Services	Regulatory 508 Compliance Remediation Services for PDF Files to Make Member, Provider, Board and Other Materials Accessible to Persons With Disabilities on the Website as Required by CMS, DHCS and Section 508 Regulations	120,000	X	X
Purchased Services	Insurance Broker Services	115,008	X	X
Purchased Services	Benefit Broker Services	115,000	X	X
Purchased Services	Data Scanning and Storage	110,004	X	X
Purchased Services	Telecom Expense Management System	100,000	X	X
Purchased Services	Claims Pricing Automation Enhancements & Other Purchased Services	84,600	X	X
Purchased Services	Funding for Photography and Video Production Services Needed to Support New CalOptima Initiatives	72,000	X	X

Attachment B: Administrative Budget Details

	Medi-Cal: Non-Salary Operating Expenses			
Specific Type	Objective of the Item Proposed	Budget FY 2022-23 Input	Authorization	Appropriation
Purchased Services	Flexible Spending Accounts (FSA)/Consolidated Omnibus Budget Reconciliation Act (COBRA)	65,000	X	X
Purchased Services	Health Screening	65,000	X	X
Purchased Services	Sponsorship of PBS Featuring Brand Placement and Raising Awareness of Health Topics	60,000	X	X
Purchased Services	Healthcare Productivity Automation Services	60,000	X	X
Purchased Services	Telework, Handling, Deliveries and Security Guards	55,596	X	X
Purchased Services	Background Screening	54,720	X	X
Purchased Services	Executive Coaching	50,000	X	X
Purchased Services	Retirement Funds Advisory	50,000	X	X
Purchased Services	COVID Cleaning and Building Sanitization	49,992	X	X
Purchased Services	Employee Assistance Program	40,000	X	X
Purchased Services	TB Shots and Other General Purchased Services	39,996	X	X
Purchased Services	Member Experience Survey and Workforce Enhancement	36,000	X	X
Purchased Services	Employee Wellness and Ad Hoc Programs	32,490	X	X
Purchased Services	Pre Employment Applicant Testing	25,000	X	X
Purchased Services	Tax Form Processing Fees and Other General Purchased Services	13,500	X	X
Purchased Services	Destruction of Electronic Media	12,000	X	X
Purchased Services	Phishing Test Service	12,000	X	X
Purchased Services	Medicare Third Party Liability (TPL)	9,600	X	X
Purchased Services	Compensation System Subscription Fee	9,000	X	X
Purchased Services	October Cyber Security Awareness Month	5,000	X	X
Purchased Services	Imaging Services	3,576	X	X
Purchased Services	General Services for Customer Service, Operations Management, Executive Office, Audit & Oversight, and Other Various Departments	2,000	X	X
	Total Non-Salary Operating Expenses	**50,274,061**		

Attachment B: Administrative Budget Details

	OneCare Connect: Non-Salary Operating Expenses			
Specific Type	**Objective of the Item Proposed**	**Budget FY 2022-23 Input**	**Authorization**	**Appropriation**
Other Operating Expenses	Training and Seminars for Professional Development and Education	12,762	X	X
Other Operating Expenses	Travel Expenses for Visits to Provider Offices, Presentations, Health Fairs, Community Events, Annual Audits and Conferences/Seminars	8,750	X	X
Other Operating Expenses	Subscriptions, Certifications and Professional Dues	8,425	X	X
Other Operating Expenses	Member Outreach Activities and Promotional Items for Community Events	4,750	X	X
Other Operating Expenses	Office Supplies Needed for Everyday Department Operations	1,372	X	X
Other Operating Expenses	Food Services Allowances, as Needed, for Sponsoring Member and Provider Meetings, Conferences, Community Events, Compliance Week, and Department Training and Meeting	502	X	X
Printing & Postage	Maintenance of Enrolled Members (Printing, Fulfillment, Postage), Member Routine Annual and Quarterly Mailings, Other Related Printing and Postage Expenses	267,139	X	X
Printing & Postage	Marketing Materials, Including Sales Brochures, Posters, Handouts and Other Member and Provider Oriented Materials and Postage	69,750	X	X
Printing & Postage	Printing of Enrollment Materials, Retainment Materials, and Other Related Printing Expenses	50,000	X	X
Printing & Postage	Member and Provider Materials, Fulfillment and Other Printing Fees for Various Departments	18,202	X	X
Professional Fees	Independent Validation Audit for Close Out of CMS Program	64,998	X	X
Professional Fees	Annual Compliance Program Effectiveness (CPE) Audit	45,000	X	X
Professional Fees	Medicare Data Validation Audit	15,000	X	X
Purchased Services	Pharmacy Benefits Management	466,800	X	X
Purchased Services	Claims Processing through Automation Data Flow	75,000	X	X
Purchased Services	Language Interpretation, Face to Face Interpreter Services, Telephonic Interpreter and Video Interpreting Services, and Translation of Member Materials	48,918	X	X
Purchased Services	Advertising and Media Buys (Newspapers, Magazines, Radio, Bus Shelter, Campaigns, Other Media)	45,000	X	X
Purchased Services	Third Party Liability Subrogation Recovery Services	21,467	X	X
Purchased Services	Purchased Services Needs for Customer Service	450	X	X
	Total Non-Salary Operating Expenses	**1,224,285**		

Attachment B: Administrative Budget Details

	OneCare: Non-Salary Operating Expenses			
Specific Type	**Objective of the Item Proposed**	**Budget FY 2022-23 Input**	**Authorization**	**Appropriation**
Other Operating Expenses	Marketing and Outreach Activities and Promotional Items for Various Events	27,000	X	X
Other Operating Expenses	Member Outreach Activities and Promotional Items for Community Events	18,400	X	X
Other Operating Expenses	Promotional Items for Community Events, Sponsorships and Registration Fees and Venue Rental	17,752	X	X
Other Operating Expenses	Training and Seminars for Professional Development and Education	12,762	X	X
Other Operating Expenses	Subscriptions, Certifications and Professional Dues	7,219	X	X
Other Operating Expenses	Travel Expenses for Visits to Provider Offices, Presentations, Health Fairs, Community Events, Annual Audits and Conferences/Seminars	6,650	X	X
Other Operating Expenses	Food Service Allowances, as Needed, for Sponsoring Member and Provider Meetings, Conferences, Community Events, Compliance Week, and Department Training and Meeting	5,798	X	X
Other Operating Expenses	Office Supplies Needed for Everyday Department Operations	1,852	X	X
Printing & Postage	Marketing Materials, Including Sales Brochures, Posters, Handouts and Other Member and Provider Oriented Materials and Postage	560,250	X	X
Printing & Postage	Maintenance of Enrolled Members (Printing, Fulfillment, Postage), Member Routine Annual and Quarterly Mailings, Other Related Printing and Postage Expenses	500,000	X	X
Printing & Postage	Printing of Enrollment Materials, Retainment Materials, Broker Agency Enrollment Kits, and Other Related Printing Expenses	450,000	X	X
Printing & Postage	Member and Provider Materials, Fulfillment and Other Printing Fees for Various Departments	16,198	X	X
Professional Fees	Annual Contract Bid for OneCare, Rebasing and Other Actuarial Services	235,000	X	X
Professional Fees	Percentage of Premium Sufficiency, Fully Integrated Special Needs Plans (FIDE SNP) Consideration and Other Related Actuarial Consulting Services	60,000	X	X
Professional Fees	Annual Compliance Program Effectiveness (CPE) Audit	45,000	X	X
Professional Fees	Medicare Data Validation Audit	15,000	X	X
Purchased Services	Broker Agency Commission for Member Enrollment	1,500,000	X	X
Purchased Services	Pharmacy Benefits Management	628,200	X	X
Purchased Services	Advertising and Media Buys (Newspapers, Magazines, Radio, Bus Shelter, Campaigns, Other Media)	255,000	X	X
Purchased Services	Language Interpretation, Face to Face Interpreter Services, Telephonic Interpreter and Video Interpreting Services, and Translation of Member Materials	62,460	X	X
Purchased Services	Claims Processing through Automation Data Flow	30,000	X	X
	Total Non-Salary Operating Expenses	**4,454,541**		

Attachment B: Administrative Budget Details

	PACE: Non-Salary Operating Expenses			
Specific Type	**Objective of the Item Proposed**	**Budget FY 2022-23 Input**	**Authorization**	**Appropriation**
Other Operating Expenses	Software License and Support, Repairs and Maintenance of Minor Equipment, Building and Unforeseen Incidentals and Building Security Services	60,633	X	X
Other Operating Expenses	Outreach Events and Promotional Marketing Items to Help Elevate PACE Center and Support Program Enrollment and Expansion	27,223	X	X
Other Operating Expenses	Electricity, Gas, Water and Other Related Expenses	8,100	X	X
Other Operating Expenses	General Liability, Property, Earthquake and Other Insurance Fees	6,750	X	X
Other Operating Expenses	Food Service Allowances, as Needed, for Sponsoring, Enrollment and Retention Events, Member and Provider Meetings, Conferences and Trainings	6,225	X	X
Other Operating Expenses	Minor Equipment and Supplies (Kitchen, Rehab, Social Day, Staff Break Room, Clinic/Rehab Equipment)	3,972	X	X
Other Operating Expenses	Staff Development Training (Registration Fees, Travel, Accommodations, Incidentals)	3,002	X	X
Other Operating Expenses	Property Tax Assessment	1,800	X	X
Other Operating Expenses	Staff Travel and Mileage for Home Visits, Marketing, Conferences and Enrollment	1,080	X	X
Other Operating Expenses	Office Supplies for Staff	1,080	X	X
Other Operating Expenses	Subscriptions, Membership, Registration for Dietetic and Other Discipline Specific Memberships	1,017	X	X
Printing & Postage	Participant Newsletter, Typesetting for Translated Materials, Printing, Fulfillment and Postage Costs for Direct Mail Campaign, Marketing Materials and Other Printing Expenses	242,810	X	X
Professional Fees	Part D Actuarial Services and Other Financial Consulting Fees	4,950	X	X
Purchased Services	Advertising (Radio, Television, Print, Outdoor, Digital and Other Mediums) to Promote and Support Enrollment and Participation	510,000	X	X
Purchased Services	Health Outcomes and Satisfaction Surveys, Encounter Data File Formatting, Sterilization of Medical Equipment, Provider Communication, Appointment Services, Telehealth Support Services, Medical Equipment Calibration and Other Related Expenses	14,156	X	X
	Total Non-Salary Operating Expenses	**892,798**		

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	MSSP: Non-Salary Operating Expenses			
Specific Type	**Objective of the Item Proposed**	**Budget FY 2022-23 Input**	**Authorization**	**Appropriation**
Other Operating Expenses	Information Management Software for Long Term Care	50,000	X	X
Other Operating Expenses	Cell Phones and Data Plans for Field Staff and Management Team Who Complete Onsite Home Assessments	40,000	X	X
Other Operating Expenses	Regular Home Visits with Members for Field Staff	10,000	X	X
Other Operating Expenses	Professional Certifications	6,000	X	X
Other Operating Expenses	Professional Development and Education	2,000	X	X
Other Operating Expenses	Routine Office Supplies for Field and Office Staff	1,800	X	X
Professional Fees	Annual Finance Audit	16,000	X	X
	Total Non-Salary Operating Expenses	**125,800**		

Attachment B: Administrative Budget Details

	Facilities: Non-Salary Operating Expenses			
Specific Type	**Objective of the Item Proposed**	**Budget FY 2022-23 Input**	**Authorization**	**Appropriation**
Other Operating Expenses	Electricity	474,800	X	X
Other Operating Expenses	Janitorial Night Contract	400,400	X	X
Other Operating Expenses	Property, Liability and Earthquake Insurance	270,000	X	X
Other Operating Expenses	Engineering Contract	257,700	X	X
Other Operating Expenses	Janitorial Day Contract	149,600	X	X
Other Operating Expenses	Plumbing	126,500	X	X
Other Operating Expenses	Other Repair and Maintenance (Signage, Steam Cleaning, Roof, Locksmith, Pest Control Contract, Lobby Seasonal Decoration, Common Area Maintenance, and Other Maintenance)	110,300	X	X
Other Operating Expenses	Electrical Repairs and Supplies	103,800	X	X
Other Operating Expenses	HVAC Miscellaneous	96,560	X	X
Other Operating Expenses	Janitorial Supplies	86,400	X	X
Other Operating Expenses	Security Equipment and Maintenance	63,800	X	X
Other Operating Expenses	Exterior Landscape Contract	45,600	X	X
Other Operating Expenses	Water - Building	45,300	X	X
Other Operating Expenses	Other Fire/Life Safety Expenses (Phone, Emergency Generator, Other Expenses)	35,900	X	X
Other Operating Expenses	Windows	30,100	X	X
Other Operating Expenses	Landscape Extras	29,600	X	X
Other Operating Expenses	Elevator Maintenance Contract	27,600	X	X
Other Operating Expenses	Gas	26,760	X	X
Other Operating Expenses	HVAC Maintenance Contract	24,700	X	X
Other Operating Expenses	Water Treatment	22,900	X	X
Other Operating Expenses	Property Tax Assessments	20,700	X	X
Other Operating Expenses	Walls, Ceilings, Floors, Sidewalks, Railings	19,500	X	X
Other Operating Expenses	Painting	15,200	X	X
Other Operating Expenses	Trash	11,500	X	X
Other Operating Expenses	Parking Lot Maintenance and Sweeping	10,100	X	X
Other Operating Expenses	Door Maintenance and Repair	8,800	X	X
Printing & Postage	Postage and Courier	1,800	X	X
Purchased Services	Property Management, Administration Fee and Other Related Expenses	344,800	X	X
Purchased Services	Security Contract	323,000	X	X
	Total Non-Salary Operating Expenses	**3,183,720**		

Attachment B1: Digital Transformation Administrative Budget Details

	Medi-Cal: Non-Salary Operating Expenses			
Specific Type	Objective of the Item Proposed	Budget FY 2022-23 Input	Authorization	Appropriation
Other Operating Expenses	SOC (Security Operation Center) as a Service	1,576,000	X	X
Other Operating Expenses	Privileged and Identity Access Management	375,000	X	X
Other Operating Expenses	Data Protection and Digital Forensics & Incident Services	368,000	X	X
Other Operating Expenses	Cloud Government/Storage Subscription (Non Digital)	230,000	X	X
Other Operating Expenses	End Point Protection/Detection/Response Services	200,000	X	X
Other Operating Expenses	Zero Trust Network Architecture	168,000	X	X
Other Operating Expenses	Training & Seminar - Professional & Organizational Development and Education - System and Software Update Training - Process Improvement Training - Financial and Reporting Software Upgrade and Training - Training Classes for Facility Management, Environmental and Safety Issues - Training Classes for Professional Certifications and Continuing Legal Education	163,200	X	X
Other Operating Expenses	Anti-Phishing/SPAM and Various Subscriptions	77,000	X	X
Other Operating Expenses	Professional Dues and Member Fees for Various Professional Associations	53,760	X	X
Other Operating Expenses	Application Software Maintenance - IT Development Tools (Data Modeling, Architecture, Technical Libraries, Documentation, Technical Frameworks, Electronic Data Interchange, Software Development Testing)	41,520	X	X
Other Operating Expenses	Travel - Conferences/Seminars and Meetings for Managers and Staff - State Meetings Related to Regulatory and Legislative Issues, Strategic Development - Association Meetings - Vendor Site Visits, Field Staff Visits - Mileage and Parking Reimbursement for Community Events and Presentations, Provider Offices and Member Enrollment	39,600	X	X
Other Operating Expenses	Office Supplies for Various Departments' Needs for Everyday Operations	300	X	X
Professional Fees	Portal, Website Support and Quality Assurance Support for Enhancements of Software Development and Frameworks	600,000	X	X
Professional Fees	Core Systems Upgrade Consultation, Technical Training and Other Core Application Support	434,500	X	X
Professional Fees	Business Intelligence Related Support for Enhancement of Software Development and Frameworks	300,000	X	X
Professional Fees	Workflow Management Support	250,000	X	X
Professional Fees	Member and Provider Centric Artificial Intelligence and Machine Learning Solution Planning and Execution	240,000	X	X
Professional Fees	Data Warehouse Support for Enhancement of Software Development and Frameworks	216,000	X	X
Professional Fees	EDI and System Integration Support for Enhancement of Software Development and Frameworks	192,000	X	X
Purchased Services	Network Operations and CAPEX Related Services	160,000	X	X
	Total Non-Salary Operating Expenses	**5,684,880**		

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CalOptima

Better. Together.

Fiscal Year 2022-23 Operating Budget

CalOptima Board of Directors Meeting
June 2, 2022

Nancy Huang, Chief Financial Officer

Agenda

- Executive Summary
- FY 2022-23 Consolidated Budget Overview
  - Operating Budget Analysis
    - Enrollment
    - Medical Costs
    - Administrative Expenses
  - Non-Operating: 500 Building
  - Budget to Support New Initiatives: Digital Transformation Strategy
- Recommended Actions
- Appendix: FY 2022-23 Operating Budget by Lines of Business

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Executive Summary

CalOptima's Mission

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

CalOptima's Vision by 2027

- Same-Day Treatment Authorizations
- Real-Time Claims Payments
- Annual Assessments of Members' Social Determinants of Health

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Executive Summary

- Budget Objectives
  - Member focused: Improve access and quality of care
  - Balanced operating budget
  - Resources to build infrastructure and capacity to support CalOptima's new Mission and Vision statements and Strategic Plan

- Federal and state policy decisions will impact CalOptima's budget
  - End of the COVID-19 Public Health Emergency (PHE) anticipated sometime between July and October 2022 (subject to federal approval)
  - State released the revised budget on May 13, 2022

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REVENUE: FY 2022-23 Budget

$4,002,166,212

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EXPENSES: FY 2022-23 Budget

$3,962,697,914

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OPERATING INCOME/MARGIN:
FY 2022-23 Budget

$39,468,298

+0.99%

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Consolidated Budget Highlights

FY 2022-23 Consolidated Budget	
Average Enrollment	909,523
Revenue	$4,002,166,212
Medical Costs	$3,763,613,678
Medical Loss Ratio (MLR)	***94.04%***
Administrative Expenses	$199,084,236
Administrative Loss Ratio (ALR)	***4.97%***
Operating Income/Margin	$39,468,298 or 0.99%

CalOptima spends 94 cents of every dollar received on member care.

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FY 2022-23 Consolidated Operating Budget Overview

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Operating Budget Items

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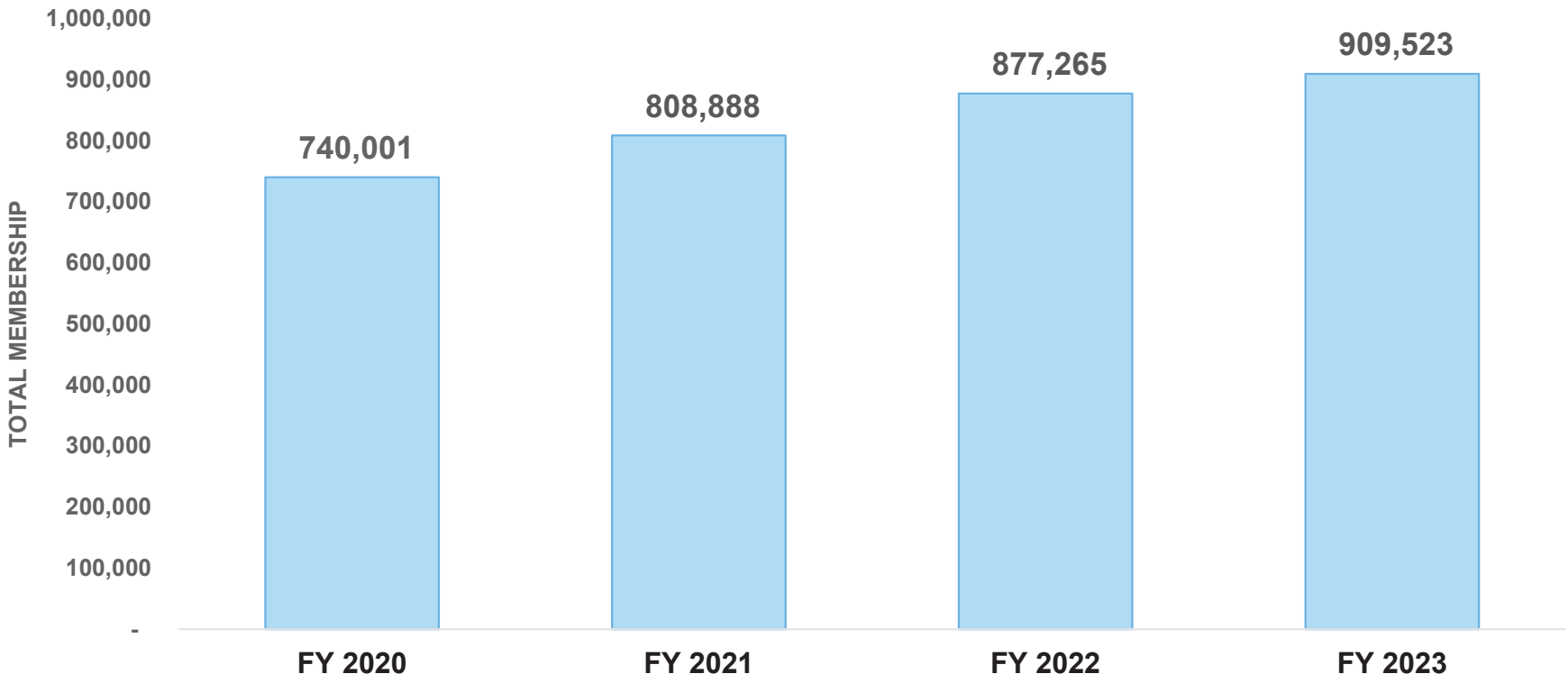
Consolidated Enrollment: Trend and Forecast



CalOptima has seen a 23% or 170,000 increase in enrollment since the beginning of the pandemic

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Enrollment Projections: Average Member Months

LOB	FY 2019-20	FY 2020-21	FY 2021-22*	FY 2022-23 Budget	Change FY 2021-22 to FY 2022-23
Medi-Cal	723,961	792,070	859,772	**891,950**	3.7%
OneCare Connect	14,203	14,764	14,742	**7,324**	-50.3%
OneCare	1,459	1,667	2,327	**9,772**	319.9%
PACE	378	387	424	**477**	12.6%
Total:	**740,001**	**808,888**	**877,265**	**909,523**	**3.7%**

- Effects of Medi-Cal eligibility redetermination accounted for by line of business
  - Anticipate reduced membership beginning September 2022, two months after the end of the Public Health Emergency in July 2022

* Forecast based on actuals through February 2022

Note: Rounding may impact calculations

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Consolidated Income Statement: Budget to Budget Comparison

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Consolidated Income Statement: FY 2021-22 Budget vs. FY 2022-23 Budget

	FY 2021-22 Budget *	FY 2022-23 Budget	FY 2022-23 vs. FY 2021-22 Budget
Average Monthly Enrollment	839,514	909,523	70,009
Revenue	$3,656,416,025	$4,002,166,212	$345,750,187
Medical Costs	$3,561,452,012	$3,763,613,678	$202,161,666
Administrative Expenses	$178,885,813	$199,084,236	$20,198,423
Operating Income/Loss	**($83,921,800)**	**$39,468,298**	**$123,390,098**
MLR	*97.40%*	*94.04%*	*(3.36%)*
ALR	*4.89%*	*4.97%*	*0.08%*

* Includes Board actions and budget adjustments as of March 2022

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FY 2021-22 Budget vs. FY 2022-23 Budget: Medical Costs

Consolidated	FY 2021-22 Budget *	FY 2022-23 Budget	FY 2022-23 vs. FY 2021-22 Budget
Revenue	$3,656,416,025	$4,002,166,212	$345,750,187
Provider Capitation	$1,241,149,558	$1,404,781,904	$163,632,346
Claims Payments	$2,161,672,869	$2,005,787,055	($155,885,814)
Long Term Care (LTC)/Skilled Nursing Facilities	*$524,574,072*	*$622,961,488*	*$98,387,416*
Prescription Drugs	*$437,083,451*	*$97,344,832*	*($339,738,619)*
Professional, Facility and Other Ancillary	*$1,200,015,346*	*$1,285,480,735*	*$85,465,389*
Case Management & Other Medical	$158,629,585	$353,044,719	$194,415,134
Total:	**$3,561,452,012**	**$3,763,613,678**	**$202,161,666**
MLR	*97.40%*	*94.04%*	*(3.36%)*

* Includes Board actions and budget adjustments as of March 2022

Note: FY 2022-23 Budget Prescription Drugs includes Medicare lines of business only

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FY 2021-22 Budget vs. FY 2022-23 Budget: Administrative Expenses

	FY 2021-22 Budget *	FY 2022-23 Budget	FY 2022-23 Budget vs. FY 2021-22 Budget
Revenue	**$3,656,416,025**	**$4,002,166,212**	**$345,750,187**
Salaries, Wages & Benefits	**$112,908,586**	**$130,270,544**	**$17,361,958**
Non-Salary Expenses: Operating	**$57,778,218**	**$60,155,204**	**$2,376,986**
Professional Fees	*$8,926,316*	*$8,353,980*	*($572,336)*
Purchased Services	*$15,729,002*	*$16,523,409*	*$794,407*
Printing & Postage	*$7,015,989*	*$6,781,966*	*($234,023)*
Other Operating Expenses	*$26,106,911*	*$28,495,849*	*$2,388,938*
Non-Salary Expenses: Other	*$8,199,009*	*$8,658,488*	*$459,479*
Depreciation & Amortization	*$8,386,800*	*$9,001,800*	*$615,000*
Indirect Cost Allocation, Occupancy	*($187,791)*	*($343,312)*	*($155,521)*
Total Administrative Expenses	**$178,885,813**	**$199,084,236**	**$20,198,423**
ALR	***4.89%***	***4.97%***	***0.08%***

* Includes Board actions and budget adjustments as of March 2022

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Administrative Expenses: Forecast to Budget Comparison

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FY 2021-22 Forecast vs. FY 2022-23 Budget: Administrative Expenses

	FY 2021-22 Forecast *	FY 2022-23 Budget	FY 2022-23 Budget vs. FY 2021-22 Forecast
Revenue	**$4,512,012,817**	**$4,002,166,212**	**($509,846,605)**
Salaries, Wages & Benefits	**$95,037,675**	**$130,270,544**	**$35,232,869**
Non-Salary Expenses: Operating	**$44,277,854**	**$60,155,204**	**$15,877,350**
Professional Fees	*$4,025,707*	*$8,353,980*	*$4,328,273*
Purchased Services	*$13,805,830*	*$16,523,409*	*$2,717,579*
Printing & Postage	*$5,058,015*	*$6,781,966*	*$1,723,951*
Other Operating Expenses	*$21,388,302*	*$28,495,849*	*$7,107,547*
Non-Salary Expenses: Other	**$6,418,055**	**$8,658,488**	**$2,240,433**
Depreciation & Amortization	*$6,556,170*	*$9,001,800*	*$2,445,630*
Indirect Cost Allocation, Occupancy	*($138,115)*	*($343,312)*	*($205,197)*
Total Administrative Expenses	**$145,733,584**	**$199,084,236**	**$53,350,652**
ALR	***3.23%***	***4.97%***	***1.74%***

* Forecasted based on annualized actuals as of March 2022; Revenue excludes directed payments

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Administrative Budget: Bridge for FY 2021-22 Forecast vs. FY 2022-23 Budget

G&A Expense	Bridge	Description
Salaries, Wages & Benefits	**$35.2M**	Open positions (106 FTEs), new positions (38 FTEs) requested for maintenance of business, cost of living (6%), market and salary grade adjustments, merit increase (4%), upgrades and retention bonuses, supplemental pay for holiday premium, teleworking and commuter allowance, health insurance premium and overtime
Non-Salary Expenses: Operating		
Professional Fees	**$4.3M**	Internal audit, legal fees, consulting for new initiatives and software applications, compensation study, marketing and advertising support, financial and other required audits
Purchased Services	**$2.7M**	Broker agency commission for member enrollment, increase in EDI clearinghouse, forensic review, and prepayment edit, member interpretation and translation, and advertising and regulatory compliance services
Printing & Postage	**$1.7M**	Increase in mailing and processing of member packages and notices, postage costs, direct mail campaign, member enrollment, and increased support in marketing and outreach materials for members and providers
Other Operating Expenses	**$7.1M**	Increase in computer equipment replacement, software licenses and maintenance agreements, insurance policy increase, planned outreach activities for members, providers and community events, building maintenance and supplies, and staff education and development
Non-Salary Expenses: Other		
Depreciation & Amortization, Indirect Cost Allocation, Occupancy	**$2.2M**	FY 2021-22 and FY 2022-23 capital items placed in service
Total G&A	**$53.4M**	

Note: Assumes 7.5% vacancy factor in FY 2022-23 Budget based on actual experience

Totals may not add due to rounding.

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Non-Operating

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Newly Acquired 500 Building

	FY 2022-23 Budget
Annual Revenue	$2,070,000
Estimated Operating Expenses	$980,000
Net Change:	**$1,090,000**

- Based on real estate consultant's December 2021 report
- Building expenses are treated as non-operating for FY 2022-23

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Budget to Support New Initiatives

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Digital Transformation Strategy

	FY 2022-23 Budget
Salaries, Wages & Benefits	$5,292,233
Professional Fees	$2,232,500
Purchased Services	$160,000
Other Operating Expenses	$3,292,380
Total:	**$10,977,113**

- ***March 17, 2022: Board authorized a three-year strategy and created a $100 million restricted reserve to fund digital transformation efforts***
- ***Proposed budget reflects operating expenses during Year 1 of implementation***

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CalOptima Consolidated Income Statement: Attachment A

Attachment A

CalOptima Fiscal Year 2022-23 Budget
By Line of Business

	Medi-Cal	OCC	OneCare	PACE	MSSP	Facilities	Other	Consolidated
Member Months	10,703,401	87,887	117,263	5,728	6,816	-	-	10,914,280
Avg Members	891,950	7,324	9,772	477	568	-	-	909,523
Revenues								
Capitation revenue	$ 3,595,159,756	$ 167,628,058	$ 188,484,971	$ 47,851,218	$ 3,042,209	$ -	$ -	$ 4,002,166,212
Total	$ 3,595,159,756	$ 167,628,058	$ 188,484,971	$ 47,851,218	$ 3,042,209	$ -	$ -	$ 4,002,166,212
Medical Costs								
Provider capitation	$ 1,260,978,417	$ 70,623,820	$ 73,179,668	$ -	$ -	$ -	$ -	$ 1,404,781,904
Professional Facility & Ancillary	$ 1,185,211,585	$ 33,072,291	$ 44,387,911	$ 22,808,949	$ -	$ -	$ -	$ 1,285,480,735
LTC/Skilled Nursing Facilities	$ 612,794,229	$ 8,924,314	$ -	$ 847,445	$ 395,500	$ -	$ -	$ 622,961,488
Prescription Drugs	$ -	$ 38,194,494	$ 54,257,469	$ 4,892,869	$ -	$ -	$ -	$ 97,344,832
Case Mgmt & Oth Medical	$ 317,562,637	$ 8,810,763	$ 8,727,199	$ 15,945,857	$ 1,998,263	$ -	$ -	$ 353,044,719
Total	$ 3,376,546,867	$ 159,625,681	$ 180,552,247	$ 44,495,120	$ 2,393,763	$ -	$ -	$ 3,763,613,678
MLR	*93.92%*	*95.23%*	*95.79%*	*92.99%*	*78.69%*			*94.04%*
Gross Margin	$ 218,612,889	$ 8,002,377	$ 7,932,724	$ 3,356,098	$ 648,446	$ -	$ -	$ 238,552,534
Administrative Expenses								
Salaries, Wages, & Employee Benefits	$ 114,426,884	$ 5,626,427	$ 7,123,243	$ 2,126,441	$ 967,549	$ -	$ -	$ 130,270,544
Non-Salary Operating Expenses	$ 50,274,061	$ 1,224,285	$ 4,454,541	$ 892,798	$ 125,800	$ 3,183,720	$ -	$ 60,155,204
Depreciation & Amortization	$ 6,300,000	$ -	$ -	$ 10,800	$ -	$ 2,691,000	$ -	$ 9,001,800
Indirect Cost Allocation, Occupancy Expense	$ (3,907,922)	$ 4,333,100	$ 4,872,200	$ 155,430	$ 78,600	$ (5,874,720)	$ -	$ (343,312)
Total	$ 167,093,023	$ 11,183,812	$ 16,449,984	$ 3,185,468	$ 1,171,949	$ -	$ -	$ 199,084,236
ALR	*4.65%*	*6.67%*	*8.73%*	*6.66%*	*38.52%*			*4.97%*
Operating Income/(Loss)	$ 51,519,866	$ (3,181,434)	$ (8,517,260)	$ 170,629	$ (523,503)	$ -	$ -	$ 39,468,298
Investment Income							$ 6,000,000	$ 6,000,000
Digital Transformation Strategy							$ (10,977,113)	$ (10,977,113)
500 Building							$ 1,090,000	$ 1,090,000
CHANGE IN NET ASSETS	**$ 51,519,866**	**$ (3,181,434)**	**$ (8,517,260)**	**$ 170,629**	**$ (523,503)**	**$ -**	**$ (3,887,113)**	**$ 35,581,185**

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Recommended Actions

- Approve CalOptima FY 2022-23 Operating Budget, as reflected in Attachment A: Fiscal Year 2022-23 Operating Budget for all Lines of Business

- Authorize the expenditures and appropriate the funds for items listed in Attachment B: Administrative Budget Details and Attachment B1: Digital Transformation Administrative Budget Details
  - Items will be procured in accordance with CalOptima Policy GA.5002: Purchasing Policy

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Appendix: FY 2022-23 Operating Budget by Line of Business

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Medi-Cal

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Medi-Cal Budget

	FY 2020-21 Actual	FY 2021-22 Forecast*	FY 2022-23 Budget
Average Monthly Enrollment	793,023	849,584	891,950
Revenue	$3,731,986,412	$4,103,220,473	$3,595,159,756
Medical Costs	$3,347,011,967	$3,781,807,979	$3,376,546,867
Administrative Expenses	$118,122,422	$122,847,028	$167,093,023
Operating Income/Loss	**$266,852,023**	**$198,565,466**	**$51,519,866**
MLR	89.68%	92.17%	93.92%
ALR	3.17%	2.99%	4.65%

* Forecasted as of March 2022

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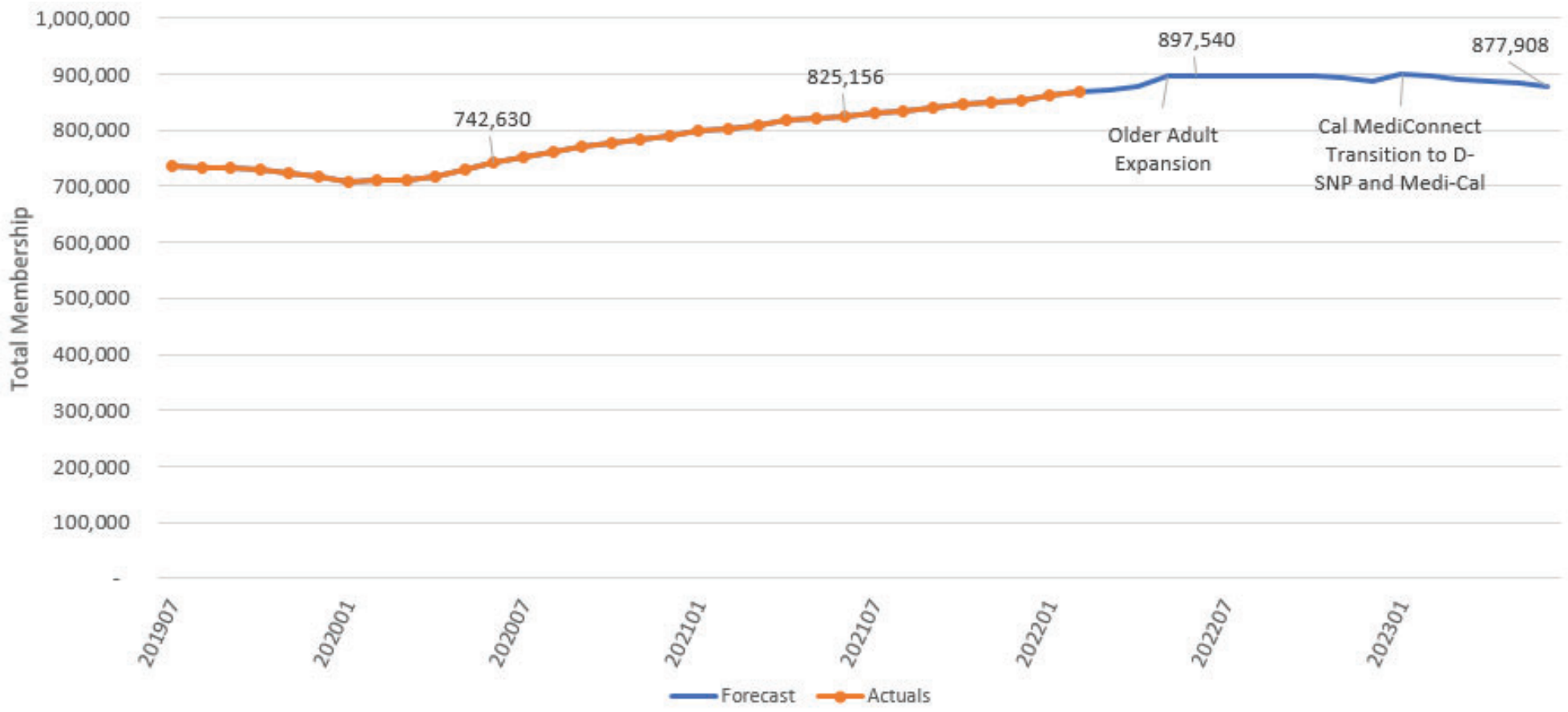
Medi-Cal Enrollment: Trend and Forecast



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Medi-Cal Revenue

- Rate assumptions

	Medi-Cal Classic	Medi-Cal Expansion	Medi-Cal Whole Child Model (WCM)
Base Rates	July – December 2022: Calendar Year (CY) 2022 rates		
	January – June 2023: Draft CY 2023 rates expected October 2022		
	• Assumes 1% increase	• Assumes 0% increase	• Assumes 0% increase
Coordinated Care Initiative (CCI) Rates	July 2022 – June 2023: Utilized CY 2022 rates • Reweighted for projected cohort mix		NA

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Medical Costs: Provider Rate Updates for Medi-Cal Classic and Expansion

Medical Cost	Unit Cost Change	Detail Trend	$ Est. Impact
Health Network Capitation: Extend COVID supplemental payment	Increase (Temporary)	• Continue current supplemental payment post-public health emergency for delegated TANF and SPD members, through June 30, 2023, to ensure successful transition	$30M
Direct Provider Fee-For-Service: Extend COVID supplemental payment	Increase (Temporary)	• Continue current supplemental payment post-public health emergency, through June 30, 2023, to ensure successful transition	$28M

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OneCare

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OneCare Budget

- OneCare Connect enrollment will transition to OneCare D-SNP on January 1, 2023

	FY 2020-21 Actual	FY 2021-22 Forecast *	FY 2022-23 Budget **
Average Monthly Enrollment	1,669	2,255	9,772
Revenue	$25,967,205	$34,264,565	$188,484,971
Medical Costs	$24,310,718	$34,242,713	$180,552,247
Administrative Expenses	$1,919,893	$2,248,662	$16,449,984
Operating Income/Loss**	**($243,406)**	**($2,226,810)**	**($8,517,260)**
MLR	93.62%	99.94%	95.79%
ALR	7.39%	6.56%	8.73%

* Forecasted as of March 2022

** Includes OCC enrollment effective January 2023

Note: FY 2020-21 Actual and FY 2021-22 Forecast include prior year adjustments

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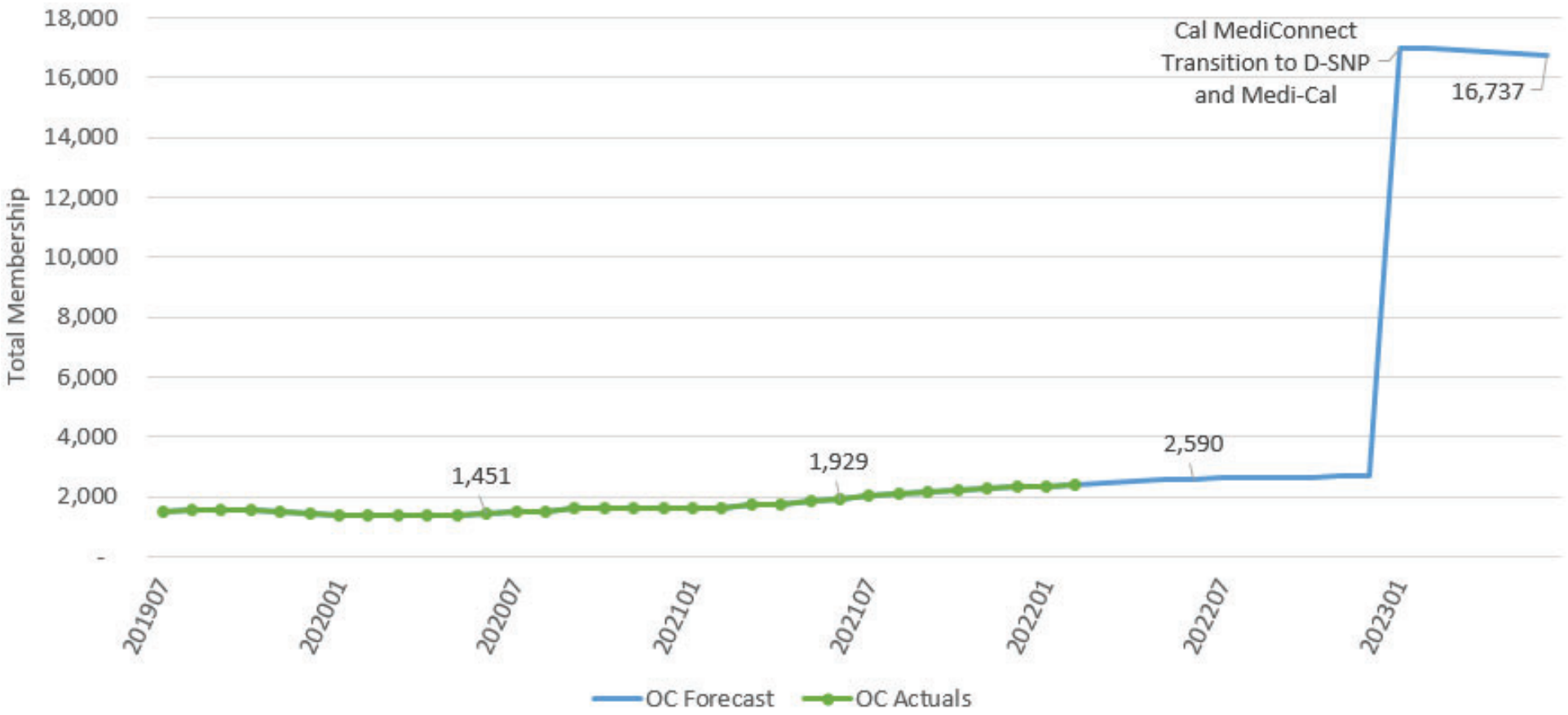
OneCare Enrollment: Trend and Forecast



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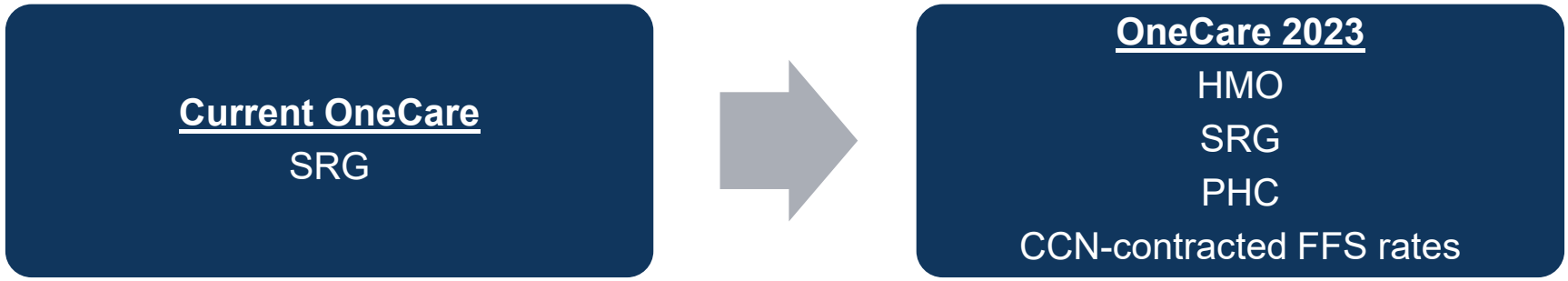
OneCare – Rebased Capitation Rate

- April 18, 2022: Milliman completed rebasing analysis with recommended Percent of Premium (POP) rates
- Budget assumes OneCare Connect risk arrangements will transition to OneCare



- Recommended funding
  - Effective date: January 1, 2023
  - Hospital: 46.4%; Professional: 34.1%
  - CalOptima additionally funds Personal Care Coordinators, quality initiatives, and currently absorbs impact of sequestration reduction

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OneCare Budget Assumptions

- Enrollment projected to increase 320% from prior year
- OneCare revenue rate assumptions*
  - 2% sequestration reduction resumes July 2022; CalOptima will continue to absorb this reduction

Medicare Part C	Medicare Part D
• CMS CY 2022 Monthly Membership Report actuals • Forecasted 69.4% increase to Part C revenue PMPM beginning CY 2023. Combination of base rate and RAF score changes driven by higher acuity of OCC transitioning members	• CMS CY 2022 Monthly Membership Report actuals • Forecasted 4.2% increase to Part D revenue PMPM beginning CY 2023. Combination of base rate, RAF, other adjustments.

- Medical Costs
  - Uses updated capitation POP percentages
  - Forecasts increases primarily in inpatient trend (acuity mix driven unit cost) and pharmacy (unit cost)
  - Includes expenses for approved supplemental benefits

* Used most current rates available

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OneCare Program Improvement Opportunities

- Continue efforts to capture appropriate member diagnostic information
  - Improving data submission processes will positively impact reported Risk Adjustment Factors
  - Implemented the Primary Care Engagement and Clinical Documentation Integrity Program to promote quality care
  - Request for Proposal released in March 2022 to select a vendor for improved data submission process
- Promote enrollment growth and program quality
  - Improve economies of scale
  - Maximize rebate dollars to provide supplemental benefits
  - Increase marketing efforts and community outreach to improve new member enrollment and retention

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OneCare Connect

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OneCare Connect Budget

- OneCare Connect program sunsets on December 31, 2022

	FY 2020-21 Actual	FY 2021-22 Forecast *	FY 2022-23 Budget **
Average Monthly Enrollment	14,704	14,758	7,324
Revenue	$344,174,513	$331,624,376	$167,628,058
Medical Costs	$323,080,535	$305,245,024	$159,625,681
Administrative Expenses	$18,341,930	$17,905,186	$11,183,812
Operating Income/Loss**	**$2,752,048**	**$8,474,166**	**($3,181,434)**
MLR	93.87%	92.05%	95.23%
ALR	5.33%	5.40%	6.67%

* Forecasted as of March 2022

** Six-month operating budget from July 1, 2022, through December 31, 2022. Budget includes expenses for run-out period.

Note: FY 2020-21 Actual and FY 2021-22 Forecast include prior year adjustments

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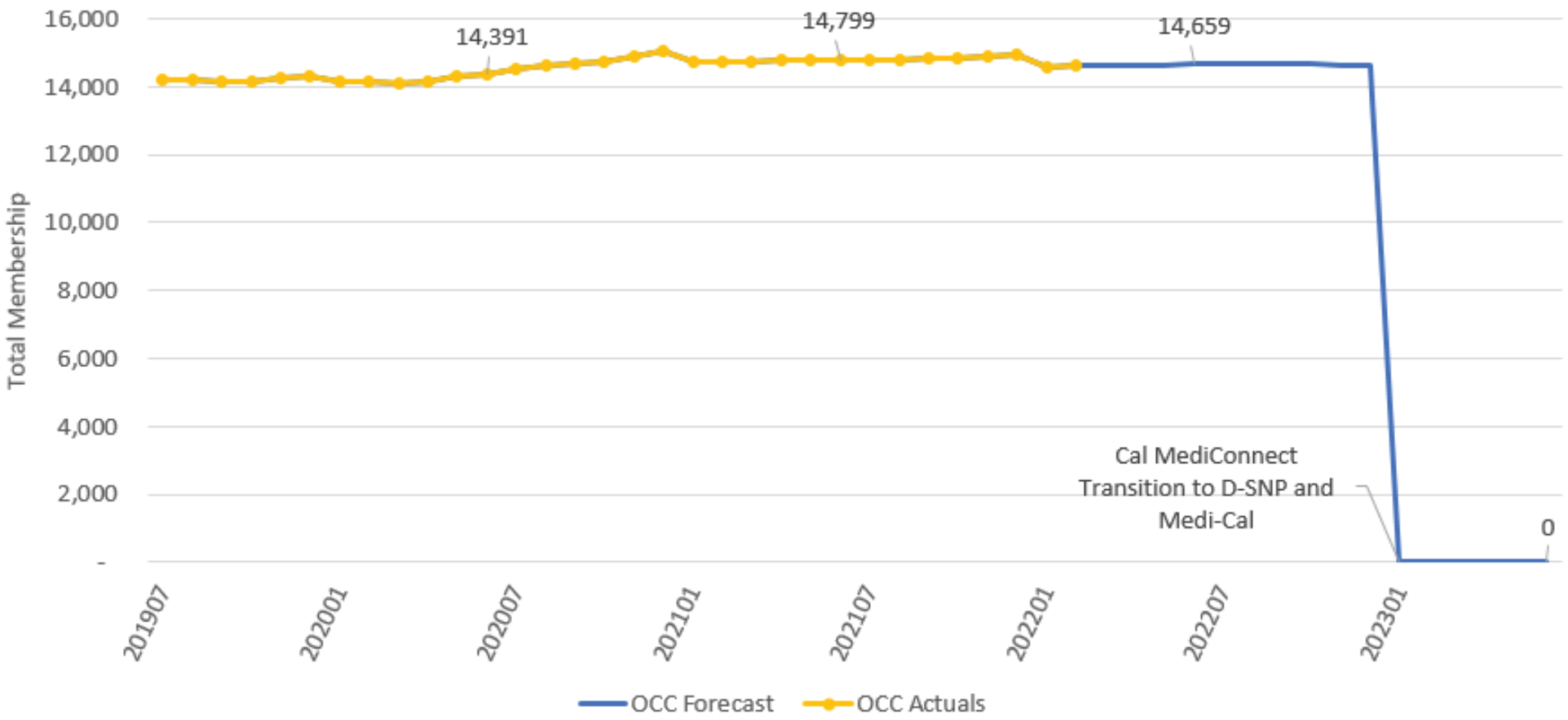
OneCare Connect Enrollment: Trend and Forecast



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OneCare Connect Budget Assumptions: Revenue

- OneCare Connect Revenue Rate Assumptions
  - Year 3+ savings targets of 5.5%
  - Quality withhold of 4%
  - 2% sequestration reduction resumes July 2022

Medicare Part C	Medicare Part D	Medi-Cal *
CMS CY 2022 Monthly Membership Report actuals for base rate and trended RAF score	CMS CY 2022 Monthly Membership Report actuals for base rate and trended RAF score	CY 2022 Rates adjusted for forecasted population mix

- OneCare Connect Medicare rates are not developed from a bid process that uses actual plan data. Staff used most current county benchmark base rate available.

* DHCS plan rates use Rate Development Template (RDT) base data that has a two-year lag

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OneCare Connect Budget Assumptions: Enrollment and Medical Expense

- Medical Expense
  - Provider Capitation
    - Medicare component: Based on POP rates of 45% Hospital and 34.4% Professional
    - Medi-Cal component: Based on fixed PMPM rates
  - FFS: Based on actual experience trended through December 2022
    - Includes projected increases in Inpatient services (acuity mix driven unit cost), Inpatient Skilled Nursing Facility (utilization and unit cost), and Pharmacy (unit cost)
    - Includes expenses for Medicare supplemental benefits to align with OneCare supplemental benefits

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PACE

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PACE Budget

	FY 2020-21 Actual	FY 2021-22 Forecast*	FY 2022-23 Budget
Average Monthly Enrollment	389	414	477
Revenue	$39,020,930	$40,452,971	$47,851,218
Medical Costs	$33,312,760	$34,030,494	$44,495,120
Administrative Expenses	$2,041,555	$1,969,375	$3,185,468
Operating Income/Loss	**$3,666,616**	**$4,453,102**	**$170,629**
MLR	85.37%	84.12%	92.99%
ALR	5.23%	4.87%	6.66%

* Forecasted as of March 2022

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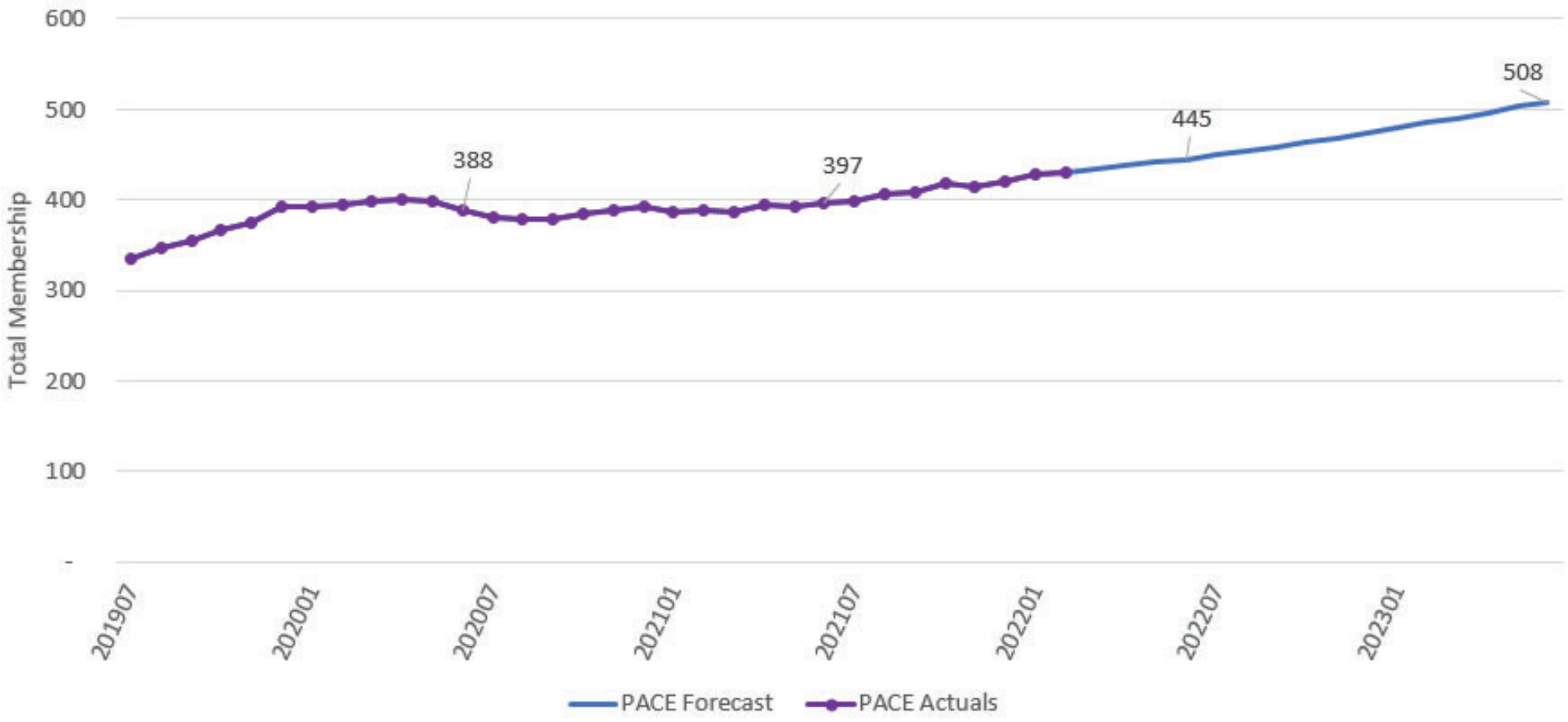
PACE Enrollment: Trend and Forecast



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PACE Budget Assumptions

Medicare Part C	Medicare Part D	Medi-Cal
• CMS CY 2022 Monthly Membership Report actuals • Forecasted 9.1% increase to Part C revenue PMPM beginning CY 2023. Combination of base rate and RAF score changes.	• CMS CY 2022 Monthly Membership Report actuals • Forecasted 0.1% increase to Part D revenue PMPM beginning CY 2023. Combination of base rate, RAF, other adjustments.	PMPM rates based on CY 2022 rates and reflect a 1.5% increase CY 2023 • Utilized RDT reported cost • RDT credibility increasing annually with additional membership growth

Medical costs

- Based on mix of actual experience and industry benchmarks
- Reclassifies 91% of some administrative expenses as medical costs to better reflect the actual costs of delivering medical care
- Assumes transition back to pre-pandemic operations at the PACE Center

Note: Used most current rates available

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CalOptima's Vision by 2027

- Same-Day Treatment Authorizations
- Real-Time Claims Payments
- Annual Assessments of Members' Social Determinants of Health

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken June 2, 2022
Regular Meeting of the CalOptima Board of Directors

Report Item
17. Approve the CalOptima Fiscal Year 2022-23 Capital and Digital Transformation Year One Capital Budgets

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

Recommended Actions
1. Approve the CalOptima Fiscal Year (FY) 2022-23 Capital and Digital Transformation Year One Capital Budgets; and
2. Authorize the expenditures and appropriate the funds for the following items, which shall be procured in accordance with CalOptima Board-approved policies:
    a. Attachment A: FY 2022-23 Capital Budget by Project; and
    b. Attachment A1: FY 2022-23 Digital Transformation Year One Capital Budget by Project.

Background
As of March 31, 2022, CalOptima recorded gross capital assets of $107.8 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 costs of these assets an accumulated depreciation totaling $62.6 million. Staff will record capital assets acquired in FY 2022-23 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 $45.2 million, as of March 31, 2022. Prior Board-approved capital budgets were $14.7 million in FY 2021-22, and $16.2 million in FY 2020-21.

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 for 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
A. FY 2022-23 Capital Budget
Management proposes a Capital Budget of $13,688,363 million for FY 2022-23 with four (4) asset categories as summarized in the following table:

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Asset Category	FY 2022-23 Budget	% of Total
1. Information Technology Services (ITS)		
Hardware	*$1,215,000*	
Software	*$1,838,232*	
Professional fees related to implementation	*$575,000*	
Subtotal:	$3,628,232	26.5%
2. 505 Building Improvements	$1,962,131	14.3%
3. 500 Building Improvements	$7,692,000	56.2%
4. PACE	$406,000	3.0%
Total:	**$13,688,363**	**100%**

* Totals may not add due to rounding

More detailed information is provided in Attachment A: Fiscal Year 2022-23 Capital Budget by Project.

FY 2022-23 Capital Budget by Asset Category

1. Information Technology Services: ITS represents $3,628,232 or 26.5% of the Capital Budget.

Capital Project Type	FY 2022-23 Budget	% of Total
Infrastructure	$2,460,232	67.8%
Applications Management	$1,168,000	32.2%
Total:	**$3,628,232**	**100%**

This category includes funding for hardware, software, and professional fees related to the implementation of multiple systems upgrades. 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 $1,962,131 or 14.3% of the Capital Budget.

Capital Project Type	FY 2022-23 Budget	% of Total
Furniture Upgrades	$500,000	25.5%
Office Suite Renovation and Improvements	$450,000	22.9%
Building Security Projects	$276,000	14.1%
Touchless Faucets	$183,000	9.3%
Parking Lot Security	$112,000	5.7%
Capital Lease Copiers	$111,000	5.7%
Parking Lot Improvement	$102,000	5.2%
Electric Car Charging Station	$68,000	3.5%
IDF Room HVAC Unit Replacement	$60,000	3.1%
Road Warning Light (Crosswalk)	$50,000	2.6%
Freight Elevator Refresh	$42,000	2.1%
LED Canopy Light Fixtures	$8,131	0.4%

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Capital Project Type	FY 2022-23 Budget	% of Total
Total:	**$1,962,131**	**100%***

* Total may not add due to rounding

3. 500 Building Improvements: 500 Building Improvements represent $7,692,000 or 56.2% of the Capital Budget. Estimates are based on the potential availability of vacant space in FY 2022-23.

Capital Project Type	FY 2022-23 Budget	% of Total
Tenant Improvements	$3,422,000	44.5%
Technology Updates	$2,100,000	27.3%
Office Furniture and Other Equipment	$1,370,000	17.8%
HVAC Equipment Replacement	$650,000	8.5%
Touchless Water Fixtures	$100,000	1.3%
Security System	$50,000	0.7%
Total:	**$7,692,000**	**100%***

* Total may not add due to rounding

4. Program for All-Inclusive Care for the Elderly (PACE): The remaining portion of $406,000 or 3.0% of the Capital Budget is for capital expenditures at the PACE Center.

Capital Project Type	FY 2022-23 Budget	% of Total
Parking Lot Improvement	$230,000	56.7%
Additional Furniture, Fixtures and Equipment	$55,000	13.5%
Interior Light Improvement	$45,000	11.1%
Monument Sign	$25,000	6.2%
Technology Upgrades	$25,000	6.2%
Kitchen Flooring	$15,000	3.7%
Clinic Speaker Equipment	$11,000	2.7%
Total:	**$406,000**	**100%***

* Total may not add due to rounding

B. FY 2022-23 Digital Transformation Year One Capital Budget

On March 17, 2022, the CalOptima Board of Directors authorized a three-year Digital Transformation and Workplace Modernization Strategy and created a $100 million restricted reserve to fund digital transformation efforts. Management proposes a Digital Transformation Year One Capital Budget of $34,196,000 from this restricted reserve for capital projects during Year One of implementation.

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Capital Project Type	FY 2022-23 Budget	% of Total
Infrastructure	$7,524,000	22.0%
Applications Management	$10,462,000	30.6%
Applications Development	$16,210,000	47.4%
Total:	**$34,196,000**	**100%**

More detailed information is provided in Attachment A1: Fiscal Year 2022-23 Digital Transformation Year One Capital Budget by Project.

Fiscal Impact

Investment in the FY 2022-23 Capital and Digital Transformation Year One Capital Budgets will reduce CalOptima's investment principal by $13,688,363 and $34,196,000 respectively. Depreciation expenses for Capital Budget projects are reflected in the proposed FY 2022-23 CalOptima Operating Budget.

Rationale for Recommendation

The FY 2022-23 Capital and Digital Transformation Year One Capital Budgets will enable necessary system upgrades, enhance operational efficiencies, support CalOptima's updated Mission and Vision statements and Strategic Plan, comply with federal and state requirements, and improve and upgrade the 505 Building, 500 Building and PACE Center.

Concurrence

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

Attachments

1. Attachment A: Fiscal Year 2022-23 Capital Budget by Project
2. Attachment A1: Fiscal Year 2022-23 Digital Transformation Year One Capital Budget by Project

/s/ Michael Hunn — *05/27/2022*
Authorized Signature — **Date**

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Attachment A: FY 2022-23 Capital Budget by Project

INFRASTRUCTURE	HARDWARE	SOFTWARE	PROFESSIONAL FEES	TOTAL CAPITAL
Replace End of Support Servers (Non Virtual Machines)	390,000		10,000	400,000
Tool for Database Auditing and Compliance	50,000	150,000	100,000	300,000
Replace End of Support Servers for Production Environment	251,000			251,000
New Ticketing Tool for Caloptima Staff		150,000	100,000	250,000
Virtual Environment for Claims Automations	100,000	100,000	20,000	220,000
Replace End of Support Servers for Non-Production Environment	211,000			211,000
Upgrading the Internet Web Proxy		170,000	30,000	200,000
Replace Virtual Servers Hosts	95,000			95,000
Tool for Database Monitoring Solution		79,800		79,800
Security Monitoring Tool for Servers and Networks		75,000		75,000
Tool for Web Monitoring Solution		55,000		55,000
Transition Legacy Mail Components to Microsoft Cloud			50,000	50,000
Tool to Automate File Transfer		50,000		50,000
Tool for Desktop Monitoring and Troubleshooting		50,000		50,000
Monitoring Solution for Servers And Network Devices (Troubleshooting)		45,000		45,000
Enhanced Microsoft Video Conferencing Solution	40,000			40,000
Failover Phone System for PACE	28,000	8,000		36,000
Tool to Track Database Inventory and Optimize Database Performance		27,432		27,432
Additional Features for Remote Support Tool for Service Desk		25,000		25,000
TOTAL INFRASTRUCTURE	**$ 1,165,000**	**$ 985,232**	**$ 310,000**	**$ 2,460,232**

APPLICATIONS MANAGEMENT	HARDWARE	SOFTWARE	PROFESSIONAL FEES	TOTAL CAPITAL
Electronic Health Information Exchange - Interoperability Phase II - Plan to Plan		500,000	150,000	650,000
Integrated Provider Data Management System		350,000	110,000	460,000
License Language & Font Packages	50,000			50,000
Electronic Health Record System		3,000	5,000	8,000
TOTAL APPLICATIONS MANAGEMENT	**$ 50,000**	**$ 853,000**	**$ 265,000**	**$ 1,168,000**

505 BUILDING IMPROVEMENTS	BUILDING	EQUIPMENT	PROFESSIONAL FEES	TOTAL CAPITAL
Furniture Upgrades	500,000			500,000
Office Suite Renovation and Improvements	400,000		50,000	450,000
Building Security Projects	241,000		35,000	276,000
Touchless Faucets	183,000			183,000
Parking Lot Security	112,000			112,000
Capital Lease Copiers	111,000			111,000
Parking Lot Improvement	102,000			102,000
Electric Car Charging Station	68,000			68,000
IDF Room HVAC Unit Replacement	60,000			60,000
Road Warning Light (Crosswalk)	50,000			50,000
Freight Elevator Refresh	42,000			42,000
LED Canopy Light Fixtures	8,131			8,131
TOTAL 505 BUILDING IMPROVEMENTS	**$ 1,877,131**	**$ -**	**$ 85,000**	**$ 1,962,131**

500 BUILDING IMPROVEMENTS	BUILDING	EQUIPMENT	PROFESSIONAL FEES	TOTAL CAPITAL
Tenant Improvements	3,422,000			3,422,000
Technology Updates	2,100,000			2,100,000
Office Furniture amd Other Equipment	1,370,000			1,370,000
HVAC Equipment Replacement	650,000			650,000
Touchless Water Fixtures	100,000			100,000
Security System	50,000			50,000
TOTAL 505 BUILDING IMPROVEMENTS	**$ 7,692,000**	**$ -**	**$ -**	**$ 7,692,000**

PACE	BUILDING	EQUIPMENT	PROFESSIONAL FEES	TOTAL CAPITAL
Parking Lot Improvement	230,000			230,000
Additional Furniture Fixtures and Equipment	50,000		5,000	55,000
Interior Light Improvement	45,000			45,000
Monument Sign	25,000			25,000
Technology Upgrades		25,000		25,000
Kitchen Flooring	15,000			15,000
Clinic Speaker Equipment		10,000	1,000	11,000
TOTAL PACE	**$ 365,000**	**$ 35,000**	**$ 6,000**	**$ 406,000**

TOTAL FY 2022-23 CAPITAL BUDGET	**$ 11,149,131**	**$ 1,873,232**	**$ 666,000**	**$ 13,688,363**

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Attachment A1: FY 2022-23 Digital Transformation Year One Capital Budget by Project

INFRASTRUCTURE	HARDWARE	SOFTWARE	PROFESSIONAL FEES	TOTAL CAPITAL
Network Bandwidth Upgrade for All Sites (Wide Area Network)	4,615,000		190,000	4,805,000
Internet Bandwidth Upgrade for All Sites	2,514,000		60,000	2,574,000
Virtual Private Network Upgrade		75,000		75,000
Test Environment for Database High Availability	50,000	20,000		70,000
TOTAL INFRASTRUCTURE	**$ 7,179,000**	**$ 95,000**	**$ 250,000**	**$ 7,524,000**

APPLICATIONS MANAGEMENT	HARDWARE	SOFTWARE	PROFESSIONAL FEES	TOTAL CAPITAL
Care Management System		2,500,000	500,000	3,000,000
Enterprise Robotic Process Automation		1,000,000	500,000	1,500,000
Cloud Migration - Financial System		756,000	556,000	1,312,000
Clinical Evidence Based Criteria/Guidelines		950,000		950,000
Customer Relationship Management System		693,750	231,250	925,000
Automation Batch Processing Software		375,000	150,000	525,000
Orange County - Health Information Exchange Participation		425,000	75,000	500,000
Customer Service Enhanced System Functions		250,000	150,000	400,000
Member and Provider Portal Enhanced Stability		250,000	75,000	325,000
Automation Testing Tool		250,000	75,000	325,000
Electronic Cloud Based Fax Solution		200,000	75,000	275,000
Customer Service System Enhanced Functions		150,000	50,000	200,000
Provider Portal integration with Clinical Guidelines		75,000	50,000	125,000
Real Time - Application Programming Interface		100,000		100,000
TOTAL APPLICATIONS MANAGEMENT	**$ -**	**$ 7,974,750**	**$ 2,487,250**	**$ 10,462,000**

APPLICATIONS DEVELOPMENT	HARDWARE	SOFTWARE	PROFESSIONAL FEES	TOTAL CAPITAL
Digital Transformation Strategy Planning and Execution Support			3,140,000	3,140,000
Artificial Intelligence/Machine Learning Tools to Turn Data into Information		2,148,750	716,250	2,865,000
Migrate Data Warehouse/Analytics to the Cloud		1,350,000	450,000	1,800,000
Real-Time Data Exchange with Partners Enhancement		1,227,000	409,000	1,636,000
Regulatory Encounter Processing Vendor Replacement		1,012,500	337,500	1,350,000
Migration of Provider and Member Portals to the Cloud		918,750	306,250	1,225,000
Migrate Standardized HIPAA Data Exchange to the Cloud		900,000	300,000	1,200,000
Predictive Analytics to Support CalAIM and SDOH		675,000	225,000	900,000
Migrate Website Content Management System to the Cloud		562,500	187,500	750,000
Software Quality Assurance/Testing Tools		211,500	70,500	282,000
Data Warehouse Architecture Enhancement		187,500	62,500	250,000
Migrate User Authentication Process for Member and Provider Portal to Cloud		169,500	56,500	226,000
Analytics for Member and Provider Use of Web Tools		112,500	37,500	150,000
Mobile Application Development Tool		109,500	36,500	146,000
Enterprise Data Quality Enhancement		101,250	33,750	135,000
Migrate Operational Reportng/Analytics to the Cloud		76,500	25,500	102,000
Mobile Application Development Testing Tool		39,750	13,250	53,000
TOTAL APPLICATIONS DEVELOPMENT	**$ -**	**$ 9,802,500**	**$ 6,407,500**	**$ 16,210,000**

TOTAL FY 2022-23 DIGITAL TRANSFORMATION YEAR ONE CAPITAL BUDGET	**$ 7,179,000**	**$ 17,872,250**	**$ 9,144,750**	**$ 34,196,000**

FY 2022-23 Capital Budget

CalOptima's Mission

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

CalOptima's Vision by 2027

- Same-Day Treatment Authorizations
- Real-Time Claims Payments
- Annual Assessments of Members' Social Determinants of Health

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Agenda

- FY 2022-23 Capital Budget – Routine Services
  - Information Technology Services
  - 505 Building Improvements
  - 500 Building Improvements
  - PACE
- FY 2022-23 Digital Transformation Year One Capital Budget
- Recommended Actions

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FY 2022-23 Capital Budget

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ROUTINE CAPITAL:
FY 2022-23 Budget (Operating Budget Funded)

$ 13,688,363

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DIGITAL TRANSFORMATION CAPITAL:
FY 2022-23 Budget (Reserves Funded)

$ 34,196,000

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TOTAL CAPITAL: FY 2022-23 Budget

$47,884,363

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FY 2022-23 Capital Budget - Routine Services

Asset Category	FY 2022-23 Budget	% of Total
Information Technology Services (ITS)		
Hardware	*$1,215,000*	
Software	*$1,838,232*	
Professional fees related to implementation	*$575,000*	
Subtotal:	$3,628,232	26.5%
505 Building Improvements	$1,962,131	14.3%
500 Building Improvements	$7,692,000	56.2%
PACE	$406,000	3.0%
Total:	**$13,688,363**	**100.0%**

- Departments submit requests for capital projects based on strategic and operational needs
- ITS Department reviews technology requests

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Information Technology Services (ITS)

Capital Project Type	FY 2022-23 Budget
Infrastructure (e.g., Server, Compliance Database, Virtual Environment for Claims Automation, Storage, Security)	$2,460,232
Applications Management (e.g., Electronic Health Information Exchange, Provider Data Management System)	$1,168,000
Total:	**$3,628,232**

- Represents nearly 26.5% of Capital Budget
- Addresses information technology infrastructure needs to support current internal operations
- Ensures compliance with state and federal requirements

Note: Project details can be found in Attachment A: Fiscal Year 2022-23 Capital Budget by Project

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505 Building Improvements

Capital Project Type	FY 2022-23 Budget
Furniture Upgrades	$500,000
Office Suite Renovation and Improvements	$450,000
Building Security Projects	$276,000
Touchless Faucets	$183,000
Parking Lot Security	$112,000
Capital Lease Copiers	$111,000
Parking Lot Improvement	$102,000
Electric Car Charging Station	$68,000
IDF Room HVAC Unit Replacement	$60,000
Road Warning Light (Crosswalk)	$50,000
Freight Elevator Refresh	$42,000
LED Canopy Light Fixtures	$8,131
Total:	**$1,962,131**

- Represents 14.3% of Capital Budget

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500 Building Improvements

Capital Project Type	FY 2022-23 Budget
Tenant Improvements	$3,422,000
Technology Updates	$2,100,000
Office Furniture and Other Equipment	$1,370,000
HVAC Equipment Replacement	$650,000
Touchless Water Fixtures	$100,000
Security System	$50,000
Total:	**$7,692,000**

- Represents 56.2% of Capital Budget
- Estimates based on potential availability of vacant space in FY 2022-23

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PACE

Capital Project Type	FY 2022-23 Budget
Parking Lot Improvement	$230,000
Additional Furniture, Fixtures and Equipment	$55,000
Interior Light Improvement	$45,000
Monument Sign	$25,000
Technology Upgrades	$25,000
Kitchen Flooring	$15,000
Clinic Speaker Equipment	$11,000
Total:	**$406,000**

- Represents 3.0% of Capital Budget

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FY 2022-23 Digital Transformation Year One Capital Budget

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FY 2022-23 Digital Transformation Year One Capital Budget ($100 million total reserve)

Capital Project Type	FY 2022-23 Budget
Infrastructure (e.g., Route WAN Bandwidth Upgrade, Internet Networks Bandwidth Upgrade)	$7,524,000
Applications Management (e.g., Care Management System, Enterprise Robotic Process Automation, Cloud Migration, Clinical Evidence Based Guidelines, Customer Relationship Management System)	$10,462,000
Applications Development (e.g., Digital Transformation Strategy Planning, Artificial Intelligence/Machine Learning Tools, Migrate Data Warehouse/Analytics to the Cloud, Real-Time Data Exchange with Partners Enhancement)	$16,210,000
Total:	**$34,196,000**

- March 17, 2022: Board authorized a three-year strategy and created a $100 million restricted reserve to fund digital transformation efforts
- Proposed budget reflects capital projects during Year 1 of implementation
- For details, see Attachment A1: Fiscal Year 2022-23 Digital Transformation Year One Capital Budget by Project

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Recommended Actions

- Approve the CalOptima Fiscal Year 2022-23 Capital and Digital Transformation Year One Capital Budgets

- Authorize the expenditures and appropriate the funds for the following items, which shall be procured in accordance with CalOptima Board-approved policies:
  - Attachment A: Fiscal Year 2022-23 Capital Budget by Project
  - Attachment A1: Fiscal Year 2022-23 Digital Transformation Year One Capital Budget by Project

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CalOptima's Vision by 2027

- Same-Day Treatment Authorizations
- Real-Time Claims Payments
- Annual Assessments of Members' Social Determinants of Health

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken June 2, 2022
Regular Meeting of the CalOptima Board of Directors

Report Item
18. Adopt Strategic and Tactical Priorities for 2022-2025

Contacts
Michael Hunn, Chief Executive Officer, (657) 900-1481
Yunkyung Kim, Chief Operating Officer, (714) 246-8408

Recommended Action(s)
1. Adopt Strategic and Tactical Priorities for 2022-2025

Background and Discussion
CalOptima was created by the Orange County Board of Supervisors in 1993 as a County Organized Health System (COHS) to meet the needs or Orange County residents and providers in the Medicaid system.

In July of 1994, the CalOptima Board of Directors (Board) adopted the Mission, Goals, and Objective Statement for O.P.T.I.M.A as developed by the Provider Advisory Committee and the Consumer/Beneficiary Advisory Committee.

At that time, the Board wanted to ensure that the statement regarding the inclusion of the County-responsible indigent population in O.P.T.I.M.A was linked to the availability of adequate funding for services provided to this population.

The following mission was adopted and defined in Policy #AA. 1201:

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

CalOptima also adopted the following vision statement:

- To be a model public agency and community health plan that provides an integrated and well-coordinated system of care to ensure optimal health outcomes for all our members.

In 2013, during a strategic planning session conducted by the Board updating the mission was considered. Ultimately, it was agreed up on that the original mission statement did not require any changes.

Today, CalOptima is the single largest health insurer in Orange County, providing coverage for one in four residents through four programs:

- Medi-Cal
- OneCare
- OneCare Connect

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On March 17, 2022, the Board formally adopted new mission and vision statements.

- Mission-To serve member health with excellence and dignity, respecting the value and needs of each person.
- Vision-By 2027, remove barriers to healthcare access for our members, implement same day treatment authorizations and real-time claims payments for our providers, and annually assess members' social determinants of health.

Beginning in December of 2021, staff developed five strategic priorities and tactical priorities. Over the last six months, CalOptima has sought feedback from advisory committees, health networks, hospitals, and clinics among others. The five strategic priority areas are as follows:

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

The strategic priority areas and tactical priorities will support planning and development for CalOptima through 2025. Staff will return to the Board with a Strategic Plan using these priorities for approval.

Fiscal Impact
There is no fiscal impact.

Rationale for Recommendation
Development of the proposed Strategic Priority Areas is consistent with the direction provided by the Board of Directors to support planning and development of CalOptima programs and initiatives.

Concurrence
James Novello, Outside General Counsel, Kennaday Leavitt

Attachments
1. Strategic Priorities One Pager
2. Resolution of New Mission and Vision Statement for CalOptima

/s/ Michael Hunn — *05/27/2022*
Authorized Signature — **Date**

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Mission	*To serve member health with excellence and dignity, respecting the value and needs of each person.*				
Vision	*By 2027, remove barriers to healthcare access for our members, implement same day treatment authorizations and real-time claims payments for our providers, and annually assess members' social determinants of health.*				
Core Strategy	**The 'inter-agency' co-creation of services and programs, together with our delegated networks, providers, and community partners, to support the mission and vision.**				
Strategic Priorities 2022-2025	**Organizational and Leadership Development**	**Overcoming Health Disparities**	**Finance and Resource Allocation**	**Accountabilities & Results Tracking**	**Future Growth**
Tactical Priorities 2022-2025	• *Cultural Alignment throughout CalOptima* • *Talent Development & Succession Planning* • *Effective & Efficient Organizational Structures* • *Aligned Operating Systems & Structures* • *Staff Leadership Development Institutes (Training) & Executive Coaching* • *Organizational Excellence Annual Priorities* • *On-going updated Policies & Procedures* • *Governance & Regulatory Compliance Trainings* • *Board Priorities*	• *CalOptima's 'Voice & Influence'* • *Local, Federal & State Advocacy* • *Collaboration with the County, HCA, BeWell, the Networks and Community Based Organizations* • *Support for Community Clinics & Safety Net Providers* • *Medical Affairs Value Based Care Delivery* • *CalAIM initiatives* • *Focus on Equity & Communities Impacted by Health Inequities* • *Co-Created Needs Assessment within Equity Communities & Neighborhoods* • *ITS Architecture that supports the Core Strategy* • *DHCS Comprehensive Quality Strategy*	*Operating Budget Priorities* • *Balanced Operating Budget* • *New Programs & Services Budgeting (CalAIM, DHCS Quality Strategy)* • *Fiscal Strategic Plan Priorities (KPI/KFI)* • *Quarterly Budget Reconciliation* *Capital Budget Priorities* • *Capital Planning & Asset Management, including Real-Estate Management and Acquisition(s)* • *New ITS Architecture* *New Policy and Program Development based on Funding* • *Reserve/Spending Policies & Priorities* • *Aligned Incentives for Network Quality & Compliance* • *Contracting & Vendor/Provider Management*	• *Updated By-Laws* • *Executive Priorities & Outcomes* • *COBAR Clarity* • *Inter-Agency Team Priorities* • *Public/Private Implementation Work Group* • *Resource Allocation for Inter-Agency Initiatives* • *Partner CalAIM Opportunities for Outcomes Metrics* • *Research Analytics for Efficacy Reporting (Metrics of Success)* • *Regular Board Training Sessions*	• *Member Access to Quality Care* • *Participate in Covered California* • *Site Utilization (PACE etc.)* • *Services/Programs Aligned with Future Reimbursements from DHCS and CMS* • *Demographic & Analytics by Micro-Community* • *ITS Data Sharing to benefit the member* • *Implement Programs & Services (CalAIM) & Plan for Site Locations* • *Industry Trends Analysis (Trade Associations, Lobbyists etc.)* • *Enhanced ITS security posture*

DRAFT STRATEGIC AND TACTICAL PRIORITIES May_2022

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RESOLUTION NO. 22-0317-01

RESOLUTION OF THE BOARD OF DIRECTORS
ORANGE COUNTY HEALTH AUTHORITY
d.b.a. CalOptima

RESOLUTION FOR MISSION AND VISION STATEMENT

WHEREAS, the governing body of the Orange County Health Authority, dba CalOptima, ("CalOptima") adopted Mission, Goals, and Objective Statement O.P.T.I.M.A in July of 1994;

WHEREAS, this mission statement adopted in 1994 stated, the mission is to provide members with access to quality health care services delivered in a cost-effective and compassionate manner;

WHEREAS, the adoption of the mission statement was reflected in Policy #AA. 1201;

WHEREAS, the governing body of CalOptima has adopted a new mission and vision statement on March 17, 2022 and will be reflected in Policy #AA. 1201;

WHEREAS, the governing body adopted CalOptima's new mission and vision statement as follows;

- Mission: To serve member health with excellence and dignity, respecting the value and needs of each person.
- Vision: By 2027, remove barriers to healthcare access for our members, implement same day treatment authorizations and real-time claims payments for our providers, and annually assess members' social determinants of health.

NOW, THEREFORE, BE IT RESOLVED that the governing body of CalOptima adopts a new mission and vision statement.

APPROVED AND ADOPTED by the Board of Directors of the Orange County Health Authority, d.b.a., CalOptima this 17th day of March 2022.

AYES: Becerra, Chaffee, Contratto, Corwin, Do, Mayorga, Schoeffel, Shivers

NOES: None

ABSENT: Tran

ABSTAIN: None

/s/ _____
Title: Chair, Board of Directors
Printed Name and Title: Andrew Do, Chair, CalOptima Board of Directors

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

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken June 2, 2022
Regular Meeting of the CalOptima Board of Directors

Report Item
19. Authorize the CalOptima Administrative Fellowship Program

Contacts
Yunkyung Kim, Chief Operating Officer, (714) 246-8408
Brigette Hoey, Chief Human Resources Officer, (714) 246-8405

Recommended Action
Authorize the Chief Executive Officer to launch the CalOptima Administrative Fellowship Program effective September 1, 2022.

Background
To seek talented individuals and promote CalOptima as a desirable employer in Orange County, CalOptima management requests the Board of Directors' approval to launch its first administrative fellowship program.

The program is intended for masters-trained individuals who are committed to making a difference in the health care system for Orange County's most vulnerable populations. This program will be designed for those who want to learn about practical health care operations and who want to develop their leadership potential in a public agency environment. This one-year limited fellowship program will provide opportunities to gain administrative experience in an integrated managed care setting.

Fellows will receive guidance and mentorship from senior leaders as they participate in CalOptima's important initiatives and projects. CalOptima will seek three (3) highly motivated, self-driven individuals who are interested in Health Care Management and Administration and have graduated from a relevant master's program within the past twenty-four (24) months.

Discussion
The administrative fellowship program concept is well tested. Other health plans, such as Kaiser Permanente and St. Joseph Health, have been offering administrative fellowship programs for several years. A competitive fellowship program will enhance CalOptima's recruitment opportunities and empower the next generation of health care leaders. This program will enable CalOptima to train motivated, educated, and thoughtful emerging leaders who can make a difference and continue CalOptima's mission.

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Fiscal Impact
The annual fiscal impact for three (3) administrative fellows is $206,000. Funding for the period of September 1, 2022, through June 30, 2023, is a budgeted item in the proposed Fiscal Year (FY) 2022-23 Operating Budget. Management will include funding for the period of July 1, 2023, through August 31, 2023, in the FY 2023-24 Operating Budget.

Rationale for Recommendation
The administrative fellowship program will be beneficial to both CalOptima and fellows. The program will allow CalOptima to find talent and fellows to experience hands-on health plan operations.

Concurrence
Troy R. Szabo, Outside General Counsel, Kennaday Leavitt

Attachments
1. Fellowship/job description
2. Fellowship sample curriculum

/s/ Michael Hunn *05/27/2022*
Authorized Signature **Date**

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Administrative Fellow (Draft)

Department(s): Medical Management
Reports to: Chief Medical Officer
FLSA status: Non-Exempt
Revised:

Job Summary

Under the direction of Executive Leadership (e.g., Chief Executive Officer, Chief Medical Officer, Chief Operating Officer, Chief Information Officer, Chief Financial Officer, etc.), the Administrative Fellow (Fellow) will work with key administrative personnel to gain knowledge and experience in the management of CalOptima, as well as the broader health care landscape. The Fellow will be assigned to select projects related to the business and operations of CalOptima. The Fellow will work directly with the primary preceptor to receive guidance and feedback on projects and opportunities. Over the course of the twelve (12) month fellowship, the Fellow will have the opportunity to formally meet with the CalOptima CalTeam senior leaders one-on-one and sit in on executive management meetings while tackling various inter-departmental projects. While working closely with the CalOptima CalTeam, the Fellow will need to use discretion and independent judgment, in assessing situations, considering alternatives, and determining appropriate courses of action. Throughout the fellowship, the Fellow will gain insight into the inner workings of a large complex health plan organization and how its work is realized in the surrounding community.

The Administrative Fellowship program is a twelve (12) month limited term appointment. The program is designed to provide fellows with an educational, interactive, and enriching experience that will contribute to their professional development, as well as to their understanding of CalOptima and health plan operations. In addition, the program will help create opportunities for fellows to enhance skills in project development, strategic implementation and operations management. Most fellows will experience a balance of project and operational work, with an emphasis on health plan operations. Learning opportunities can include but are not limited to the administrative aspects of the following specialized areas:

- Behavioral Health
- Case Management
- Claims Administration
- Financial Analysis
- Grievance and Appeals
- Information Technology Services
- Population Health
- Program for All-Inclusive Care of the Elderly (PACE)
- Project Management

- Quality Assurance
- Quality Improvement
- Special Programs
- Utilization Management

The following items are required for consideration:

- Completion of application and supplemental questions
- Resume
- A statement of interest on why you are interested in this Fellowship program (2 pages maximum)
- A writing sample from school or work (2 pages maximum)
- Two letters of recommendation (one academic and one professional)

Position Responsibilities

- Participates in a mission driven culture of high-quality performance, with a member focus on customer service, consistency, dignity, and accountability.
- Assists the team in carrying out department responsibilities and collaborates with others to support short and long-term goals/priorities for the department.
- Gathers, analyzes and interprets information relating to the synthesis of recommendations, reporting, and presenting development and delivery, and initiating process improvements.
- Works collaboratively with executive leadership to assist in projects related to CalOptima.
- Attends all related meetings and responds to other meetings and committees as required.
- Communicates outcomes appropriately.
- Maintains compliance with all state and federal legal requirements, such as the Occupational Safety and Health Administration (OSHA), Health Insurance Portability and Accountability Act (HIPPA), etc.
- Participates with executive leadership in the design, development, integration and implementation of strategic initiatives, health improvement, community outreach, mission integration, clinical research and other defined initiatives.
- Responds to the needs of others through effective communication, mutual respect, and consistent follow through in order to generate trust and enhance personal effectiveness.
- Participates on project related work teams, fosters shared problem solving and supports decisions of the work team.
- Other projects and duties as assigned.

Possesses the Ability to:

- Consistently demonstrate behaviors that aligns with the core values and mission statement of CalOptima.
- Initiate and follow-through on projects with supervision or guidance.
- Communicate clearly and concisely, both verbally and in writing, with all levels of management, staff, physicians, patients and public.
- Establish and maintain effective working relationships with CalOptima leadership and staff.

- Focus and be detail-oriented, handle sensitive and confidential situations and demonstrate an attitude of professionalism and cooperation throughout the fellowship.
- Consistently function in an environment that includes varying, unpredictable, or crisis circumstances while exercising appropriate interpersonal and critical thinking skills.
- Treat all information and data within the scope of the position with appropriate confidentiality and level of security.
- Have excellent time management and organizational skills.
- Have strong analytical, interpersonal, presentation, leadership, collaboration, and customer service skills.
- Work effectively in a flexible work environment with results-oriented approach.
- Be an innovative, practical and collaborative strategic problem solver.
- Understand health care delivery systems and economics.
- Plan and oversee the implementation of short-term, discrete projects.
- Utilize computer and appropriate software (e.g., Microsoft Office: Excel, Outlook, PowerPoint, Word) and job-specific applications/systems to produce correspondence, charts, spreadsheets, and/or other information applicable to the position assignment.

Experience & Education

- Degree in Master of Business Administration, Master of Healthcare Administration, Master of Public Health, Master of Science in Nursing, Master of Public Administration, or relevant field required.
- Master's degree received within the past twenty-four (24) months required.
- Candidates must be U.S. Citizens or permanent residents. CalOptima is unable to sponsor work visas.

Physical Demands and Work Environment

The physical demands and work environment characteristics described here are representative of those that must be met by an employee to successfully perform the essential functions of this job. Reasonable accommodations may be made to enable individuals with disabilities to perform the essential functions.

- *Physical demands:* Employee must be able to sit for extended periods of time, as well as work at the computer for long periods. Employee is required to use hands and fingers, especially for typing on the computer and using the mouse. Employee must be able to communicate, particularly for phone use and in meetings.

- *Work Environment:* Typical office environment with moderate noise levels in a cubicle environment and controlled office temperatures.

Disclaimer:

The Job duties, elements, responsibilities, skills, functions, experience, educational factors and the requirements and conditions listed in this job description are representative only and not exhaustive of the tasks that an employee may be required to perform. The Employer reserves the right to revise this job description at any time and to require employees to perform other tasks as circumstances or conditions of its business, competitive considerations, or work environment change.

CalOptima Administrative Fellowship Program Curriculum

Program Overview

This program is intended for masters-trained fellows who are passionate about making a difference in health care system for Orange County's most vulnerable population. Through this program, fellows will learn about practical health plan operations and have opportunities to develop their leadership potential in a public agency setting. This 18-month fellowship program provides a unique environment to gain valuable administrative experience in an integrated managed care setting.

Mentors

- Richard Pitts, DO, PhD – Chief Medical Officer
- Brigette Hoey, MPA, CLRM– Chief Human Resources Officer
- Yunkyung Kim – Chief Operations Officer
- Nancy Huang – Chief Financial Officer
- Additional Mentors to be determined

Resources:

- CalOptima Intranet (InfoNet)
    - Clerk of the Board SharePoint site
    - Policies & Procedures (Compliance 360)
    - Medical Management SharePoint site
    - Human Resources SharePoint Site
- Department of Health Care Services (DHCS) website: https://www.dhcs.ca.gov/
- Centers for Medicare and Medicaid Services (CMS) website: https://www.cms.gov/

Proposed Rotation Schedule 1: General
(Please note that these are proposed/tentative schedules; adjustments can be made.)

Quarter	Learning Area	Lead Executive/Mentor
Quarter 1	Medical Management	Dr. Richard Pitts
Quarter 2	Finance	Nancy Huang
Quarter 3	Operations	Yunkyung Kim
Quarter 4	Human Resources	Brigette Hoey

Proposed Rotation Schedule 2: Specialized

Quarter	Learning Area	Lead Executive/Mentor
Quarter 1	Finance	Chief Financial Officer
Quarter 2	Finance	Executive Director of Finance

Quarter	Learning Area	Lead Executive/Mentor
Quarter 3	Finance	Budget & Vendor Management
Quarter 4	Finance	Financial Analysis

Sample Quarterly Schedule

Quarter 1: Medical Management

During the 10-week course, the fellow will cover the following, including but not limited to:

- Clinical Operations
  - Case Management
  - Long Term Services and Support
  - Utilization Management
- Quality
  - Population Health Management
  - Quality Analytics
  - Quality Improvement
- Behavioral Health Integration
- Pharmacy Management
- Program of All-Inclusive Care for the Elderly (PACE)
- Project(s) using “Design Thinking and Innovation”

Quarter 2: Finance

10 weeks committed. To be determined by business area.

Quarter 3: Operations

10 weeks committed. To be determined by business area.

Quarter 4: Human Resources

Recruiting

Employee Relations

Worker’s Compensation and Leaves

10 weeks committed. To be determined by business area.

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken June 2, 2022
Regular Meeting of the CalOptima Board of Directors

Report Item

20. Approve New OneCare Health Network Health Maintenance Organization, Shared-Risk Group, and Physician Hospital Consortia Contract Templates, and Authorize Template Use for New Contracts to be Executed with Currently Participating OneCare and OneCare Connect Health Networks (Except ARTA Western California Inc., Talbert Medical Group P.C., Monarch Healthcare, A Medical Group, and Monarch Health Plan Inc.).

Contact

Yunkyung Kim, Chief Operating Officer, (714) 246-8408

Recommended Actions

1. Approve the new OneCare health network Health Maintenance Organization (HMO), Shared-Risk Group (SRG), Physician Hospital Consortia-Physician (PHC-P), and Physician Hospital Consortia-Hospital (PHC-H) contract templates, effective January 1, 2023.

2. Authorize the Chief Executive Officer (CEO) to use the new OneCare contract templates to execute contracts with currently participating OneCare and OneCare Connect health networks (except ARTA Western California Inc., Talbert Medical Group P.C., Monarch Healthcare, A Medical Group, and Monarch Health Plan Inc.) effective January 1, 2023, within the parameters set forth in the Fiscal Year (FY) 2022-23 Operating Budget as approved by the Board of Directors.

Background and Discussion

Staff requests that the CalOptima Board of Directors (Board) approve the new OneCare HMO, SRG, PHC-P, and PHC-H health network contract templates, and authorize the CEO to execute contract templates with currently participating OneCare and OneCare Connect health networks (except ARTA Western California Inc., Talbert Medical Group P.C., Monarch Healthcare, A Medical Group, and Monarch Health Plan Inc.) effective January 1, 2023.

The State's Cal MediConnect program is set to end on December 31, 2022, at which time CalOptima will discontinue its OneCare Connect program. Starting January 1, 2023, OneCare will formally serve as the network for all of CalOptima's OneCare Connect members, as well as future Dual Eligible Special Needs Plan (D-SNP) members. OneCare will assume the same integrated, coordinated approach to care provided under OneCare Connect, providing the full spectrum of medical, home, and community-based services, as well as medical supplies and medications.

In anticipation of CalOptima's current OneCare Connect members' migration into OneCare and new D-SNP enrollment, staff is actively expanding the OneCare network. An amendment allowing CalOptima Community Network providers to serve under OneCare was approved by the Board on February 3, 2022. The OneCare health network HMO, SRG, PHC-P, and PHC-H contract templates currently under consideration will allow new health networks to participate under these contract models, outlining the terms for providing delegated services under OneCare. Existing contracted health networks wishing to participate in OneCare may do so under their original contract model to mitigate any potential disruption to member care. Existing networks wanting to join OneCare will have a 5-year

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term, under which they can terminate without cause upon providing a180-day notice. New networks wishing to contract under OneCare will have a 5-year initial term that needs to be satisfied prior to giving 180-day notification of termination without cause.

For uninterrupted access to care during the transition from OneCare Connect to OneCare, and to maintain a robust provider network, staff requests approval of the new OneCare HMO, SRG, PHC-P, and PHC-H, contract templates, and authority to execute the new OneCare contracts with currently participating health networks (except ARTA Western California Inc., Talbert Medical Group P.C., Monarch Healthcare, A Medical Group, and Monarch Health Plan Inc., effective January 1, 2023).

Management will inform the Board of the status of the OneCare health networks and any risk arrangement changes and return to the Board with recommendations on new health network contracts, if necessary.

Fiscal Impact
The proposed CalOptima FY 2022-23 Operating Budget includes medical costs for the OneCare and OneCare Connect programs, including the transition of the OneCare Connect program to OneCare on January 1, 2023. The recommended action to execute new OneCare contracts with currently participating OneCare and OneCare Connect health networks effective January 1, 2023, has no additional fiscal impact.

Rationale for Recommendation
Approving the new OneCare HMO, SRG, PHC-P, and PHC-H contract templates will allow for seamless member transition out of OneCare Connect and maintain a robust provider network.

Concurrence
Troy R. Szabo, Outside General Counsel, Kennaday Leavitt

Attachments
1. Entities Covered by this Recommended Board Action
2. Proposed HMO contract template
3. Proposed SRG contract template
4. Proposed PHC-P contract template
5. Proposed PHC-H contract template
6. Previous Board Action dated February 3, 2022: "Authorize Amendments to the CalOptima Community Network Professional Services Contracts to Add OneCare as a Covered CalOptima Program"

/s/ Michael Hunn *05/27/2022*
Authorized Signature **Date**

ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

OneCare Health Networks				
Name	**Address**	**City**	**State**	**Zip Code**
AltaMed Health Services Corporation	2040 Camfield Ave.	Los Angeles	CA	90040
AMVI/Prospect Medical Group	600 City Parkway West, #800	Orange	CA	92868
Family Choice Medical Group, Inc.	7631 Wyoming St. Ste. 202	Westminster	CA	92683
Noble Community Medical Associates, Inc. of Mid-Orange County	5785 Corporate Ave.	Cypress	CA	90630
United Care Medical Group, Inc.	600 City Parkway West	Orange	CA	92868

OneCare 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
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
Noble Community Medical Associates, Inc. of Mid-Orange County	5785 Corporate Ave.	Cypress	CA	90630
Prospect Medical Group, Inc.	600 City Parkway West Ste. 800	Orange	CA	92868
United Care Medical Group, Inc.	600 City Parkway West	Orange	CA	92868

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MEDICARE ADVANTAGE – HMO SERVICES CONTRACT

BETWEEN

ORANGE COUNTY HEALTH AUTHORITY DBA CALOPTIMA

AND

_____

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MEDICARE ADVANTAGE HMO SERVICES CONTRACT

This Medicare Advantage HMO Services Contract ("**Contract**") is January 1, 2023 ("**Effective Date**") by and between Orange County Health Authority, a public agency dba CalOptima ("**CalOptima**"), and _____ ("**HMOHMO**"), a California corporation organized under the laws of the State of California. CalOptima and HMO may each be referred to herein as a "**Party**" and collectively as the "**Parties**".

RECITALS

A. CalOptima is a County Organized Health System ("**COHS**") organized under Welfare & Institutions Section 14087.54 and Orange County Ordinance No. 3896.

B. CalOptima is licensed as a health care service plan by the California Department of Managed Health Care ("**DMHC**") under the Knox-Keene Health Care Service Plan Act of 1975 and its implementing regulations (collectively the "**Knox-Keene Act**") and authorized to offer a Medicare Advantage ("**MA**") plan pursuant to Title 42 of the United States Code, Chapter 7, Subchapter XVIII, Part C and its implementing regulations for individuals covered under the federal Medicare program.

C. CalOptima, as a dual–eligible special needs plan ("**DSNP**"), may only enroll those dual eligible individuals who meet all applicable Medicare Advantage eligibility requirements, and who are eligible to be enrolled in CalOptima's Medi-Cal Managed Care plan, as described in the contract between CalOptima and the California Department of Health Care Services ("**DHCS**").

D. HMO is licensed as a restricted health care service plan by the DMHC and provides or arranges for the provision of health care services to its assigned enrollees.

E. CalOptima and HMO desire to enter into the Contract whereby HMO will perform delegated administrative services and arrange for or furnish health care items and services as described herein to certain Enrollees enrolled in CalOptima's MA plan and assigned to HMO.

F. Unless defined elsewhere in the Contract, the defined terms used in this Contract shall have the meanings set forth in Attachment A.

NOW, THEREFORE, in consideration of the promises and the mutual covenants herein stated, it is agreed by and between the Parties as follows:

I. HMO SERVICE OBLIGATIONS

1.1 **Covered Services**. HMO shall provide Covered Services to Enrollees selecting, and/or assigned to, HMO in accordance with all provisions of this Contract and CalOptima Policies. The Covered Services that are to be provided by and are the financial responsibility of HMO are described in Attachment B. HMO specifically agrees to accept financial risk and responsibility for injectables pursuant to Health & Safety Code Section 1375.8.

1.1.1 HMO shall provide Covered Services: (i) in the same manner, in accordance with the same standards, and within the same time availability as offered to non-CalOptima patients; (ii) in accordance with professionally recognized standards of practice, (iii) in a culturally

competent manner to all Enrollees, including those with limited English proficiency or reading skills and from diverse cultural and ethnic backgrounds; and (iv) not discriminate in the provision of such Covered Services because of an Enrollee's race, ethnicity, color, national origin, religion, sex, sexual orientation, age, medical or claims history, mental or physical disability, genetic information, or source of payment.

1.1.2 HMO is prohibited from closing or otherwise limiting its acceptance of Enrollees as patients unless the same limitations apply to all of its commercially insured patients.

1.1.3 HMO shall use its best efforts, where consistent with sound medical practice, to ensure that Covered Services are provided only by HMO Physicians and/or other Participating Providers, except in cases of Emergency Services or Urgent Care Services, or if no such HMO Physician or Participating Provider is available to perform the appropriate Covered Services.

1.1.4 HMO shall be liable for the provision and payment of all Covered Services notwithstanding a delay in payment of the Capitation Payment.

1.1.5 HMO acknowledges that the determination of whether a service or supply was/is a Covered Service delegated to HMO rests with CalOptima, subject to the Evidence of Coverage and Appeals procedures established by the DMHC and CMS.

1.1.6 CalOptima may incorporate any change in Covered Services mandated by Laws into the Contract effective the date the change goes into effect. Whenever possible, CalOptima shall give the HMO thirty (30) calendar days' prior notice of any such change to the Contract. CalOptima shall determine the effective date of the change in Covered Services. Attachment B shall not be amended during the current Term without mutual consent of the Parties, except as may be required for continued compliance with Laws.

1.1.7 Decisions concerning whether to provide or authorize Covered Services under this Contract shall be based solely on Medical Necessity. HMO shall not deny Authorization for a Covered Service that the Enrollee or the Provider demonstrates is Medically Necessary. The actual provision of any Covered Service is subject to the professional judgment of the PCP or other physicians and/or Providers participating with HMO as to the Medical Necessity of the Covered Service, except that each Physician shall provide assessment and evaluation services ordered by a court or legal mandate. HMO acknowledges that disputes between the HMO and Enrollees about Medical Necessity can be appealed pursuant to CalOptima Policies and Laws.

1.1.8 HMO may not arbitrarily deny or reduce the amount, duration, or scope of a required Covered Service solely because of the diagnosis, type of illness, or condition. HMO may place appropriate limits on a service on the basis of criteria such as Medical Necessity or for utilization control, provided the services furnished can reasonably be expected to achieve their purpose and such a limitation complies with Laws.

1.2 **Confidentiality**. HMO and CalOptima agree to safeguard the confidentiality of Enrollee information and comply with all Laws (including, but limited to, the Health Insurance Portability and Accountability Act ("HIPAA"), 42 CFR Section 431.300 *et seq*., California Welfare and Institutions Code Section 14100.2, California Civil Code Section 56 *et seq.*, and the California Information Practices Act, Civil Code Section 1798) regarding the confidentiality and disclosure of Enrollee names, health, enrollment and personal information (including medical and Behavioral

Health information contained in Medical Records). HMO shall provide counseling to Enrollees on their right to confidentiality and obtain Enrollee consent prior to releasing confidential information unless such consent is not required pursuant to Title 22 CCR Section 51009.

1.3 **Emergency Services and Urgent Care**. HMO shall insure that it provides and pays for all Emergency Services and Urgent Care, including those services provided by Non-Participating Providers, without prior Authorization, twenty-four (24) hours each day, seven (7) days a week, in accordance with Laws and CalOptima Policies. HMO shall coordinate access to Emergency Services in accordance with CalOptima's emergency department protocol. HMO shall ensure adequate follow-up care for those Enrollees who have been screened in the emergency room and require non-Emergency Services. HMO may not specify what constitutes an Emergency Medical Condition on the basis of lists of diagnoses or symptoms.

1.4 **Days to Appointment**. HMO shall ensure that appointments for non-Emergency Services and non-Urgent Care Covered Services are scheduled within ten (10) business days of the Enrollee's request for PCP and fifteen (15) business days of Enrollee's request for Specialist Physician; that health assessments and general physical examinations and all preventative Covered Services are scheduled within thirty (30) calendar days of Enrollee's request for an appointment, and that, if HMO supplies maternity Covered Services, HMO shall ensure that the most current standards and guidelines of the American College of Obstetricians and Gynecologists are utilized as the minimum measure of quality for perinatal services. HMO shall also have a process in place for follow-up on Enrollee missed appointments.

1.5 **Twenty-Four (24) Hour HMO Coverage**. HMO shall ensure that it has, at a minimum, two HMO Physicians as follows: One (1) HMO Physician who is available twenty-four (24) hours a day to authorize Medically Necessary, Post-Stabilization Care Services and coordinate transfer of stabilized Enrollees in an emergency department, if necessary, and one (1) HMO Physician available twenty-four (24) hours a day, seven (7) days a week to resolve disputed requests for Authorizations.

1.6 **Clinical Laboratory Improvement Amendments**. HMO shall only use laboratories with a Clinical Laboratory Improvement Amendments ("**CLIA**") certificate of waiver or a certificate of registration along with a CLIA identification number.

1.7 **CalOptima Formulary Compliance**. Participating Providers shall comply with the CalOptima Formulary and its associated drug utilization and disease management guidelines and protocols. Requests for items not included in the CalOptima Formulary shall require prior Authorization by CalOptima. The prescribing Physician shall be responsible for obtaining Authorization through CalOptima and/or its designated pharmacy benefit management contractor ("**PBM**"), as appropriate. The prescribing Physician shall provide CalOptima and/or the PBM with all information necessary to process Authorization requests.

1.8 **Enrollee Access**. HMO and its Downstream Entities shall comply with all Laws and CalOptima Policies governing Enrollee access to Covered Services.

1.8.1 If HMO is unable to provide necessary Covered Services to a particular Enrollee, HMO must adequately and timely cover these services with Non-Participating Providers for the Enrollee, for as long as HMO is unable to provide them. HMO shall make prior arrangements with Non-Participating Providers for the provision of such services, shall be fully responsible for arranging and paying for such services, and shall comply with all

applicable CalOptima Policies with regard to the payment and Authorization of Non-Participating Providers.

1.8.2 HMO shall ensure that PCPs as well as Specialty Physicians are located so as to assure sufficient geographic and physical access of Enrollees to such providers as required by Laws and CalOptima Policies.

1.8.3 HMO shall ensure that each Enrollee has a PCP who is available and physically present at the service site for sufficient time to ensure access for the assigned Enrollee when medically required. This requirement does not preclude an appropriately licensed professional from being a substitute for the PCP in the event of the PCP's vacation, illness, or other unforeseen circumstances.

1.8.4 HMO shall ensure female Enrollees have direct access to a women's health specialist within the network to provide women's routine and preventative health care services. Such access may be in addition to the Enrollee's PCP.

1.8.5 HMO shall cover family planning services for all Enrollees whether they are provided by a Participating Provider or Non-Participating Provider.

1.8.6 HMO shall reasonably accommodate Enrollees and ensure programs and services are as accessible (including a sufficient number of Providers and geographic access) to an Enrollee with disabilities as they are to an Enrollee without disabilities in accordance with CalOptima Policies. HMO's facilities shall comply with the requirements of Title III of the Americans with Disabilities Act of 1990 ("**ADA**") and shall ensure access for the disabled, including, but not limited to, ramps, elevators, restrooms, designated parking spaces, and drinking water provisions. HMO shall have policies to ensure that physical, communication and programmatic barriers do not inhibit Enrollees with disabilities from obtaining all Covered Services, including addressing reasonable accommodations required by the CMS Contract and CalOptima Policies. HMO will comply with CalOptima Policies and work plan requirements related to ADA compliance relevant to services under this Contract.

1.9 **Provider Network Maintenance**. HMO agrees to employ or contract with a sufficient number of Physicians and other Providers representing the range of medical specialties necessary, in the determination of CalOptima, CMS, and the DMHC to ensure Enrollees of reasonable access to the full range of Covered Services.

1.9.1 During the Term, all Participating Providers of Covered Services must: (i) be and remain qualified in accordance with current applicable legal, professional, and technical standards; (ii) be and remain appropriately licensed, certified or registered; (iii) be and remain in good standing with Medicare and not be terminated or suspended from participation in the Medicare and/or Medi-Cal programs; and (v) have a valid NPI number, as applicable. HMO shall ensure that PCPs are located so as to assure sufficient geographic and physical access of Enrollees to such Physicians under Laws and CalOptima Policies.

1.9.2 HMO shall ensure that Participating Providers have the requisite training and experience in dealing with the medical problems frequently encountered in elderly, disabled, and special needs individuals.

1.9.3 HMO shall use primary source verification to confirm the board certification in each clinical specialty area for which the Physician is being credentialed if the Physician lists such board certification on credentialing applications.

1.9.4 HMO acknowledges that the requirements of this Section 1.9 apply to each individual Provider who is affiliated with and/or part of any medical group, independent physician associations ("**IPA**"), and/or other organization or entity that contracts with HMO to furnish Covered Services to Enrollees.

1.9.5 HMO will maintain accurate records, including records detailing the status, membership, and qualifications of the Participating Providers in the HMO's network.

1.9.6 If a Provider who seeks to become a Participating Provider is denied a contract with HMO or a Participating Provider is suspended or terminated for cause, HMO shall provide the Provider with written notice of the reason for the action, as required by Laws, including any standards and profiling data HMO used to evaluate the provider, the number and mix of similar health care Providers that HMO needs (if applicable), and notice of the Provider's right to appeal the action, including notice of the process and timing to request a hearing. In the event HMO terminates a contract with a Participating Provider for deficiencies in the quality of care provided, HMO shall give notice of the action to CalOptima, as provided by CalOptima Policies, and to the appropriate licensing and disciplinary bodies, as provided by law.

1.9.7 In the event that a Provider, including a PCP, is terminated or leaves the HMO for any reason, HMO shall give written notification of termination of such Provider to CalOptima within fifteen (15) days after receipt or issuance of the termination notice.

1.9.8 In the event that a Provider, including a PCP, is terminated or leaves the HMO for any reason, HMO shall ensure that there is no disruption in services provided to Enrollees who are receiving treatment for a chronic or ongoing medical condition in accordance with applicable Laws.

1.9.9 HMO shall notify CalOptima at least sixty (60) days before any significant change in HMO's provider network that renders HMO unable to provide one or more Covered Services within CalOptima's access to care standards. If such notice is not possible because the providers terminate their participation with less than sixty (60) days' notice or HMO terminates the providers without prior notice as a result of their endangering the health and safety of Enrollees, providers committed criminal or fraudulent acts, or providers engaged in grossly unprofessional conduct, then HMO shall notify CalOptima immediately upon receipt of notice of the termination, or sending notice to the providers of a HMO-initiated termination.

1.9.10 HMO shall ensure that no Provider who fails to meet the requirements of this section furnishes items and/or services to Enrollees, submits claims and/or receives reimbursement for any Covered Services.

1.9.11 HMO agrees that each Participating Provider with whom HMO contracts to provide Covered Services will be required to execute a contract with HMO. Such an agreement will require all Participating Providers to comply with those aspects of this Contract relating to activities of Participating Providers and with Laws, including the standards of accrediting and regulatory agencies governing CalOptima's MA Program, and any and all

provisions required by MA regulations. The HMO agreement with Participating Providers shall be made available to CalOptima and its regulatory agencies for inspection and copying upon request. HMO shall ensure that all contracts with Participating Providers allow for termination of the contract for failure to meet the requirements of this Section 1.9.

1.10 **Enrollment**. HMO shall accept as Enrollees all persons indicated as Enrollees by the CalOptima information system and transmitted to HMO and shall comply with requirements to provide notices to Enrollees in accordance with CalOptima Policies.

1.11 **Primary Care Physician**. HMO agrees that each Enrollee will select or be assigned a PCP. Enrollee must request a PCP assignment from CalOptima's Customer Service department. If the Enrollee has not selected a PCP, CalOptima shall assign the PCP per its policies. HMO agrees that it will ensure that the PCP shall be responsible for the provision, coordination, referral, and Authorization of Covered Services in accordance with the utilization management ("**UM**") program and prevailing standards of medical practice so that there is a Physician who has ultimate responsibility for the Enrollee's care management.

1.12 **HMO Medical Director**. HMO shall designate a HMO Physician as Medical Director for purposes of this Contract. The HMO Medical Director will be a member of the HMO's quality management and UM committee(s) and will be the individual to whom CalOptima communicates regarding provision of professional medical care and quality and/or appropriate utilization of medical services. The HMO Medical Director will be the individual responsible for representing HMO in the resolution of any Grievances presented to CalOptima by Enrollees related to the provision of medical care.

1.13 **Care Coordination**. CalOptima shall retain the responsibility for the initial HRA and an HRA annually thereafter in accordance with CalOptima Policies, but any update during the course of the year due to change in Enrollee's condition/circumstance would be the responsibility of the HMO, per policy. HMO shall offer care coordination and case management services to all Enrollees, which shall: (i) include coordination of care across the full continuum of service providers as appropriate to Covered Services under this Contract; (ii) ensure that care coordination services reflect a person-centered, outcome-based approach, consistent with the Model of Care and CalOptima Policies; (iii) follow Enrollee direction about level of involvement of his or her caregivers or medical providers; (iv) include the assignment of a qualified Care Coordinator to each Enrollee needing or requesting one; and (v) reflect access to appropriate community resources with a focus on providing services in the least restrictive setting and transitions between the facilities and the community.

1.14 **Model of Care**. HMO shall furnish Covered Services in compliance with CalOptima's Model of Care, including the PCC component, HRA, ICP and ICT requirements.

1.14.1 CalOptima will complete and communicate the HRA to HMO. HMO shall, upon notification by CalOptima of the need to follow-up on the results of an HRA administered by CalOptima, perform and provide any follow-up required by CalOptima.

1.14.2 HMO shall develop an ICP for each Enrollee and engage Enrollees and/or their representative in the design of the ICP in accordance with CalOptima Policies.

1.14.3 HMO shall offer an ICT for each Enrollee, as necessary, which will be developed around the Enrollee and integrate medical and LTSS and the coordination of Behavioral Health

services. Enrollees shall not be required to participate in the ICT and may opt-out at any time. Enrollees may not be dis-enrolled from the ICT for lack of participation on the ICT. The ICT shall comply with CalOptima Policies.

1.14.4 PCPs and/or the Care Coordinator, in collaboration with CalOptima, will provide basic case management services to Enrollees in accordance with CalOptima's Policies. If the Enrollee has been identified as potentially benefiting from complex case management services, HMO shall provide such services to the Enrollee.

1.14.5 HMO shall ensure the provision of discharge planning when an Enrollee is admitted to a Hospital or institution and continues into the post-discharge period. Discharge planning shall include ensuring that the necessary care, services, and supports are in place in the community for the Enrollee once he or she is discharged, including scheduling an outpatient appointment and/or conducting follow-up with the Enrollee or caregiver. HMO shall comply with CalOptima Policies addressing minimum criteria requirements for discharge planning.

1.15 **Behavioral Health Services Referrals**. HMO shall furnish and/or coordinate Behavioral Health services as specified in CalOptima Policies and this Contract.

1.15.1 For Specialty Mental Health Services, HMO shall refer Enrollees to CalOptima as the Administrative Service Organization contracted to provide assessment, referral and Authorization services.

1.15.2 For Outpatient Mental Health Services that are within a HMO' PCP's scope of practice, HMO shall manage according to current appropriate treatment guidelines. If the Outpatient Mental Health Services are outside its PCPs' scope of practice, HMO shall refer Enrollees to CalOptima's contracted behavioral health provider.

1.15.3 For Enrollees requiring alcohol or substance use disorder treatment, HMO shall manage according to the appropriate PCP treatment guidelines. If the alcohol or substance use disorder treatment are outside its PCPs' scope of practice, HMO shall refer Enrollees to CalOptima's contracted behavioral health provider. Coordination of care through the ICT will occur as is specified in CalOptima Policies and this Contract.

1.16 **LTSS Referrals**. HMO shall refer Enrollees to CalOptima for LTSS pursuant to CalOptima Policies.

1.17 **Facility Site and Medical Record Reviews**. HMO shall participate in, and comply with requirements for, PCP site and medical reviews, including facility site physical accessibility reviews, in accordance with CalOptima Policies and guidance issued by CalOptima's Regulators, including requirements, if any, related to collaborative programs.

1.18 **Transfers**. HMO agrees to assist CalOptima in facilitating the transfer of care of Enrollees if determined medically acceptable by attending Physicians and the CalOptima Medical Director. HMO will be responsible for the cost of Covered Services provided if HMO refuses to accept such transfer.

1.19 **Delegation by CalOptima to HMO**. HMO agrees to accept delegated responsibility for those activities listed in the Delegation Agreement and to perform the delegated activities in a manner consistent with the Delegation Criteria. HMO warrants that it meets CalOptima's Delegation

Criteria and acknowledges that delegation to another entity does not alter HMO's ultimate obligations and responsibilities set forth in this Contract. HMO agrees to notify CalOptima of any change in its ability to meet the Delegation Criteria within twenty-four (24) hours from the date it fails to meet such Delegation Criteria. At CalOptima's request, HMO shall identify the Compliance Officer or other appropriate health network representative to be the liaison expressly responsible for oversight of delegated obligations.

1.19.1 HMO acknowledges that it is CalOptima's responsibility to oversee, monitor and evaluate HMO's ongoing eligibility for delegation according to the Delegation Criteria and performance of the delegated activities according to the Delegation Criteria. HMO agrees to cooperate with CalOptima's oversight, monitoring, and evaluation of HMO's eligibility and performance of delegated activities, including the provision of reasonable access during regular business hours to the Enrollee inquiry files, credentialing files, clinical and Medical Records of Enrollees, and all other information requested by CalOptima. HMO shall comply with corrective actions imposed by CalOptima and/or CalOptima's Regulators in the time and manner required by them.

1.19.2 HMO acknowledges and agrees that CalOptima retains final authority and responsibility for activities delegated under this Contract. Activities not expressly delegated herein and in the Delegation Agreement by CalOptima or for which delegation is terminated are the responsibility of CalOptima.

1.19.3 HMO agrees to provide CalOptima with periodic reports on delegated activities performed by HMO as provided in the Delegation Criteria or specified in CalOptima Policies.

1.19.4 In the event CalOptima, DMHC, or CMS is dissatisfied with the performance of delegated functions and activities by HMO or its Downstream Entities, CalOptima may, in its sole discretion, modify HMO's delegated status (in respect to all or a particular delegated activity), including from fully delegated to delegated with corrective action, or may immediately revoke all or part of the delegated activities. In the event HMO breaches its obligation to perform any delegated obligations, CalOptima shall have all remedies set forth in this Contract, including the right to revoke delegation of such function(s) and impose financial and other penalties. Moreover, CalOptima shall have the right to require HMO to terminate any Downstream Entity for good cause, including breach of its obligations to perform any delegated duties. Nothing herein is intended to limit CalOptima's remedies as provided for in this Contract or at law.

1.19.5 HMO acknowledges and agrees that CalOptima, in its sole and absolute discretion, may reduce HMO's Capitation Payments to recoup additional administrative costs where CalOptima revokes or modifies activities or functions delegated to HMO under this Contract.

1.20 **Delegation and Subcontracting of Administrative Services by HMO**. Except as otherwise limited by this Contract and/or CalOptima Policies, HMO may sub-delegate Administrative Services required of HMO to a management services organization ("**MSO**"), medical group and/or IPA. Delegation shall not absolve HMO of oversight responsibilities or its obligations under this Contract. All requests for delegation of Administrative Services (i) must be in writing; (ii) are subject to successful completion of CalOptima's readiness assessment requirements; and (iii) must be approved by CalOptima in advance of undertaking the Administrative Services. HMO shall obtain written approval of delegation from CalOptima pursuant to the process detailed in CalOptima Policies.

1.21 **Subcontracts**. HMO is required to inform CalOptima of the name and business addresses of all subcontracted Downstream Entities. HMO is required to ensure that all such subcontracts are in writing and include all provisions required by this Contract to be incorporated into subcontracts. HMO acknowledges that CalOptima's FDR subcontracts are subject to the review and approval of CMS.

1.22 **Payment to Providers**. CalOptima hereby delegates claims processing functions to HMO. HMO shall review, adjudicate, and pay (as appropriate) all claims in accordance with the benefits set forth in the Evidence of Coverage, the requirements established by Laws, and the terms of this Contract. In making payments to Providers, HMO shall comply with the provisions of Attachment D, including requirements related to payment of Non-Participating Provider Emergency Services and Urgent Care claims.

1.23 **Documentation and Data Submission Integrity**. HMO and its Downstream Entities shall not submit false claims or financial reports, encounter data, and other information to CalOptima, CMS or DMHC, whether by commission or omission. HMO and applicable Downstream Entities shall implement and maintain policies and procedures that address correct completion of claims, financial reports, encounter data, and other documentation requirements and penalties for falsifying such reports and other information that require all new and current employees and/or agents compiling or providing this information to sign a statement of attestation that will acknowledge understanding and compliance with said HMO policy.

1.24 **Advance Directives**. HMO shall maintain written policies and procedures related to Advanced Directives in compliance with Laws. Providers shall document Advance Directives in patient records in accordance with Laws. HMO shall not discriminate against any Enrollee on the basis of that Enrollee's Advance Directive status. Nothing in this Contract shall be interpreted to require an Enrollee to execute an Advance Directive or agree to orders regarding the provision of life-sustaining treatment as a condition of receipt of services.

1.25 **Enrollee Appeals**. Enrollees will be notified of all applicable MA and/or Medicare Appeal rights, the form and content of which is approved by CMS. . Medicare Appeal rights and protections will be maintained and enhanced for Medicare services. HMO agrees to cooperate with CalOptima in resolving Appeals related to HMO or HMO's Participating Providers and will comply with CalOptima Policies related to Appeals.

1.26 **Organization Determination Process**. HMO agrees to comply with CMS regulations and instructions and CalOptima Policies pertaining to timely organization determination by HMO with regard to the provision, denial, reduction, or suspension of a Covered Service to an Enrollee. "**Organization determination**" is defined as a decision to provide or deny service based on CMS and CalOptima criteria. Such determinations shall be made in accordance with procedures and instructions set forth in the CalOptima Policies and Laws. HMO shall immediately notify CalOptima of any request for an expedited initial organization determination and submit to CalOptima on a monthly basis a report which tracks the requests for standard and expedited organization determinations and the timeframe within which Enrollees were informed of decisions made by HMO.

1.27 **Expedited Review Process**. HMO shall comply with CMS regulations and CalOptima Policies pertaining to expedited initial organization determinations of Enrollee's medical care and reconsideration (Appeals) thereof in the time sensitive situations. Time sensitive situations are those outlined by CMS which include medical conditions that require initial determinations to be

made within seventy-two (72) hours upon HMO receiving a request for an expedited review from a Provider, Enrollee, or CalOptima.

1.28 **Linguistic and Cultural Sensitivity**. HMO shall comply with all requirements related to the provision of linguistic and culturally sensitive services in accordance to this Contract, CalOptima's Cultural and Linguistic Services Program, and CalOptima Policies. HMO shall address the special health needs of Enrollees who are of any minority, are homeless, are disabled (both congenital and acquired disabilities), or are part of other special populations served by the CalOptima MA Program, including the capacity to communicate with Enrollees in languages other than English, when necessary, as well as those Enrollees who are deaf, hard-of-hearing, and/or visually impaired. Physician shall, in policies, administration, and services, practice the values of: (a) honoring the Enrollees' beliefs, traditions and customs; (b) recognizing individual differences within a culture; (c) creating an open, supportive, and responsive organization in which differences are valued, respected and managed; (d) through cultural diversity training, foster in staff and Participating Providers attitudes and interpersonal communication styles that respect Enrollees' cultural backgrounds and are sensitive to their special needs; and (e) referring Enrollees to linguistically and culturally sensitive programs. Pursuant to CalOptima Policies, HMO shall provide translation of written materials in the Threshold Languages as provided by CalOptima Policies. Written materials to be translated include, but are not limited to, signage, the Enrollee services guide, Enrollee information, Explanation of Coverage, Enrollee forms, Enrollee notices, and Enrollee welcome packages.

1.29 **Provision of Interpreters**. Oral interpreters, signers, and bilingual Provider services shall be provided in all languages spoken by all MA Enrollees. HMO shall provide linguistic interpreter/translator services for Enrollees as necessary at all HMO sites to ensure the availability of effective communication regarding treatment, diagnosis, medical history, and health education to Enrollees. HMO shall provide twenty-four (24)-hour access to interpreter services for all Enrollees. Upon an Enrollee or Participating Provider request for interpreter services in a specific situation where care is needed, HMO shall make all reasonable efforts to provide an interpreter in time to assist adequately with all necessary Covered Services, including Urgent Care Services and Emergency Services, as required by Laws. HMO shall routinely document all such efforts and make this documentation available to CalOptima at its request. Interpreters shall be used where needed where technical, medical, or treatment information is to be discussed. HMO shall not require an Enrollee to use friends or family as interpreters. However, a family member or friend may be used when the use of the family member or friend: (i) is requested by the Enrollee; (ii) will not compromise the effectiveness of service; (iii) will not violate Enrollee's confidentiality; and (iv) the Enrollee is advised that an interpreter is available at no cost to the Enrollee. HMO shall maintain a contract with an interpreter service agency that is on "on call" status to provide interpreter services.

1.30 **Identification of HMO and HMO Physicians**. HMO agrees that CalOptima may list the HMO's name, address, and telephone number and that of its HMO Physicians and Downstream Entities in CalOptima's roster of Participating Providers that is given to Enrollees and prospective Enrollees, and CalOptima may use such names for advertising/marketing purposes. However, CalOptima is not obligated to list the name of any particular HMO Physician in the roster of Participating Providers. The use of HMO's trademarks or logos by CalOptima is prohibited without HMO's prior written approval.

1.31 **Liaisons**. HMO shall designate an individual(s) who will assume the day-to-day responsibilities with regard to HMO's obligations under this Contract and to serve as liaison with CalOptima. HMO will also designate an individual(s) to be responsible for answering Enrollee inquiries and

responding promptly to any Enrollee grievance in accordance with CalOptima's grievance procedures and Laws.

1.32 **Provider Private Contract**. HMO understands that CalOptima is prohibited by CMS from paying capitation to, or including in its provider network, any provider that has entered into a private contract with a Medicare beneficiary for the provision of Covered Services. HMO shall notify CalOptima immediately in the event that any HMO Physician has a private contract with a Medicare beneficiary. In such an event, CalOptima reserves the right to exclude any such HMO Physician from its provider network. In addition, HMO agrees that CalOptima shall have the right to offset the amount of any reimbursement that was paid either directly or indirectly to such Provider(s) against Capitation Payments or other amounts due from CalOptima to HMO, if any.

1.33 **Disclosure of HMO PIPs**. In the event that HMO implements and maintains a physician incentive plan ("**PIP**"), HMO and its Downstream Entities must comply with all applicable requirements governing PIPs, including such requirements appearing at 42 CFR Parts 417, 422, 434, 438.6(h), and 1003.

1.33.1 HMO shall ensure that no specific payment is made directly or indirectly under a PIP to a Physician or HMO as an inducement to reduce or limit Medically Necessary services furnished to an Enrollee.

1.33.2 On an annual basis, HMO and its Downstream Entities must submit to CalOptima all information required to be disclosed to CMS and the DMHC in the manner and format specified by them.

1.33.3 HMO must provide information on its PIP to any Enrollee upon request as provided in 42 CFR Section 422.208.

1.33.4 In the event that CalOptima's Regulators find that HMO (or its Downstream Entities) has failed to comply with the requirements governing physician incentive plans and CalOptima's Regulators offset, recoup and/or otherwise seek recovery of federal financial participation ("**FFP**") amounts from CalOptima, HMO agrees that CalOptima may recover such FFP amounts attributable to HMO from HMO, including through recoupment or offset to future Capitation Payments or other amounts due from CalOptima to HMO, if any.

1.34 **Provider Grievance Process**. HMO shall establish and maintain a Provider dispute resolution process that at all times complies with the requirements of Laws. HMO shall provide CalOptima with all necessary information and reports regarding the provider dispute resolution process as required by CalOptima to meet its obligations under the CMS Contract and Laws. If HMO fails to maintain a process that complies with the requirements stated in Laws and CalOptima Policies, then following written notice of such deficiency from CalOptima to HMO, CalOptima may revoke the delegation and assume responsibility for the administration of HMO's Provider dispute resolution process.

1.35 **Provider Education**. HMO acknowledges that CMS requires that CalOptima furnish to Participating Providers certain training, education, and orientation related to the MA Program in order to operate in full compliance with this Contract and Laws. Such training and education may address the MA Program, Enrollee rights, cultural competency and clinical protocols, evidence-based guidelines and cultural awareness and sensitivity instruction. HMO and its Participating

Providers shall participate in such training, education, and orientation programs, as required by CalOptima, and shall attest to compliance with training requirements as required by CalOptima.

1.36 **State Licensure**. HMO shall maintain at all times during the Term a valid, restricted health care service Plan license with the DMHC in accordance with the Knox-Keene Act and have no adverse actions with regard to enforcement or quality management.

1.37 **CalOptima's Regulator Requirements**. The MA Program is subject to oversight by CalOptima's Regulators, which mandate that CalOptima and its FDRs comply with certain terms and conditions in rendering services to Enrollees and that certain terms be incorporated in FDR subcontracts. HMO acknowledges that it will comply with CalOptima's Regulators' requirements set forth in Attachment E.

1.38 **COB Obligations of HMO**. HMO agrees to coordinate with CalOptima for proper determination of COB and to bill and collect from other payers and third-party liens such charges for which the other payer is responsible pursuant to CalOptima Policies. HMO agrees to establish procedures to effectively identify, at the time of service and as part of its claims payment procedures, individuals and services for which there may be a financially responsible party other than the CalOptima MA Program.

1.39 **CMS Lien Rights.** HMO shall coordinate benefits either operating a cost avoidance method of paying claims, when the existence of private health coverage is known at the time the claim is processed, or using the method of post-payment recovery of the cost of services, if the coverage is identified retroactively, as set forth in CalOptima Policies. Nothing herein shall be interpreted to, in any manner, impair any lien rights retained by the U.S. Department of Health and Human Services ("**HHS**") through CMS. HMO shall make no claim for the recovery of the value of Covered Services rendered to an Enrollee when such recovery would result from an action involving tort liability of a third party, recovery from the estate of deceased Enrollee, Workers' Compensation, or casualty liability insurance awards and uninsured motorist coverage. HMO shall identify and notify CalOptima, within five (5) calendar days of discovery of potential third-party liability ("**TPL**") claims, and provide information relative to potential TPL claims, in accordance with CalOptima Policies.

1.40 **Provider Training.** HMO shall ensure that all network Providers receive training regarding the MA Program in order to operate in full compliance with all Laws, including rights and responsibilities pertaining to grievance and appeals procedures and timelines under this Contract. HMO shall ensure that network Provider training relates to MA services, policies, procedures and any modifications to existing services, policies or procedures. Training shall include methods for sharing information among network Providers, Enrollees, and/or other healthcare professionals. HMO shall conduct training for all network Providers within thirty (30) working days after the HMO places a newly contracted Provider on active status. HMO shall ensure that network Provider training includes information on all Enrollee rights, including the right to full disclosure of health care information and the right to actively participate in health care decisions. HMO will maintain policies and procedures on advance directives pursuant to 42 CFR §§ 422.128, 438.3(j), and 489.102, and will educate its network Providers concerning its policies and procedures on Advance Directives. HMO shall ensure that ongoing training is conducted when deemed necessary by either the HMO or CMS.

1.41 **Notification of Inpatient Facility Discharge Appeal Rights**. HMO's contracted Hospitals shall issue the advance written notice to Enrollees of their Hospital discharge rights upon admission and before discharge from the Hospital.

II. HMO FINANCIAL OBLIGATIONS

2.1 **Financial Security Requirements**. HMO must establish and maintain during the Term financial security requirements as specified in Article 9 of Chapter 2 of Division 1 of Title 28 of the California Code of Regulations (SB 260 Regulations), and in compliance with CalOptima Policies. HMO must establish and maintain, throughout the Term, financial security reserves, in the form of time certificates of deposit, irrevocable standby letters of credit, surety bonds naming CalOptima as beneficiary, and/or other forms of financial instruments acceptable by CalOptima, as required in CalOptima Policies.

2.2 **Financial Viability Standards and Reporting**. HMO must establish and maintain a minimum reserve of twenty-five percent (25%) of one month's Capitation Payment. Physician shall have thirty (30) days upon receiving notice from CalOptima to cure any deficit. HMO shall maintain a cash-to-claims ratio of no less than 0.75 at all times during the Term. HMO shall substantiate compliance with this requirement by submitting all applicable reports to the DMHC that are required under Title 28 CCR Section 1300.75.4.2.

2.3 **Medical Loss Ratio**. HMO shall ensure that it maintains a minimum acceptable loss ratio (as defined by CalOptima Policies) of eight five percent (85%). HMO shall comply with CalOptima requirements related to limitations on administrative costs, as set forth in CalOptima Policies.

2.4 **Termination of HMO Health Network**. If this Contract terminates or expires for any reason, CalOptima may require that HMO take certain actions and/or CalOptima may take certain actions to ensure that all items and services for which HMO is delegated financial risk under this Contract are reimbursed by HMO, including the following: (i) require HMO to reserve sufficient funds to pay any claims run out; (ii) offset HMO's future Capitation Payments or other amounts due from CalOptima to HMO under this Contract or any other agreement, if any, in order to pay HMO's claims; and/or (iii) withhold or offset HMO's Capitation Payments or other amounts due from CalOptima to HMO, including to pay-for-performance, quality incentives, and shared risk pool surpluses, if any, in order to pay amounts owed by HMO to Providers.

2.5 **Conversion of Health Network Model**. If CalOptima approves a change in the delegated model of HMO at any time during the Term, CalOptima may require additional financial protections as a condition precedent to such approval, including: (i) require HMO to reserve sufficient funds to pay any claims run out related to claims which are the financial responsibility of HMO under the existing delegated relationship; (ii) require HMO to meet additional financial security requirements, including the maintenance of financial deposits; and/or (iii) withhold or offset HMO's Capitation Payments or other amounts due from CalOptima to HMO, including pay-for-performance, quality incentives and shared risk pool surpluses, if any, in order to pay amounts owed by HMO to Providers.

2.6 **Cooperation with DMHC**. HMO shall fully cooperate and comply with the DMHC's review and audit process and permit DMHC to obtain and evaluate supplemental financial information related to HMO, in accordance with Title 28 CCR Section 1300.75.4.7. HMO shall also fully cooperate and participate in DMHC's Corrective Action Plan process, in accordance with Title 28 CCR Section 1300.75.4.8.

III. CALOPTIMA OBLIGATIONS

3.1 **CalOptima Services**. CalOptima agrees to provide certain Enrollee and Administrative Services, including processing Enrollee applications, maintaining eligibility records and a system of

verifying eligibility, processing enrollments and dis-enrollments, responding to Enrollee complaints and grievances, informing Enrollees of CalOptima Policies, providing Enrollees with membership cards and informational material, and informing Enrollees of Health Networks.

3.2 **Enrollment**. CalOptima agrees to process all enrollment applications and ensure that each Enrollee selects or is assigned to Health Networks in accordance with CalOptima Policies. CalOptima reserves the right to assign Enrollees to a Health Networks other than that selected by Enrollee.

3.3 **Model of Care and Health Risk Assessment**. CalOptima shall maintain a Model of Care, as required by CalOptima's Regulators. CalOptima shall ensure that, upon enrollment in the CalOptima MA Program, each Enrollee receives an initial HRA and an HRA annually thereafter in accordance with CalOptima Policies and that results of the HRA are shared with HMO in order to coordinate Enrollee care. HMO is responsible for interim updates to the HRA.

3.4 **Authorization Process**. CalOptima shall provide a written Authorization process for Covered Services pursuant to CalOptima Policies.

3.5 **Enrollee Grievance Process**. CalOptima will inform Enrollees that they may file a grievance through CalOptima or the CMS Ombudsman Program for complaints related to Medicare-covered benefits and services. Enrollees may also file a grievance through 1-800 Medicare.

3.6 **Enrollee Appeals**. Enrollees will be notified of all applicable MA Medicare Appeal rights through a single notice prior approved by CMS.

3.7 **CalOptima Formulary**. CalOptima shall publish and maintain the CalOptima Formulary pursuant to CalOptima Policies.

3.8 **Training and Education**. CalOptima agrees to provide Participating Provider education, training, and orientation in accordance with CMS requirements, including training regarding the CalOptima MA Program, Enrollee rights, clinical protocols, evidence-based practice guidelines, and CalOptima's cultural awareness and sensitivity instruction and cultural competency training, as applicable.

3.9 **Marketing**. HMO acknowledges that CalOptima will be responsible for marketing the CalOptima MA Program to Medicare beneficiaries. HMO acknowledges that it shall not conduct any marketing activities except as expressly approved in advance and in writing by CalOptima.

3.10 **Administration of Funds**. CalOptima will administer the funds and payments called for in this Contract to HMO in accordance with provisions outlined in Article VI.

3.11 **No Refusal to Pay or Contract Based on HMO Communications with Enrollees**. CalOptima will not refuse to contract or pay an otherwise eligible health care Provider for the provision of Covered Services solely because such Provider has, in good faith, communicated with or advocated on behalf of one or more of his or her prospective, current, or former patients regarding: (i) the provisions, terms or requirements of CalOptima's health care plans as they relate to the needs of such Provider's Enrollees; or (ii) the method by which such Provider is compensated by CalOptima for Covered Services rendered to the Enrollee.

3.12 **CalOptima Policies**. CalOptima will provide HMO with CalOptima Policies as necessary for Group to provide Covered Services to Enrollees. Those CalOptima Policies shall describe all

benefit plans, including copayments, limitations, and exclusions offered by CalOptima to Enrollees. The Provider Manual will be made available to HMO to disseminate to Physicians.

3.13 **Listing of CalOptima**. CalOptima agrees that HMO may list its name, address, telephone number, and a description of the CalOptima MA Program, along with CalOptima's name, in HMO's promotional materials and advertisements. The use of CalOptima's trademarks and logos by HMO is prohibited without CalOptima's prior written approval.

3.14 **CalOptima Oversight**. CalOptima shall monitor HMO's performance under this Contract on an ongoing basis. CalOptima may conduct regularly scheduled audits as well as an annual evaluation of the delegated functions to determine HMO's continued compliance with the Delegation Criteria. CalOptima may impose corrective action plans on HMO and/or its Downstream Entities, as necessary.

3.15 **CalOptima Accountability**. The delegation of the functions and responsibilities stated in this Contract and the Delegation Agreement does not relieve CalOptima of any of its accountability to CMS and obligations to its Enrollees under Laws. CalOptima is authorized to perform and remains liable for the performance of such obligations, notwithstanding any delegation of some or all of those obligations to HMO.

3.16 **COB Obligations of CalOptima**. CalOptima will cooperate in providing COB information to HMO by collecting appropriate data from the Enrollee at the point of enrollment and supplying such data to HMO.

3.17 **Enrollee Rights**. CalOptima shall ensure that Enrollee rights are fully respected and observed in accordance with Laws and CalOptima Policies. CalOptima shall notify Enrollees of their rights and protections at least annually and in a manner that accounts for cultural considerations, functional status, and language needs.

3.18 **Enrollee Grievances**. CalOptima retains responsibility for the Enrollee grievance process. HMO will comply with CalOptima Policies related to Enrollee grievances, including timely reporting to CalOptima and resolution of Enrollee grievances. Enrollees may file an internal Enrollee grievance at any time with CalOptima or HMO, including grievances related to reasonable accommodations and access to services under the ADA.

IV. QUALITY IMPROVEMENT PROGRAM AND CREDENTIALING

4.1 **CalOptima's Quality Improvement Program**. HMO shall comply with, and participate in, CalOptima's Quality Improvement Program ("**QIP**"). HMO shall immediately notify CalOptima of those Enrollees and cases that fall within the catastrophic and targeted case management guidelines and shall cooperate with CalOptima's case management program for catastrophic and targeted cases. HMO and its Downstream Entities shall fully cooperate with CalOptima with regard to the HEDIS measurements and HEDIS audits, guideline development, preventive services utilization, disease/risk management, clinical service monitoring, and quality improvement studies and initiatives. HMO shall comply with and accept as final the decisions of the CalOptima QIP and, pending resolution of any dispute through the dispute resolution process, comply with the decisions of the CalOptima Quality Improvement Committee.

4.2 **Quality Improvement Functions – Delegation to HMO**. HMO shall establish, maintain and operate a Quality Improvement ("**QI**") program, in accordance with the delineation of responsibilities in the Delegation Agreement, which shall include preparation of an annual QI

program plan, semi-annual work plan, and annual evaluation of effectiveness of the QI program, and report to CalOptima's QI department using the Health Industry Collaboration Effort Reporting Tool. All of the foregoing elements of the QI program shall be consistent with current industry standards, and meet CMS, National Committee for Quality Assurance ("**NCQA**"), The Joint Commission, and CalOptima QIP requirements.

4.2.1 HMO shall adopt a detailed written QI plan, which shall include: (i) well defined goals and objectives; (ii) a well-defined scope that considers all different types and levels of care and service provided to Enrollees; and (iii) clearly defined accountability and responsibility for the QI program.

4.2.2 The Board of Directors of the HMO or a multi-disciplinary QI committee designated by the Board of Directors of HMO shall oversee the QI program. This committee shall be separate from the utilization review committee (though members may be the same) and have a separate agenda. The QI committee shall meet at least on a quarterly basis. HMO shall maintain attendance records and meeting minutes related to the QI program. The QI committee shall have adequate representation from all categories of the HMO such as Physicians and non-Physician practitioners.

4.2.3 QI Program activities shall be reported in writing to HMO's Board of Directors at least on a quarterly basis. These reports shall be available to CalOptima upon request.

4.2.4 HMO's QI program shall include involvement and participation in network-wide studies/projects initiated by CalOptima. HMO shall facilitate quality studies and assist in collection of comparative data collected from all Participating Providers using objective parameters (e.g., the current version of HEDIS).

4.2.5 HMO shall develop an annual QI work plan, which includes the following: (i) goals, scope, and planned projects for the year; (ii) planned monitoring of identified issues and tracking these issues over time; (iii) planned studies/audits suggested by CalOptima or HMO; and (iv) an annual evaluation of the QI program/plan.

4.2.6 HMO shall have a written procedure for responding to the findings of QI activities, such as collecting data, analyzing results, implementing corrective action plans, and reassessing the same data for improvement.

4.2.7 Requirements for the HMO's QI program shall be established by the HMO's QI committee and requirements may change based on changes in industry standards. CalOptima's QI committee shall notify HMO of any additional changes in QI standards and requirements that shall be incorporated in HMO's QI program. HMO shall not be required to change QI program requirements more frequently than once per year.

4.2.8 HMO shall provide, upon CalOptima's request: (i) summaries of QI Committee meetings; (ii) findings following review of specific cases and other reviews; (iii) Medical Records; (iv) written responses to quality-of-care issues or Enrollee complaints; and/or (v) other information as required by CalOptima.

4.2.9 HMO shall comply with all measurement and improvement projects in the manner required by CMS, including the reporting of HEDIS, Health Outcomes Survey and Consumer Assessment of Healthcare Providers and Services measurement results consistent with

Medicare requirements. HMO shall contribute to all applicable CMS data quality assurance processes.

4.3 **Quality Improvement and Credentialing Program**. CalOptima delegates credentialing requirements to HMO as provided in the Delegation Agreement. HMO agrees to comply with CalOptima Policies regarding credentialing standards. In order to ascertain HMO's continuous compliance with CalOptima standards, CalOptima retains the right to oversee HMO's credentialing processes and to mandate changes thereto.

4.3.1 At least annually, HMO shall provide CalOptima with a written credentialing program for the purpose of review and approval by CalOptima. HMO shall also allow CalOptima, after reasonable prior notice, to conduct an on-site audit and review a sample of physician credentialing files to determine that delegation of the credentialing process is appropriate.

4.3.2 HMO's credentialing program shall comply with the requirements specified in 42 CFR Sections 422.504, 423.505 and 438.214, as applicable, which include requirements addressing selection and retention of providers, credentialing and re-credentialing requirements, and nondiscrimination. HMO's credentialing program shall include procedures used for credentialing and re-credentialing Participating Provider's according to current NCQA standards, in addition to procedures used for reducing, suspending or terminating Participating Provider's participation in the organization for reasons relating to quality of care, competence, professional conduct, or service-related issues; procedures for reporting to appropriate authorities serious quality deficiencies that could result in suspension or termination of a Participating Provider's participation; and procedures for provider appeal, as afforded by HMO's fair hearing plan and corrective actions.

4.3.3 HMO shall make best efforts to notify CalOptima within thirty (30) days of any changes involving the rules, regulations, authorities, and responsibilities of the credentialing program. In accordance with CMS requirements, CalOptima also retains the right, based on quality-of-care and service issues, to approve, suspend, or terminate arrangements with practitioners, providers, and sites. In the event that this occurs, CalOptima will notify the HMO of the quality-of-care and/or service issue, and HMO shall take appropriate action, report to appropriate authorities any serious quality deficiencies in accordance with Laws, and provide all due process as afforded by the HMO's fair hearing plan and Laws.

4.3.4 If CalOptima exercises its right to terminate a Provider's participation in the CalOptima MA program, CalOptima shall give the Provider a written statement of the reason or reasons for termination with cause and comply with the procedures required by Laws, if any.

4.4 **Release of Performance Information and Data**. HMO acknowledges that the CalOptima MA Program focuses on improving the coordination and quality of medical, Behavioral Health, LTSS, and other services for Enrollees, and, in that regard, CalOptima's Regulators will implement capitation withholds to ensure performance consistent with established quality thresholds. HMO acknowledges and agrees that CalOptima may release information and data related to the performance of HMO under this Contract to CalOptima Regulators, Providers, Enrollees, and others without further notice to HMO. The performance data will be used for purposes, including quality improvement activities, and public reporting to consumers, as identified in CalOptima Policies.

V. UTILIZATION MANAGEMENT PROGRAM

5.1 **CalOptima's Utilization Management Program**. CalOptima has implemented, and continuously updates, a UM program to ensure appropriate processes are used to review and approve the provision of Medically Necessary Covered Services to Enrollees in the timeframes required by CalOptima's Regulators. HMO and its Downstream Entities shall comply with and cooperate in CalOptima's UM program, as established in CalOptima Policies and the CalOptima UM plan, regardless of CalOptima's delegation to HMO under Section 5.2.

5.2 **UM Program Responsibility—Delegation to HMO**. CalOptima is hereby delegating to HMO the process of monitoring and evaluating on a prospective, concurrent, and retrospective basis, the utilization and Medical Necessity of Covered Services provided to HMO's Enrollees.

5.2.1 HMO's UM process shall include performing case management activities, referral management and discharge planning, and managing the denial sanction process, as well as conducting peer review for Medical Necessity and appropriateness. HMO (and its Downstream Entities) shall ensure that its UM program complies with all criteria as set forth in CalOptima Policies and required by CalOptima's Regulators.

5.2.2 In accordance with 42 CFR §§ 438.6(h) and 422.208, compensation to individuals or entities that conduct UM activities must not be structured so as to provide incentives for HMO (including HMO Physicians) or Downstream Entities to deny, limit, or discontinue Medically Necessary Covered Services to any Enrollee.

5.2.3 In the event HMO (or its Downstream Entities) fails to comply with CalOptima standards and Laws and fails to correct deficiencies within the stated time required by those provisions, CalOptima retains the right to revoke delegation of UM activities.

5.3 **Utilization Management Plan**. HMO will provide to CalOptima initially upon execution of this Contract, and annually thereafter, a written UM plan for review and approval by CalOptima.

5.3.1 HMO shall notify CalOptima within thirty (30) days of any changes involving the rules, regulations, authorities, and responsibilities for the UM plan, which shall be subject to reasonable approval by CalOptima. CalOptima approval will be assumed unless HMO is notified otherwise by CalOptima. HMO shall comply with and accept as final, the decisions of CalOptima's UM program and, pending resolution of any dispute through the dispute resolution process, comply with the decisions of CalOptima's UM program.

5.3.2 The UM plan shall include procedures approved by CalOptima to identify, assess, establish, and implement a treatment plan for Enrollees with complex or serious medical conditions. The UM plan shall also contain procedures for direct access of Enrollees to services as mandated by CMS regulations and instructions. All HMO denial letters shall provide Enrollees with timely notice and shall contain appropriate Enrollee appeals rights as approved by CMS and CalOptima. HMO agrees to cooperate with CalOptima in furnishing the required reports identified in CalOptima' Policies

5.4 **Utilization Management Committee**. HMO shall establish a UM committee that shall review and document the quality, appropriateness, level of care, and utilization of health care services provided to Enrollees. CalOptima's Medical Director and/or CalOptima staff may attend HMO UM committee meetings.

5.5 **Process and Timeframes for Authorization**. HMO (and its Downstream Entities) shall ensure that its process for initial and continuing Authorizations complies with CalOptima Policies, the UM plan and requirements established by CalOptima's Regulators, including timeframes for, and manner of, Authorization.

5.6 **No Prior Authorization**. HMO (and its Downstream Entities) shall not require prior Authorization for the following services: (i) any services for Emergency Medical Conditions (which include emergency Behavioral Health care); (ii) Urgent Care sought outside the Service Area: (iii) Urgent Care under unusual or extraordinary circumstances provided in the Service Area when the Participating Provider is unavailable or inaccessible; (iv) preventative services; (v) family planning services; (vi) Out-of-Area renal dialysis services; (vii) basic prenatal care; (viii) sexually transmitted disease services; and (ix) HIV testing.

5.7 **Second Opinions**. HMO (and Downstream Entities) shall ensure that Enrollees have the right to second opinions from qualified health professionals at no cost to the Enrollee.

5.8 **Physician Direct Referral**. HMO agrees that an Enrollee shall, without obtaining the prior Authorization of the PCP or HMO, refer him or herself directly to a specialist within said HMO per policy including any of the following conditions: an annual well woman exam by a Gynecologist, prenatal care and delivery by an Obstetrician, annual eye exam by an Optometrist, professional services related to audiology, and family planning services, including but not limited to vasectomy.

5.8.1 CalOptima will identify HMO as a provider that offers HMO Direct Referrals to Enrollees in CalOptima's provider directory and other marketing literature, if any. In the event CalOptima determines that HMO is non-compliant with the requirements of the Physician Direct Referral process, CalOptima reserves the right, at its sole discretion, to cease marketing HMO as a Physician Direct Referral provider to Enrollees.

5.8.2 HMO agrees to cooperate with CalOptima and, upon reasonable prior notice, provide CalOptima with all necessary Medical Records, policies and procedures, including utilization review, reports, and other pertinent information that may be necessary or required to enable CalOptima to ensure and verify that HMO has a Physician Direct Referral process acceptable to and in accordance with the requirements of CalOptima.

5.9 **Hospital Referrals**. HMO agrees to require HMO Physicians to admit Enrollees only to a Participating Provider Hospital with the concurrence of CalOptima, except for Emergency Services, Urgent Care, or when Authorization has been received in accordance with the UM Plan.

5.10 **Personal Care Coordinator Component to the Model of Care.**

5.10.1 "**PCC Profile**" is a monthly report generated by CalOptima that provides the compliance parameters required to receive PCC supplemental capitation.

5.10.2 HMO shall employ PCCs and participate in all PCC component requirements, as defined in the Model of Care Profile. PCCs shall assist Enrollees in the development of an ICP, ensure communication of the Enrollee's care plan with the Enrollee, physicians, HMO and health care team, and provide other related services as described in the job description, CalOptima Policy, and Model of Care Profile. HMO shall submit monthly reports and ICPs to demonstrate adherence to Model of Care requirements, including staffing of PCCs.

5.10.3 CalOptima may amend the Model of Care Profile at any time and, in such event, CalOptima shall provide HMO with thirty (30) days' written notice before the effective date of any such revisions. If HMO is unable to agree to the revisions and no resolution is reached in the thirty (30)-day period, HMO may proceed with the termination of the Contract under Article 11. In the event HMO terminates the Contract, it shall comply with all of its obligations required by this Contract and Laws including obligations related to transfer and coordination of Enrollee care following termination.

VI. COMPENSATION

6.1 **HMO Compensation**. CalOptima shall compensate HMO for Covered Services and Administrative Services delegated to HMO, as set forth in Attachment C. Such Capitation Payments shall be payment in full for Covered Services and Administrative Services, except for amounts recovered through collection of Enrollee's Share of Cost, COBs, and Stop Loss Program, if applicable. Capitation Payment shall be sent on a monthly basis by the twentieth (20th) calendar day of the month, or if such day falls on a weekend or national holiday, on the first business day thereafter, for all Enrollees eligible from the first (1st) of the month, and on whose behalf payment has been received by CalOptima from CMS by the nineteenth (19th) calendar day of the month. In the event CalOptima receives payment from CMS after the nineteenth (19th) calendar day of the month, capitation payment to HMO will be made within five (5) working days of receipt of the monthly payment by CalOptima.

6.2 **Disputes Regarding Payments or Enrollment**. Any and all disputes related to Capitation Payments and/or enrollments shall be reported to CalOptima within ninety (90) calendar days of payment, and each dispute shall be clearly defined and include supporting documentation. Failure to dispute within the established time frame indicates acceptance of the Capitation Payment by HMO.

6.3 **Capitation Rate Adjustments**. The Capitation Rates may be adjusted by CalOptima during the Contract period to reflect implementation of State or federal laws or regulations, changes in the CMS Contract or CMS policy, and/or changes in Covered Services. If CalOptima receives advance notice of adjustment from CalOptima's Regulators, CalOptima shall provide notice thereof to HMO as soon as practicable. Capitation Rates may also be adjusted in the event of de-delegation of any function delegated under this Contract.

6.4 **Enrollee Non-Liability and Hold Harmless Requirements.** HMO and its Downstream Entities shall accept CalOptima's payment as described in this Contract as payment in full. HMO and its Downstream Entities for all Covered Services and Administrative Services under this Contract and shall not hold Enrollees liable to the HMO or Providers for any sums owed to HMO by CalOptima or owed to Providers by HMO.

6.4.1 HMO and its Downstream Entities shall hold harmless CMS, CalOptima, and Enrollees in the event HMO and/or Downstream Entities cannot or will not pay for services performed by HMO or Downstream Entities pursuant to this Contract or subcontract, as applicable.

6.4.2 HMO and its Downstream Entities shall ensure that Enrollees will not be held liable for Medicare Part A and B cost sharing when the State is responsible for paying such amounts and that the HMO will (i) accept Capitation Payment as payment in full under the Contract, or (ii) bill the appropriate State source, as required at 42 CFR §422.504(g)(1)(iii). Such services must be provided at zero cost-sharing to Enrollees.

6.4.3 HMO shall not hold an Enrollee liable for the following: (i) debts of HMO, in the event of 'HMO's insolvency; (ii) Covered Services provided to the Enrollee in the event that CalOptima or HMO fails to receive payment from CMS for such services; or (iii) payments to a clinical FDR or Downstream Entity in excess of the amount that would be owed by the Enrollee if HMO had directly provided the services.

6.4.4 HMO and its Downstream Entities shall not charge Enrollees coinsurance, co-payments, deductibles, financial penalties, or any other amount in full or part, for any service provided under this Contract, except as otherwise permitted under this Contract.

6.4.5 HMO and its Downstream Entities shall not deny any service provided under this Contract to an Enrollee for Enrollee's (or any entity responsible for making payment on Enrollee's behalf) failure or inability to pay any applicable charge or shall not deny any service provided under this Contract to an Enrollee who, prior to becoming eligible, incurred a bill that has not been paid.

6.5 **Overpayments Discovered by Physician Group**. HMO shall disclose and return all overpayments to CalOptima within sixty (60) days of when HMO identified the overpayment or should have identified the overpayment through the exercise of reasonable diligence.

6.6 **Recoupment for Ineligibility; Conlan Reimbursements**. CalOptima shall recoup payments made to HMO when CMS has determined that an individual was not eligible for the MA Program and retroactively terminates the individual, including recouping any payments made for a deceased Enrollee. CalOptima may also recoup overpayments to HMO owed by HMO to Enrollees, including offsetting any such amounts owed against HMO's Capitation Payments or other amounts due from CalOptima to HMO under this Contract or any other agreement between the parties, if any. This Section 6.6 shall not be construed to limit CalOptima's right to recoup payment made to HMO on any other basis for which recoupment is appropriate.

6.7 **CalOptima Right to Recover**.

6.7.1 Overpayments. HMO acknowledges and agrees that, in the event that CalOptima determines that an amount has been overpaid or paid in duplicate, or that funds were paid which were not due under this Contract to HMO, CalOptima shall have the right to recover such amounts from HMO by recoupment or offset from current or future amounts due from CalOptima to HMO under this Contract or any other agreement between the parties, after giving HMO notice and an opportunity to return/pay such amounts.

6.7.2 Health Network Termination. In the event of termination of the Health Network or the transition of the Health Network to a different delegation model, CalOptima shall have the right to offset any unpaid claims that are the financial responsibility of Physician Group paid by CalOptima against any funds owed to Physician Group by CalOptima, including capitation payments, financial security withholds, pay-for-performance amounts, quality incentives, and shared risk pool surpluses.

6.7.3 Shared Risk Pool Payments Upon Termination. If this Contract terminates or expires for any reason and Physician Group is responsible for a deficit under any shared risk program under this Contract based on the final shared risk pool report results ("**Deficit**"), such Deficit shall be due to CalOptima as follows, as allowed by Laws: CalOptima may elect to recoup such Deficit by either (1) offsetting such Deficit amounts, upon notice to Physician Group, from any current or future amounts owed by CalOptima to Physician Group under the Contract or any other agreement

between the Parties, including capitation payments, financial security withholds, pay-for-performance amounts, quality incentives, and shared risk pool surpluses; or (2) sending an invoice to Physician Group that payment for such Deficits are due to CalOptima within thirty (30) days of Physician Group's receipt of the CalOptima invoice.

6.7.4 Regulator Recoupment Upon Termination. If following the termination or expiration of this Contract, CalOptima's Regulators find that Physician Group (or its Downstream Entities) has failed to comply with the requirements governing physician incentive plans and CalOptima's Regulators offset, recoup and/or otherwise seek recovery of FFP, as described in Section 1.33, CalOptima may elect to recoup such FFP amounts, as allowed by Laws, by either: (1) offsetting such FFP amounts, upon notice to Physician Group, from any current or future amounts owed by CalOptima to Physician Group under the Contract or any other agreement between the Parties, including capitation payments, financial security withholds, pay-for-performance amounts, quality incentives, or shared risk pool surpluses; or (2) sending an invoice to Physician Group that payment for such FFP amounts are due to CalOptima within thirty (30) days of Physician Group's receipt of the CalOptima invoice.

6.7.5 Dispute Resolution. Physician Group may use CalOptima's provider dispute resolution procedure, as described under CalOptima's Policies, and/or the dispute resolution procedures under this Contract to resolve any disputes related to the calculation or payment of such Deficits or FFP amounts.

6.7.6 Survival. This Section 6.7 shall survive the termination or expiration of the Contract.

6.8 **Retroactive Cancellation**. CalOptima will discourage retroactive cancellation of any Enrollee. However, CalOptima may make exceptions as required by CMS or due to legitimate administrative processing requirements of CMS. CalOptima may make retroactive additions or cancellations of Enrollees, as necessary for administrative or business reasons, and such retroactive additions or cancellations of Enrollees shall not exceed ninety (90) days.

VII. REPORTING REQUIREMENTS

7.1 **Data Reporting Requirements**. HMO shall comply with the data reporting requirements set forth in this Contract, including the requirements specified in Standard Reporting Requirements set forth in CalOptima Policies and guidelines (referred to as the Timely and Appropriate Submission requirements). HMO shall provide such additional data and modify the form, content, instructions, and timetables for the collection and reporting of data, as may be required by CalOptima Policies.

7.2 **Eligibility Reports**. CalOptima will maintain, update, and distribute monthly Enrollee eligibility reports for each month in which the persons included on such list are eligible for CalOptima MA Program. This report will identify the HMO, PCP selected by the Enrollee, and the Enrollee's coverage. The report will be sent to HMO and PCPs by the tenth (10th) of each month, identifying eligible Enrollees from the first (1st) of the month.

7.3 **Utilization Data**. HMO shall, upon request, provide CalOptima with information on the utilization and cost of Covered Services provided to Enrollees in such detail as to allow CalOptima to conduct analysis of costs as required by CMS, as dictated by sound business practices and for the conduct of quality management and UM activities by CalOptima. Such information to be provided by HMO will not include information beyond that customarily provided on a claim form (such as Form CMS-1500) and shall be provided in the form of a paper report, computer disc, computer tape, or

electronic file, as agreed by the parties. Required data will be delivered by HMO to CalOptima not later than forty-five (45) days following written request by CalOptima.

7.4 **Submission of Electronic Encounter Data**. HMO must meet any claims, diagnosis, and Encounter Data reporting requirements, as determined from time to time by CalOptima and CalOptima's Regulators.

7.4.1 HMO agrees to furnish CalOptima with complete, timely, reasonable, and accurate Encounter Data for Covered Services rendered to Enrollees. The Encounter Data will be furnished to CalOptima through Electronic Data Interchange (EDI) or a mutually acceptable format and shall be received by CalOptima per the Policy and Encounter Requirements Manual. HMO also agrees to furnish Medical Records that may be required to obtain any additional information or corroborate the Encounter Data. HMO further agrees to have its Chief Executive Officer (CEO) attest and certify the completeness and truthfulness of the Encounter Data submitted.

7.4.2 HMO shall be subject to financial penalties and/or sanctions if CalOptima determines that Physician is reporting to CalOptima less than all professional encounters in the CalOptima required format and timelines. Financial penalties or sanctions shall be assessed upon HMO should CalOptima determine that HMO is not meeting the standards defined in CalOptima Policies. This Section 7.4.2 shall survive the expiration or termination of this Contract, whether with or without cause, by rescission or otherwise, as to all Covered Services provided under this Contract prior to termination. Based on CalOptima's quarterly determinations and following thirty (30) days' prior notice to HMO, CalOptima may withhold three (3%) percent of Capitation Payment if CalOptima determines that the monthly Encounter Data that HMO must provide has not been received by CalOptima within the prior quarter. If at the quarterly determination following such withhold, CalOptima determines that HMO has satisfactorily delivered to CalOptima the previously non-delivered Encounter Data; such withheld Capitation Payment shall be paid to HMO, without interest. In the event that HMO does not deliver such Encounter Data to CalOptima prior to such quarterly determination, CalOptima shall be entitled to retain such withheld Capitation Payment and may withhold three (3%) percent from each quarter's Capitation Payment until CalOptima receives the Encounter Data.

7.5 **Financial Reporting**. HMO shall prepare financial information requested in accordance with Generally Accepted Accounting Principles ("**GAAP**"). Where financial statements and projections are requested by CalOptima and/or CalOptima's Regulators, these statements and projections should be prepared in accordance with the 1989 HMO Financial Report of Affairs and Conditions Format. Where appropriate, reference has been made to the Knox-Keene Act rules found under Title 28 CCR Section 1300.51 *et. seq*. Information submitted shall be based on HMO's current operations. HMO shall submit financial information consistent with filing requirements of the DMHC, unless otherwise specified by CMS.

7.6 **Financial Statements**. CalOptima, as a Knox-Keene Act health care service plan, is required by CalOptima's Regulators to monitor the financial viability of its contracted provider network on an on-going basis. HMO agrees to provide CalOptima annually with a copy of HMO's audited financial statements, including letters to management for the most recent fiscal year end along with an opinion letter on these statements from the accounting firm that completed an audit on these financial statements. Financial statements shall be presented in a form specified by CalOptima that clearly shows the financial position of HMO as related to Enrollees. HMO shall allow representatives of CalOptima, upon written request, to verify the financial reports. In the event

audited statements are unavailable, HMO agrees to provide CalOptima with the unaudited financial statements at HMO's fiscal year end. The unaudited financial statements will include: balance sheets, income statement and statement of cash flows, notes to the financial statement, name of the person preparing these statements, and representation letters from the senior financial executives of the HMO, attesting that these financial statements were prepared in accordance with GAAP and fairly present the financial condition of the HMO.

7.7 **Reports Regarding Disclosure of Confidential Enrollee Information**. If HMO, or any of its officers, employees, agents, or Downstream Entities, becomes aware of the unauthorized disclosure of confidential Enrollee information or of "personal information", within the meaning of California Civil Code Section 1798.3, HMO shall report said unauthorized disclosure to CalOptima's Privacy Officer immediately upon discovery of said disclosure, providing information on the information disclosed and how the disclosure occurred. For purposes of this section, "unauthorized disclosure" includes any unauthorized access, whether such access was through inadvertence, mistake, theft, or other means, and whether or not HMO had reasonable control to avoid the disclosure. Nothing herein is intended to limit or replace HMO's separate obligations under the Business Associate Agreement and Laws.

7.8 **Additional Information Required by CalOptima's Regulators**. HMO and Downstream Entities shall, at the request of CalOptima or CalOptima's Regulators, provide the following: (i) all information related to the performance of CalOptima's responsibilities, including non-medical information for the purposes of research and evaluation, to CalOptima's Regulators; (ii) any information required to comply with all Laws; and (iii) any information required for external rapid cycle evaluation, including program expenditures, service utilization rates, rebalancing from institutional to community settings, Enrollee satisfaction, Enrollee complaints and Appeals, and enrollment/disenrollment rates.

VIII. RECORD RETENTION, ACCESS AND CONFIDENTIALITY

8.1 **Disclosure of Records**. HMO and its Downstream Entities agree to maintain and make available contracts, books, documents, records, and electronic systems, including, Medical Records, (collectively, the "**Records**") to CalOptima, HHS, CMS, the Comptroller General, the U.S. Government Accountability Office, any Quality Improvement Organization, or accrediting organizations, including NCQA, their designees, and other representatives of regulatory or accrediting organizations, for inspection, evaluation, and auditing. For purposes of utilization management, quality improvement, and other CalOptima administrative purposes, CalOptima and CalOptima's Regulators shall have access to, and copies of, at reasonable time upon request, the Medical Records, books, charts, and papers relating to the provision of health care services to Enrollees, the cost of such services, and payments received by HMO or any of HMO Physicians from Enrollees (or from others on their behalf). Copies of the Medical Record shall be provided at no charge to CalOptima. Unless a longer time is required under applicable law, the records described herein shall be maintained for at least ten (10) years from the final date of the Contract or from the completion of any audit, whichever is later.

8.2 **Medical Records**. HMO will require that all HMO Physicians and Downstream Entities establish and maintain in an accurate and timely manner, for each Enrollee who has obtained Covered Services from a Group Provider or Downstream Entity, a legible Medical Record which shall be kept in detail consistent with good medical and professional practice in accordance with Laws and CalOptima Policies. Such Medical Records shall include a historical record of diagnostic and therapeutic services recommended or provided by, or under the direction of, the Provider. Such Medical Records shall be in such a form as to allow trained health professionals, other than the

Provider, to readily determine the nature and extent of the Enrollee's medical problem and the services provided and permit peer review of the care provided. HMO shall ensure that medical information is released in accordance with applicable Laws, or pursuant to valid court orders or subpoenas, subject to compliance with applicable privacy laws. HMO shall ensure than an individual is delegated the responsibility of securing and maintaining Medical Records at each HMO or Downstream Entity site.

8.3 **Right to Inspection**. Medical Records referred to in Section 8.2 above will be and remain the property of HMO or HMO Physicians and will not be removed or transferred from their offices except in accordance with Laws. CalOptima or its designated representatives will have the right, in accordance with this Article 8, to inspect, review, and make copies of such records at HMO's expense upon request to facilitate CalOptima's obligation to conduct quality management, utilization monitoring, and peer review activities.

8.4 **Records Related to Recovery for Litigation**. Upon request by CalOptima, HMO and its Downstream Entities shall timely gather, preserve, and provide to CalOptima, in the form and manner specified by CalOptima, any information specified by CalOptima, subject to any lawful privileges, in HMO's or its Downstream Entities' possession, relating to threatened or pending litigation by or against CalOptima, HHS, and CMS. If HMO asserts that any requested documents are covered by a privilege, HMO shall: (1) identify such privileged documents with sufficient particularity to reasonably identify the document while retaining the privilege; and (2) state the privilege being claimed that supports withholding production of the document. Such request shall include a response to a request for documents submitted by any party in any litigation by or against CalOptima. HMO acknowledges that time may be of the essence in responding to such request. HMO shall use all reasonable efforts to immediately notify CalOptima of any subpoenas, document production requests, or requests for records received by HMO or its Downstream Entities related to this Contract or subcontracts entered into under this Contract.

8.5 **State and Federal Site Visits**. HMO agrees to permit CalOptima, the DMHC, HHS, and/or CMS to conduct a site evaluation of HMO and its facilities in accordance with Laws and to comply with the agencies' recommendations, if any.

8.6 **Enrollee Access to Records**. HMO (including HMO Providers) and its Downstream Entities shall ensure that Enrollees have access to their Medical Records in accordance with the requirements of Laws. An Enrollee shall be provided a copy of his or her Medical Records, upon request, and shall have the right to request corrections or amendments to their Medical Records as specified in 45 CFR Part 164. HMO and Downstream Entities shall furnish a copy of the Enrollee's Medical Records to another treating or consulting Provider regardless of whether the requesting Provider is a Participating Provider, at no cost to CalOptima or the Enrollee when (i) such a transfer of Medical Records facilitates the continuity of that Enrollee's care; (ii) the Enrollee is transferring from one Provider to another for treatment; and (iii) an Enrollee seeks to obtain a second opinion on the diagnosis or treatment of a medical condition.

IX. INSURANCE AND LIABILITY

9.1 **Indemnification**. Each Party agrees to defend, indemnify, and the other Party and the State and CMS harmless, with respect to any and all claims, costs, damages, and expenses, including reasonable attorney's fees, that are related to or arise out of the negligent or willful performance or non-performance by the indemnifying Party, or any functions, duties, or obligations of such Party. Neither termination of the Contract nor completion of the acts to be performed under this Contract shall release either Party from its obligation to indemnify as to any claims or cause of action

asserted so long as the event(s) upon which such claims or cause of action is predicated shall have occurred prior to the effective date of termination or completion. CalOptima and HMO agree to promptly notify the other Party of any claims or demands that arise and for which indemnification hereunder is sought.

9.2 **Insurance Requirements**.

9.2.1 **HMO Liability Insurance**. HMO agrees to procure and maintain, at its own expense, the insurance policies required by this Section 9.2 and Laws and shall require its Downstream Entities to maintain similar policies of insurance where HMO's insurance does not cover its Downstream Entities. The coverage programs in this Section 9.2 above shall insure the HMO, HMO Physicians and their employees against any claim for damages arising by reason of personal injuries or death occasioned directly or indirectly in connection with the performance of, or the failure to perform any service provided by HMO Physicians, their employees or agents.

9.2.2 **Professional/Medical Malpractice**. Each HMO Physician and Participating Provider providing Covered Services to Enrollees shall maintain a professional liability (medical malpractice) insurance policy for the specialty or type of service that the HMO Physician provides with minimum limits of one million dollars ($1,000,000) per incident and three million dollars ($3,000,000) in the aggregate per Physician per year for all Physicians who are partners, associates or employees of HMO. HMO warrants that all Physicians that it contracts with for the provision of Covered Services will carry professional liability coverage in the same amount and that each Hospital providing Covered Services to Members shall maintain a professional liability insurance policy with a minimum of five million dollars ($5,000,000) per incident/five million dollars ($5,000,000) in the aggregate per year. If HMO, HMO Physicians, or its Downstream Entities have a claims-made malpractice insurance policy, they agree to keep the policy in effect for at least seven (7) years past any termination of the Contract or purchase "tail" coverage. Said "tail" coverage shall have the same policy limits as the primary professional liability policy.

9.2.3 **Commercial General Liability/Commercial Automobile Liability**. HMO and each Participating Provider who has entered into a contract with HMO to provide Covered Services under this Contract shall maintain a Commercial General Liability insurance policy and a Commercial Automobile Liability insurance policy with minimum limits as follows:

- Commercial General Liability: One million dollars ($1,000,000) per occurrence and three million dollars ($3,000,000) in the aggregate.

- Commercial Automobile Liability: One million, two hundred thousand dollars ($1,200,000) combined single limit for bodily injury or property damage covering any automobile, whether owned, leased, hired, or rented, on an ISO form CA 0001 or equivalent.

CalOptima must be named as an additional insured on Comprehensive General Liability and Commercial Automobile Liability insurance policies with respect to performance under this Contract.

9.2.4 **Workers' Compensation**. HMO Physician and each Participating Provider who has entered into a contract with HMO to provide Covered Services under this Contract shall

maintain a Workers' Compensation Insurance policy that provides statutory coverage with minimum limits as follows:

- Employers' Liability Insurance:
  - One million dollars ($1,000,000) Bodily Injury by Accident - each accident.
  - One million dollars ($1,000,000) Bodily Injury by Disease - policy limit
  - One million dollars ($1,000,000) Bodily Injury by Disease - each employee

9.2.5 **Managed Care Errors and Omissions**. Physician shall maintain a Managed Care Errors and Omissions Insurance policy with minimum limits as follows:

- Managed Care Errors and Omissions: Ten million dollars ($10,000,000) each claim/ten million dollars ($10,000,000) aggregate

9.2.6 **Electronic and Computer Crimes Insurance**. HMO and its Downstream Entities shall maintain electronic and computer crimes insurance and employee fidelity insurance with limits of at least one million dollars ($1,000,000) if HMO and/or its Downstream Entities will be paying claims or receiving funds on behalf of CalOptima, or will be storing, transmitting, and/or receiving personally identifiable and/or protected health information on a regular basis in carrying out its obligations under this Contract..

9.2.7 **Insurer Ratings**. Insurance required under this Article IX shall be provided by an insurer:

(a) Rated by A.M. Best with a rating of A V or better; and

(b) "Admitted" to do business in California or an insurer approved to do business in California by the California Department of Insurance and listed on the Surplus Lines Association of California List of Eligible Surplus Lines Insurers (LESLI); or

(c) An Unincorporated Interindemnity Trust Arrangement as authorized by the California Insurance Code 12180.7

9.2.8 **Captive Risk Retention Group/Self Insured**. Where any of the insurance(s) mentioned in this Article IX is provided by a captive risk retention group or self-insured, insurer ratings requirements above may be waived at the sole discretion of CalOptima, but only after review of the captive risk retention group's or self-insured's audited financial statements.

9.2.9 **Cancellation or Material Change**. HMO shall not of its own initiative cause such insurance as addressed in this Article IX to be cancelled or materially changed during the Term.

9.2.10 **Proof of Insurance**. Certificates of Insurance of the insurance policies and/or evidence of self-insurance required under this Article IX shall be provided to CalOptima prior to Effective Date, annually thereafter, and upon request.

X. COOPERATION

10.1 **Non-Interference**. HMO and Downstream Entities may not prohibit of otherwise restrict a health care professional, acting within the lawful scope of practice, from freely communicating with Enrollees about their treatment and the following, regardless of benefit coverage limitations:

10.1.1 The Enrollee's health status, medical care, or treatment options (including any alternative treatments that may be self-administered), including the provision of sufficient information to provide an opportunity for the Enrollee to decide among all relevant treatment options;

10.1.2 The risks, benefits, and consequences of treatment or non-treatment; or

10.1.3 The opportunity for the Enrollee to refuse treatment and to express preferences about future treatment decisions.

10.2 **No Counseling to Dis-enroll**. HMO and HMO Physicians agree that they will not, during the Term, provide advice to or counsel any Enrollee to dis-enroll from CalOptima, and HMO and HMO Physicians will not solicit such Enrollee to become enrolled with any other health maintenance organization, preferred provider organization, or any other similar hospitalization, medical payment plan or insurance program.

10.3 **Cooperation**. CalOptima and HMO agree that, to the extent compatible with the separate and independent management of each, they will at all times maintain an effective liaison and close cooperation with each other to provide maximum benefits to Enrollees at the most reasonable cost, consistent with quality standards of hospital and physician care.

10.4 **Signs**. HMO agrees that CalOptima may post notices, mutually acceptable as to size, content and form in a prominent place instructing Enrollees as to proper procedures and limitations on coverage.

10.5 **Free Exchange of Information**. No provision of this Contract shall be construed to prohibit, nor shall any provision in any contract between HMO and its employees or Downstream Entities, prohibit, the free, open, and unrestricted exchange of any and all information of any kind between Providers and Enrollees regarding the nature of the Enrollee's medical condition, the health care treatment options and alternatives available and their relative risks and benefits, whether or not covered or excluded under the Enrollee's Evidence of Coverage, and the Enrollee's right to appeal any adverse decision made by HMO or CalOptima regarding coverage of treatment which has been recommended or rendered. HMO and CalOptima agree not to penalize nor sanction any Provider in any way for engaging in such free, open, and unrestricted communication with an Enrollee nor for advocating for a particular service on an Enrollee's behalf.

XI. TERM AND TERMINATION

11.1 **Term of Contract**. The term of this Contract shall become effective on the Effective Date and continue in effect for five (5) years through _____ ("Initial Term") and five (5) additional one-year automatic extensions except as directed otherwise by the Board.

11.2 **Sanctions and Terminations for Cause**. If HMO fails to fulfill any of its duties and obligations under this Contract, including: (i) committing acts to discriminate against Enrollees; (ii) engaging in any practice that would reasonably be expected to have the effect of denying or discouraging enrollment with the HMO by Enrollees whose medical condition or history indicated a need for substantial future medical services; (iii) not providing Covered Services in the scope or manner required under this Contract; (iv) engaging in prohibited marketing activities; (v) failing to comply with CalOptima's compliance and fraud, waste and abuse programs; (vi) failing to meet financial

requirements in Article II; (vii) committing fraud, waste or abuse relating to Covered Services or any and all obligations, duties, and responsibilities under this Contract; (viii) failure to enforce claims payment prohibitions on HMO Physicians who are denied the right to submit claims and/or receive reimbursement for services furnished to Enrollees; (ix) failure of HMO Physicians to comply with pharmacy requirements as determined by CalOptima; (x) failure to submit Encounter Data or comply with other reporting requirements pursuant to this Contract and CalOptima Policies; and/or (xi) failure to take corrective action related to any such obligation or duty in the time or manner required by CalOptima, CalOptima may take any one or more of the actions described in this Article XI.

11.3 **Corrective Action Plans**. CalOptima may require a Corrective Action Plan ("**CAP**") in the event that any report, audit, survey, site review or investigation indicates that the HMO or any Downstream Entity is not in compliance with any provision of this Contract.

11.3.1 A CAP shall be required if CalOptima receives a substantiated complaint or grievance related to the standard of care provided by the HMO or any Downstream Entities. CalOptima shall issue a written notice of deficiency and shall require that a CAP to be submitted within thirty (30) calendar days following the date of notice unless otherwise stated. The CAP shall include the time and manner in which the deficiency shall be corrected. CAPs are subject to approval by CalOptima, which may be approved as submitted, accepted with specific modifications, or rejected. CalOptima may extend or reduce the time allowed for completion of the CAP depending upon the nature of the deficiency.

11.3.2 Notwithstanding any request for a CAP, CalOptima may impose monetary penalties, suspend enrollment, reduce maximum enrollment, or impose other sanctions when the HMO is not in compliance with the provisions of this Contract, CalOptima Policies, and minimum performance requirements as established by CalOptima. All monetary fines are payable to CalOptima within thirty (30) calendar days of receipt of written notice, unless otherwise stated in the notice. Failure to submit payment to CalOptima for any monetary fines within the thirty (30) calendar day period shall result in CalOptima deducting the penalty plus administrative fees from the HMO's Capitation Payment.

11.4 **CalOptima Termination for Cause**. Notwithstanding and in addition to any other provisions of this Contract, CalOptima may terminate this Contract for cause effective upon thirty (30) calendar days' written notice; cause shall include, but shall not be limited to, the actions set forth in Section 11.2. CalOptima's rights and remedies provided in this provision shall not be exclusive and are in addition to any other rights and remedies provided by law or this Contract.

11.5 **HMO Termination for Cause**. HMO may terminate this Contract for cause only upon thirty (30) calendar days' written notice and only in the event that CalOptima fails to make payments due under this Contract within fifteen (15) calendar days of when such amounts are due and payable.

11.6 **Immediate Terminations**. In addition to all other sanction and termination rights, CalOptima may terminate Contract immediately upon delivery of written notice to HMO if:

11.6.1 HMO (including HMO Physicians) and/or its Downstream Entities are unable to secure the necessary governmental licenses, approvals, and/or certificates required for the performance of their duties;

11.6.2 CalOptima determines that the health, safety, or welfare of Enrollees is jeopardized by continuation of this Contract;

11.6.3 HMO commits fraud, waste, or abuse; or

11.6.4 CMS fails to authorize or reauthorize CalOptima to operate a MA Program for a period that overlaps the Term.

11.7 **Without Cause Termination**. Following the Initial Term, either Party may terminate this Contract for convenience, without cause, by giving written notice to the other Party of at least one hundred and eighty (180) calendar days' prior to the effective date of such termination.

11.8 **Bankruptcy**. If during the Term there is filed by or against HMO in any court pursuant to any statute of the United States or any state, a petition in bankruptcy or insolvency or for reorganization or for the appointment of a receiver or trustee or conservator of all or a portion of HMO's assets, or if HMO makes an assignment for the benefit of creditors, or if HMO becomes unable, admits in writing its inability, or fails generally to pay its debts as they become due, this Contract may, at the option of CalOptima, be canceled and terminated. In the event of the filing of a petition for bankruptcy by or against HMO, HMO shall assure that all of HMO's functions and duties related to the Contract are performed in accordance with the terms of the Contract. CalOptima shall have the right to withhold any and all amounts otherwise due to HMO until HMO fully discharges its obligations under the Contract. CalOptima shall also have the immediate right of offset by permanently retaining any and all withheld amounts as necessary to ensure that all HMO obligations have been met.

11.9 **Termination of CMS Contract.** In the event the CMS Contract with CalOptima is terminated or not renewed, the provisions of this Contract shall automatically terminate unless otherwise specified by CalOptima and subject to any provisions that survive termination. Any term provided in the Contract is subject to CMS's continuing approval of CalOptima's MA Program. HMO agrees to assist CalOptima with such transfer of care requirements mandated by CMS in the event of termination of the CMS Contract.

11.10 **Continuation of Benefits**. HMO and its Participating Providers agree that, in the event of CalOptima's insolvency or cessation of operations, benefits to Enrollees will continue through the period for which capitation has been paid or until the discharge of Enrollee from an inpatient facility, whichever time is greater. Covered Services to an Enrollee confined in an inpatient facility on the date of insolvency or other cessation of operations will continue until their appropriate discharge.

11.11 **HMO Obligations Following Termination**. In the event of termination of this Contract, at CalOptima's sole option, HMO will continue to provide Covered Services, and CalOptima shall reimburse for such services per the Medicare fee schedule, to Enrollees until CalOptima has made arrangements with alternative Providers to render care to Enrollees. HMO shall cooperate and assist CalOptima in the transfer of Enrollee care in the event this Contract or any relevant Downstream Entity subcontract is terminated for any reason. HMO shall provide a plan for the orderly termination of services under this Contract, in form and substance acceptable to CalOptima.

11.12 **Prohibition on Use of Certain HMO Physicians**. HMO agrees that CalOptima reserves the right to require HMO, upon notification from CalOptima, to prohibit any HMO Physician or Downstream Entity from providing services, whether Covered Services or otherwise, to Enrollees

when CalOptima deems such prohibition to be in the best interests of the Enrollees, provided that imposition of the foregoing prohibition shall not terminate this Contract.

XII. GENERAL PROVISIONS

12.1 **Dispute Resolution**.

12.1.1 **Provider Appeals Process**. CalOptima maintains a Provider dispute resolution process. HMO may appeal any aspect of the CalOptima MA Program, including a decision to impose a sanction, terminate this Contract, or take other actions against HMO, by filing a complaint pursuant to CalOptima Policies. HMO shall exhaust all administrative remedies and any government claims requirements, as applicable, before commencing arbitration.

12.1.2 **Meet and Confer**. For any dispute not subject to or resolved by the provider appeals process, or if either Party has a dispute it seeks to address informally, the Parties shall use reasonable efforts to informally meet and confer to try and resolve the dispute. The Parties shall meet and confer within thirty (30) days of a written request submitted by either Party in an effort to settle any dispute. At each meet-and-confer meeting, each Party shall be represented by persons with final authority to settle the dispute. If either Party fails to meet within the thirty (30)-day period, that Party shall be deemed to have waived the meet-and-confer requirement, and at the other Party's option, the dispute may proceed immediately to arbitration under Section 12.1.3.

12.1.3 **Arbitration**. If the Parties are unable to resolve any dispute arising out of or relating to this Contract under Sections 12.1.1 and 12.1.2, either Party may submit the dispute for resolution exclusively through confidential, binding arbitration, instead of through trial by court or jury, in Orange County, California. The Parties may agree in writing prior to commencing the arbitration on the dispute resolution rules and arbitration service that will be used to resolve the dispute. If the Parties cannot reach such an agreement, the arbitration will be conducted by Judicial Arbitration and Mediation Services ("**JAMS**") in accordance with the commercial dispute rules then in effect for JAMS; provided, however, that this Contract shall control in instances where it conflicts with JAMS's (or the applicable arbitration service's) rules. The arbitration shall be conducted on an expedited basis by a single arbitrator. The Parties prefer that the arbitrator be a retired judge of the California Superior, Appellate, or Supreme Court or of a United States court sitting in California. If no such retired judge is available, the arbitrator may be an attorney with at least fifteen (15) years of experience, including at least five (5) years in managed health care. If the Parties are unable to agree on the arbitrator within thirty (30) days of the date that the arbitration service accepts the arbitration, the arbitrator shall be selected by the arbitration service from a list of four potential arbitrators (all of whom shall be on arbitration services' panel of arbitrators) submitted by the Parties, two from each side; provided, however, that nothing stated in this section shall prevent a Party from disqualifying an arbitrator based on a conflict of interest. In making decisions about discovery and case management, it is the Parties' express agreement and intent that the arbitrator at all times promote efficiency without denying either Party the ability to present relevant evidence. In reaching and issuing decisions, the arbitrator shall have no jurisdiction to make errors of law and/or legal reasoning. The Parties shall share the costs of arbitration equally, and each Party shall bear its own attorneys' fees and costs.

12.1.4 **Exclusive Remedy**. With the exception of any dispute that under Laws may not be settled through arbitration, arbitration under Section 12.1.3 is the exclusive method to resolve a

dispute between the Parties arising out of or relating to this Contract that is not resolved through the provider appeals or meet-and-confer processes.

12.1.5 **Waiver**. By agreeing to binding arbitration as set forth in Section 12.1.3, the Parties acknowledge that they are waiving certain substantial rights and protections which otherwise may be available if a dispute between them was determined by litigation in a court, including the right to a jury trial, attorneys' fees, and certain rights of appeal.

12.2 **Interpretation of Contract Language**. CalOptima has the right to final interpretation of the Contract language when disputes arise. HMO has the right to appeal disputes concerning Contract language to CalOptima.

12.3 **Waiver**. The waiver by either Party of a breach or violation of any provision of this Contract will not operate as or be construed to be a waiver of any subsequent breach thereof. To be effective, a waiver must in writing signed by the Parties.

12.4 **Assignment**. This Contract and the rights, interests, duties, and obligations hereunder shall not be assigned, transferred, pledged, or hypothecated in any way by HMO nor shall the duties and obligations imposed herein be subcontracted or delegated without the prior written consent of CalOptima, which consent may be withheld in CalOptima's sole and absolute discretion for any reason or no reason. HMO acknowledges and agrees that CalOptima's consent, if any, to assignment and/or delegation is subject to the approval of CMS. Therefore, any assignment and/or delegation of this Contract, including the rights, interests, duties, and obligations hereunder, shall be void unless prior written consent is obtained from CalOptima and CMS. HMO further acknowledges and agrees that CalOptima may require HMO and the proposed assignee/sub-delegate to cooperate in due diligence and sub-delegation assessment activities as part of its review of any request for consent to assignment of this Contract and the rights, interests, duties, and obligations hereunder. HMO agrees to cooperate and provide such information as requested by CalOptima. HMO acknowledges and agrees that (i) CalOptima's due diligence and/or assessment activities related to any proposed assignment may take one hundred eighty (180) days or more; (ii) in no event shall CalOptima's due diligence and/or delegation assessment activities be construed as CalOptima's consent to assignment; and (iii) any consent to assignment by CalOptima must be reflected in a separate writing executed by CalOptima and other relevant parties. CalOptima may, from time to time, establish policies and procedures regarding its processes for initiating review and approval of any proposed assignment of this Contract. For purposes hereof, the term "**assignment**" shall include any of the following: (i) the change of more than twenty-five percent (25%) of the ownership or equity interest in HMO (whether in a single transaction or in a series of transactions); (ii) the change of more than twenty-five percent (25%) of the directors or trustees of HMO; (iii) the merger, reorganization, or consolidation of HMO with another entity with respect to which Physician is not the surviving entity; and/or (iv) a change in the management of HMO from management by persons appointed, elected, or otherwise selected by the governing body of HMO (e.g., the Board of Directors) to a third-party management person, company, group, team or other entity.

12.5 **Independent Parties**. None of the provisions of this Contract are intended to create nor will be deemed or construed to create any relationship between the Parties other than that of independent contractors, solely for the purposes of effecting the provisions of the Contract. Neither of the Parties nor any of their respective officers, directors, or employees shall act as nor be construed to be the agent, the employee, or the representative of the other Party.

12.6 **Integration of Entire Contract**. This Contract contains all of the terms and conditions agreed upon by the Parties regarding the subject matter of this Contract. Any prior agreements, promises, negotiations or representations of or between the Parties, either oral or written, relating to the subject matter of this Contract that are not expressly set forth in this Contract are null and void and of no further force or effect.

12.7 **Invalidity or Unenforceability**. The invalidity or unenforceability of any terms or provisions hereof will in no way affect the validity or enforceability of any other term or provision.

12.8 **Amendment**. CalOptima may amend this Contract immediately upon written notice to HMO in the event such amendment is required in order to maintain compliance with Laws. CalOptima may deem all other amendments to the Contract effective after at least forty-five (45) business days' notice or earlier if agreed to by HMO. All amendments of this Contract are subject to CMS approval.

12.9 **No Waiver of Immunity or Privilege**. Any information delivered, exchanged, or otherwise provided hereunder shall be delivered, exchanged, or otherwise provided in a manner, which does not constitute a waiver of immunity or privilege under applicable law.

12.10 **Choice of Law; Jurisdiction and Venue**. This Contract shall be governed by and construed in accordance with all State and federal laws and regulations governing the CMS Contract. The Parties consent to the jurisdiction of the California Courts with venue in Orange County California.

12.11 **Force Majeure**. Either Party, upon prompt written notice to the other Party, shall be excused from performance hereunder for any period that it is prevented from meeting the terms of this Contract as a result of a catastrophic occurrence or natural disaster, including, but not limited to, an act of war and excluding labor disputes ("**Force Majeure Event**");

12.12 **No Liability of County of Orange**. As required under Ordinance No. 3896, as amended, of the County of Orange, State of California, CalOptima and the HMO hereby acknowledge and agree that the obligations of CalOptima under this Contract are solely the obligations of CalOptima, and the County of Orange, State of California, shall have no obligation or liability therefor.

12.13 **Confidential and Proprietary Information**. HMO agrees to maintain confidential the following information (the "**Confidential Information**"): (a) eligibility lists and any other information containing the names, addresses and telephone numbers of CalOptima Enrollees; (b) CalOptima's administrative service manuals and all forms related thereto; (c) the financial arrangements between CalOptima and any Participating Provider; and (d) any other information compiled or created by CalOptima that is proprietary to CalOptima and that CalOptima identifies as proprietary to HMO in writing. HMO shall not disclose or use the Confidential Information for its own benefit or gain either during the Term or after the date of termination of this Contract. HMO may use the Confidential Information to the extent necessary to perform its duties under this Contract or upon express prior written permission of CalOptima. Upon the effective date of termination of this Contract, HMO shall promptly return to CalOptima the Confidential Information in its possession, upon CalOptima's notice.

12.14 **Third Party Beneficiaries**. Nothing in this Contract, express or implied, is intended to or shall confer upon any other person or entity, any right, benefit or remedy of any nature whatsoever.

12.15 **Survival**. The terms set forth in the following sections shall survive the expiration or termination of this Contract, whether with or without cause, by rescission or otherwise, as to all Covered

Services provided under this Contract prior to termination: Sections 6.2, 6.5, 7.8, Article 8, 9.1, 11.10, 11.11, 12.1, 12.2, 12.3, 12.5, 12.6, 12.7, 12.9, 12.10, 12.12, 12.13, 12.14, and any other sections that, by their terms, are intended to survive termination of the Contract.

12.16 **Recitals and Exhibits**. The recitals and exhibits set forth in this Contract are made a part of the Contract by this reference.

12.1 **Without Limitation**. Any reference in the Contract to "include(s)" or "including" means inclusion without limitation, unless otherwise distinguished within the text.

12.2 **Notices**. All notices shall be in writing and shall be deemed to have been duly given on the date of service if personally served on the Party to whom notice is given, or seventy-two (72) hours after mailing by electronic mail transmission, United States priority mail, United States mail first class (Certified Mail or Registered Mail), addressed to the Party to whom notice is to be given and such party's address as set forth below or such other address provided by notice.

To: CalOptima

Attention: Chief Operating Officer
505 City Parkway West
Orange, California 92868

To: HMO

_____

_____

_____

XIII. CONDITIONS PRECEDENT TO CONTRACT COMMENCEMENT

13.1 **Contract Effectiveness**. The Contract is subject to CalOptima's determination, in its sole discretion, that the following conditions have been met prior to the Effective Date: (i) HMO has successfully met all criteria in CalOptima's readiness assessment, including financial viability and delegated function criteria; HMO has signed CalOptima's Business Associate Agreement; and (iii) HMO has furnished all required documentation and data requested by CalOptima (e.g., insurance documents, licenses).

13.2 **Additional CalOptima Regulator Requirements**. CalOptima, in its sole discretion, may condition this Contract upon HMO's ability to meet other criteria imposed by CalOptima Regulators.

XIV. SIGNATURES

SUBJECT TO (I) THE UNITED STATES GOVERNMENT PROVIDING FUNDS FOR THE TERM OF THIS CONTRACT AND FOR THE PURPOSES WITH RESPECT TO WHICH IT IS ENTERED INTO; AND (II) THE APPROVAL OF THIS CONTRACT BY DMHC AND CMS, THIS CONTRACT SHALL BECOME EFFECTIVE ON THE EFFECTIVE DATE AND SHALL TERMINATE ON AS PROVIDED IN THIS CONTRACT.

IN WITNESS WHEREOF, CalOptima and HMO have executed this Contract as indicated below.

FOR HMO:	FOR CALOPTIMA:
_____	_____
SIGNATURE	SIGNATURE
_____	Yunkyung Kim
PRINT NAME	PRINT NAME
_____	Chief Operations Officer
TITLE	TITLE
_____	_____
DATE	DATE

ATTACHMENT A
DEFINITIONS

1. "**Administrative Services**" means those non-clinical, administrative functions that are the responsibility of the HMO as set forth under the Contract and in CalOptima Policies.

2. "**Advance Directive**" means an individual's written directive or instruction, such as a power of attorney for health care or a living will, recognized under state law (whether statutory or as recognized by the courts of the state) for the provision of that individual's health care if the individual is unable to make his or her health care wishes known.

3. "**Appeals**" means an Enrollee's actions, both internal and external to CalOptima, requesting review of the denial, reduction, or termination of benefits or services from CalOptima.

4. "**Authorization/Authorized**" means the approval of CalOptima, or its delegate (which may include HMO), for the provision or referral of Covered Services, obtained in accordance with, and as further described in, the Provider Manual and this Contract.

5. "**Behavioral Health**" means the mental health services and substance use disorder services arranged for or provided to Enrollees by a separate Mental Health Plan, CalOptima, or their subcontractors.

6. "**CalOptima Formulary**" means the CalOptima Approved Drug List, the Disposable Medical Equipment/Supplies List, the CalOptima OneCare Formulary, and any additional formularies as may be designated by CalOptima and provided to CalOptima's designated pharmacy benefits manager "**PBM**". There is no applicable CalOptima Formulary for the PACE program.

7. "**CalOptima Policies**" means CalOptima policies and procedures, including CalOptima's Provider Manual, that are amended from time to time at the sole discretion of CalOptima and incorporated into this Agreement by this reference.

8. "**CalOptima's Regulators**" means those government agencies that regulate and oversee CalOptima's and its FDRs' activities and obligations under this Contract including the Department of Health and Human Services, CMS, and the DMHC and other government agencies that have authority to set standards and oversee the performance of the parties to this Contract, as well as their respective agents and contractors quality improvement organizations.

9. "**Capitation Payment**" means the monthly payment paid to HMO by CalOptima for delivery for Covered Services to Enrollees, which is determined by multiplying the applicable Capitation Rate by HMO's monthly enrollment.

10. "**Capitation Rate**" means the rate set by CalOptima for the delivery of Covered Services to an Enrollee.

11. "**Care Coordinator**" means a clinician or other trained individual employed by or contracted with HMO who is accountable for providing care coordination services for Enrollees, as required by CalOptima Policies and who services on one or more ICTs.

12. "**C.C.R.**" means the California Code of Regulations.

13. "**C.F.R.**" means the Code of Federal Regulations.

14. "**CMS**" means the Center for Medicare & Medicaid Services.

15. "**CMS Contract**" means the agreement between CMS and CalOptima under which CalOptima can establish its MA Program for Enrollees.

16. "**COB**" refers to the coordination of benefits and determination of order of financial responsibility that applies when two or more health benefit plans provide coverage of items and services for an individual.

17. "**Compliance Program**" means the program (including the compliance manual, code of conduct and CalOptima Policies) developed and adopted by CalOptima to promote, monitor, and ensure that CalOptima's operations and practices and the practices of its Board members, employees, contractors, and Providers comply with applicable law and ethical standards. The Compliance Program includes CalOptima's Fraud, Waste and Abuse ("**FWA**") plan.

18. "**Covered Services**" means those health care items, drugs, and services that an Enrollee is entitled to receive pursuant to a Program applicable to that Enrollee. Covered Services must generally be referred and Authorized in confirming with CalOptima's Policies, including its utilization management program."

19. "**Delegation**" means the process by which CalOptima expressly grants, by formal written agreement to another entity, the authority to carry out a function that would otherwise be required to be performed by CalOptima in order to meet its obligations under the CMS Contract.

20. "**Delegation Agreement**" means the formal written agreement by which CalOptima grants to another entity the authority to carry out a function that would otherwise be required to be performed by CalOptima to meet its obligations under the CMS Contract.

21. "**Delegation Criteria**" means those criteria adopted by CalOptima, for the delegation of activities in the areas of UM, medical records audits, the Office Site Review, 'Enrollee's rights and responsibilities, and credentialing, as set forth in CalOptima Policies.

22. "**DMHC**" means the California Department of Managed Health Care.

23. "**Downstream Entity**" means all Providers and other persons or entities with which HMO has entered into a written subcontract (acceptable to CMS) to perform administrative functions and/or health care services to satisfy HMO's obligations to CalOptima under this Contract, continuing down to the ultimate provider of services. The term "HMO" as used in the terms of this Contract shall also include its subcontractors when such subcontractors are Downstream Entities, even if not expressly referenced in the particular provision.

24. "**Emergency Medical Condition**" means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, with an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in: (i) placing the health of the individual (or with respect to a pregnant woman, the health of the woman and her unborn child) in serious jeopardy; or (ii) serious impairment to bodily functions; or (iii) serious dysfunction of any bodily organ or part.

25. "**Emergency Services**" means those covered inpatient and outpatient services that are (i) furnished by a Provider qualified to furnish Emergency Services; and (ii) needed to evaluate and/or stabilize an Enrollee's Emergency Medical Condition.

26. "**Encounter Data**" means the record of an Enrollee receiving any item(s) or service(s) provided through Medicaid or Medicare under a prepaid, capitated, or any other risk basis payment methodology submitted to CMS. The encounter data record shall incorporate HIPAA security, privacy, and transaction standards and be submitted in ASCX12N 837 or any successor format required by CalOptima's Regulators.

27. "**Enrollee**" means an eligible individual who is enrolled in the CalOptima MA Program.

28. "**Evidence of Coverage**" means the document approved by CalOptima's Regulators and issued by CalOptima to Enrollees that describes Enrollee's benefits under the CalOptima MA Program.

29. "**FDR**" means a party that enters into a written agreement (acceptable to CMS) to provide administrative or health care services to CalOptima and/or its Enrollees that are governed by the CMS Contract.

30. "**FQHC**" means an entity that meets all of the requirements for designation as a federally qualified health center under § 1861(aa)(3) of the Social Security Act and is approved for participation in the MA program.

31. "**Grievance**" means an oral or written expression of dissatisfaction, including any compliant, dispute, request for reconsideration, or appeal, made by an Enrollee.

32. "**Health Network**" means HMO, a physician-hospital consortium, or health care service plan (such as an HMO) that is contracted with CalOptima to provide items and services to Enrollees on a capitated basis.

33. "**HMO Physician**" means a Physician who is employed by or under contract with HMO to provide physician services.

34. "**HEDIS**" means the set of standardized performance measures sponsored and maintained by the NCQA.

35. "**HRA**" means the health risk assessment tool that identifies an Enrollee's primary, acute, LTSS, Behavioral Health, and functional needs.

36. "**HIPAA**" means the Health Insurance Portability and Accountability Act of 1996, Public Law 104-191, the Health Information Technology for Economic and Clinical Health Act, Public Law 111-005, and regulations promulgated thereunder by the U.S. Department of Health and Human Services, including Title 45 of the C.F.R, Parts 160 and 164.

37. "**Hospital(s)**" means licensed acute care hospital(s) that have entered into an agreement with CalOptima or HMO to provide services to Enrollees in the CalOptima program and where HMO customarily admits patients.

38. "**ICP**" means the plan of care developed by an Enrollee and/or his/her ICT or CalOptima.

39. "**Indian Enrollee**" means an Enrollee who is an Indian (as defined in the Indian Health Care Improvement Act of 1976 [25 U.S.C. §§ 1603(13), 1603 (13 and 23), or 1679(a)] or who has been determined as an Indian under 42 C.F.R. § 136.12.

40. "**Indian Health Care Provider**" means a health care program operated by the Indian Health Services or by an Indian Tribe, Tribal Organization, or Urban Indian Organization, as those terms are defined in Section 4 of the Indian Health Care Improvement Act (25 U.S.C. § 1603).

41. "**ICT**" means an interdisciplinary care team comprised of the primary care provider and Care Coordinator and other Providers at the discretion of the Enrollee that work with the Enrollee to develop, implement, and maintain the ICP.

42. "**Laws**" means any local, State, or federal statute, regulation, rule, or executive or agency order applicable to this Contract.

43. "**LTSS**" means the range of long-term services and supports that help Enrollees meet their daily needs for assistance and improve the quality of their lives and which include: (i) In-Home Supportive Services ("**IHSS**"); (ii) Community-Based Adult Services ("**CBAS**"); (iii) Multi-purpose Senior Services Program ("**MSSP**") services; and (iv) skilled nursing facility services and sub-acute care services.

44. "**Medically Necessary**" or "**Medical Necessity**" means when addressing Covered Services: (i) under Medicare, reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member, or otherwise medically necessary under 42 U.S.C. Section 1395y.

45. "**Medical Record**" means any record kept or required to be kept by any Provider that documents medical services received by the Enrollee, including inpatient, outpatient, emergency care, referral requests, and Authorizations in accordance with applicable laws including Title 28 C.C.R. § 1300.80(b), Title 42 U.S.C. § 1396a(w), 42 C.F.R. § 456.111 and 42 C.F.R. § 456.211 and CalOptima Policies.

46. "**Mental Health Plan**" means the entity that has contracted with DHCS to provide Specialty Mental Health Services to individuals, including Enrollees.

47. "**Model of Care**" means the component of CalOptima's quality improvement framework that is evidence-based, includes certain clinical and non-clinical elements, and is in addition to the comprehensive care coordination requirements specified in CalOptima Policies.

48. "**Non-Covered Services**" means those services that are not benefits under the CalOptima MA Program in accordance with CalOptima's Evidence of Coverage and applicable state and federal laws and regulations.

49. "**Non-Participating Provider**" means an institution, professional, or other Provider of health care services who has not entered into an agreement, either with CalOptima or HMO, to provide medical and other services to Enrollees.

50. "**Out-of-Area**" means that area that is outside the Service Area.

51. "**Outpatient Mental Health Services**" means outpatient services that are provided to Enrollees with mild to moderate mental health conditions including: (i) individual/group mental health evaluation and treatment (psychotherapy); (ii) psychological testing when clinically indicated to evaluate a mental health condition; (iii) outpatient services for the purpose of monitoring drug therapy; (iv) psychiatric consultation for mediation management; and (v) outpatient laboratory supplies and supplements.

52. "**Participating Provider**" means an institution, professional, or other provider of health care services who has entered into an agreement, either with CalOptima or HMO, to provide health care services to Enrollees.

53. "**PCC**" means the personal care coordinator(s) employed by HMO to comply with the CalOptima MOC Program.

54. "**PCC Component to the Model of Care Profile**" means the PCC Components identified in the Model of Care Profile.

55. **"Physician"** means a person with an unrestricted license to practice medicine or osteopathy in the state in which they practice.

56. "**Physician Direct Referral**" means the process whereby a PCP has the authority the decide whether a referral is deemed necessary for an Enrollee and if deemed necessary the PCP will directly refer that Enrollee within said HMO to any of the specialties or services specified in CalOptima Policies without requiring the prior Authorization of HMO.

57. "**Post-Stabilization Care Services**" means services related to an Emergency Medical Condition that are provided after an Enrollee is Stabilized in order to maintain the Stabilized condition, or under some circumstances, to improve or resolve the condition.

58. "**Preclusion List**" means the CMS-compiled list of providers and prescribers who are precluded from receiving payment for MA items and services or Part D drugs furnished or prescribed to Medicare beneficiaries.

59. "**PCP**" means a primary care physician responsible for supervising, coordinating, and providing initial and primary care to Enrollees; for serving as the medical home; for processing initial referrals for Specialist Physician care; and for maintaining the continuity of patient care.

60. "**Program**" is health care benefit program offered by CalOptima to Enrollees. Programs and their designs are subject to change periodically.

61. "**Provider**" means a physician, nurse, nurse mid-wife, nurse practitioner, medical technician, physician assistant, hospital, laboratory, health maintenance organization ("**HMO**"), or other person or institution who furnishes health care items or services.

62. "**Provider Manual**" means that comprehensive online document, as amended from time to time, and describes CalOptima's Policies and procedures affecting HMO Physicians' services under this Contract.

63. "**Referral**" means the process by which the Participating Provider Physician directs an Enrollee to seek and obtain Covered Services from a health professional or for care at a facility.

64. "**Rural Health Clinic (RHC)**" means an entity that meets all of the requirements for designation as a rural health clinic under § 1861(aa)(1) of the Social Security Act and is approved for participation in the MA program.

65. "**Service Area**" means the geographic area within Orange County, California.

66. "**Shared Risk Services**" will mean those Covered Services that are the financial responsibility under the Hospital Budget, as set forth in Attachment B.

67. "**Specialist Physician**" means any physician who is not a PCP, has the requisite training and education, and meets all other requirements set by CalOptima Policies for specialists.

68. "**Stabilize**" or "**Stabilized**" means, with respect to an Emergency Medical Condition, to provide such medical treatment of the condition to assure within reasonable medical probability that no material deterioration of the condition is likely to result or occur during the transfer of the individual from a facility, or in the case of a pregnant woman, that the woman has delivered the child and placenta.

69. "**Threshold Language"** means those languages as determined by CalOptima's Regulators from time to time and identified in guidance on translation requirements provided to CalOptima.

70. "**Urgent Care**" means services required to prevent serious deterioration of health following the onset of an unforeseen condition or injury and are medical services required promptly to prevent impairment of health due to symptoms that do not constitute an Emergency Medical Condition but that are the result of an unforeseen illness, injury or condition for which medical services are immediately required.

ATTACHMENT B
CALOPTIMA SENIOR PLAN
MATRIX OF FINANCIAL RESPONSIBILITY
January 1, 2023

HMO	RESPONSIBLE PARTY		
SERVICES	**GROUP**	**HOSPITAL**	**PLAN**
Medicare Part A Services – Not Otherwise Assigned Herein or in Any Agreement Incorporating This Exhibit:			
Inpatient		**X**	
Outpatient		**X**	
Medicare Part B Services Not Otherwise Assigned Herein or in Any Agreement Incorporating This Exhibit	**X**		
Some of the main services and those related to the Risk Sharing Program are listed below:			
Acupuncture (Medicare covered)	**X**		
Allergy			
Testing and Treatment	**X**		
Serum	**X**		
Ambulance – Air and Ground			
Emergency		**X**	
Inter-facility Transfers (all vehicle types)		**X**	
Amniocentesis			
Facility Component			
Outpatient (if not provided in physician office setting)		**X**	
Professional Component	**X**		
Audiologic			
Diagnostic	**X**		
Biofeedback	**X**		
Blood & Blood Products/Blood Transfusions (including professional component)			
Autologous Blood Donation		**X**	
From Blood Bank		**X**	
Cataract Surgery			
Professional Component	**X**		
Facility Component (Hospital Based Outpatient – Including Implanted Lenses)		**X**	
Facility Component (Ambulatory Surgery Center – Including Implanted Lenses)		**X**	

SERVICES	GROUP	HOSPITAL	PLAN
Chemical Dependency Rehabilitation and Detox (Medicare Covered)			
Professional Component	**X**		
Facility Component		**X**	
Methadone outpatient clinics			**X**
Chemotherapy			
Drugs – Outpatient (Part B)		**X**	
Drugs – Outpatient (Part D)			**Rx**
Professional Component	**X**		
Facility Component		**X**	
Chiropractic (Medicare covered)	**X**		
Dental Services (Medical)			
Professional Component	**X**		
Facility Component		**X**	
Facility Component (Non-Hospital) Based	**X**		
Diabetic Supplies			
Insulin and syringes (Rx Benefit)-see Medication-Outpatient Prescription Drug Benefit			**Rx**
Home Glucose Monitoring Equipment and Supplies)	**X**		
Diagnostic Testing			
Technical Component (Outpatient)	**X**		
Professional Component	**X**		
Durable Medical Equipment (DME)			
Outpatient	**X**		
Emergency Room			
Facility Component		**X**	
Professional Component (including interpretive reports)	**X**		
Endoscopy			
Facility Component		**X**	
Professional Component	**X**		
Family Planning			
Therapeutic Abortion Services, Tubal Ligation, Vasectomy, etc.			
Facility Component		**X**	
Professional Component	**X**		
Fetal Monitoring			
Facility Component		**X**	

SERVICES	GROUP	HOSPITAL	PLAN
Professional Component	X		
Genetic Testing/Counseling	X		
Health Education	X		
Hemodialysis/Dialysis			
Outpatient (Includes drugs per Medicare guidelines)		X	
Professional Component	X		
Home Health Care			
Medicare covered home health services (Including home IV therapy, excluding Part D drugs)		X	
Home Health Supplies (see medical supplies)		X	
Hospice	**Medicare FFS has primary responsibility**		
Hospitalization			
Facility Component (Including pre-admission diagnostic services)		X	
Interpretive Reports	X		
Professional Component (Including hospital-based physicians)	X		
Immunization and Inoculations (Part B)	X		
Immunization and Inoculations (Part D)			**Rx**
Infusion Therapy			
Professional Component	X		
Facility Component		X	
Part B drugs		X	
Part D drugs			**Rx**
Injectables -- (Outpatient) (see also Chemotherapy)			
Part B drugs		X	
Part D drugs			**Rx**
Lithotripsy			
Professional Component	X		
Facility Component		X	
Mammography	X		
Maternity/Obstetrics			
Facility Component		X	
Professional Component	X		
Medical supplies (includes catheters)			

SERVICES	GROUP	HOSPITAL	PLAN
Outpatient	X		
Medication			
Outpatient – Prescription Drug Benefit (Part D)			**Rx**
Outpatient medications (Part B)		X	
Mental Health			
Facility Component (includes Partial Hospitalization)		X	
Professional Component			X
Nuclear Medicine			
Inpatient, Facility Component (therapeutic)		X	
Outpatient, Facility Component	X		
Professional Component	X		
Nutrition			
Nutritional/Dietetic Counseling (Medicare Covered)	X		
Parenteral Nutrients, Supplies, Kits and Pumps			
Part B		X	
Part D			X
Enteral Nutrients, Supplies, Kits and Pumps			
Outpatient			X
Organ Transplants			
Pre Evaluation (All Inclusive)	X		
Organ Acquisition		X	**Medicare FFS for Kidney only**
Transplant Professional Component	X		
Transplant Facility Component (includes organ acquisition)		X	
Post Transplant (up to one year for transplant related services)			
Professional Component	X		
Post Transplant Facility Component (Inpatient)		X	
Post Transplant Facility Component (Outpatient – if provided in physician office setting)	X		
Orthotics and Prosthetics (Medicare Covered)			
Outpatient (Medicare defined coverage applies)		X	
Ostomy Supplies			
Outpatient	X		

SERVICES	GROUP	HOSPITAL	PLAN
Out of Area (Emergent and Urgently Needed Services)			
Facility Component		X	
Professional Component	X		
Outpatient Diagnostic Tests and Services (All Inclusive)	X		
Outpatient Surgery			
Facility Component (Hospital Based)		X	
Facility Component (Freestanding Ambulatory Surgery Center)		X	
Professional Component	X		
Cardiac catheterization and Angiograms (Professional)	X		
Cardiac catheterization and Angiograms (Facility)		X	
Physical Therapy (See Rehabilitation)			
Pain Management			
Professional	X		
Facility (if provided in other than physician office setting)		X	
Physician Visits/Consultations (inclusive of all settings)	X		
Podiatry Services (Medicare covered)	X		
Radiation Therapy			
Professional	X		
Facility, outpatient facility		X	
Radiology Services			
Outpatient, Preoperative, and Inpatient Professional Component	X		
Inpatient (facility component)		X	
Rehabilitation (Short Term e.g.: PT, OT, Speech, Cardiac)			
Outpatient Facility Component	X		
Professional Component	X		
Skilled Nursing Facility (SNF)			
Facility Component (All Inclusive)		X	
Professional Component	X		
Social Services – Medical	X		
Surgically Implanted Devices – All Categories		X	
Vision Care			
Annual routine exam			X
Glasses			X
Lenses and Frames incidental to cataract surgery (Medicare covered)	X		
Screening, Physician Office	X		

SERVICES	GROUP	HOSPITAL	PLAN
Notes:			
1. Financial responsibility is based on Medicare benefit interpretations and limitations.			
2. The symbol "Rx" denotes outpatient prescription drug services.			
Assignment of financial responsibility as outlined in this document is independent of the questions of medical necessity, coverage or benefits.			

ATTACHMENT C
CAPITATION RATES AND RISK SHARING

1. **Capitation Allocation**

1.1 **Allocation of Non-Part D CMS Revenue**. Each month, CalOptima shall allocate both the non-Part D related capitation that CalOptima receives from CMS for Enrollees affiliated with HMO and any applicable premiums that CalOptima charges Enrollees affiliated with HMO (collectively, the "**Total Revenues**") as follows:

Facility and Other Services ("**Hospital Budget**")	xx.x%
Physician Group Capitation Fees	xx.x%
Total paid to HMO	xx.x%

1.2 **MLR**. In accordance with Section 2.3, "Medical Loss Ratio", of the Contract, HMO shall maintain a minimum acceptable loss ratio of eighty-five percent (85%). Should HMO not meet the minimum eighty-five percent (85%) MLR, CalOptima reserves the right to require HMO to return to CalOptima the difference between eighty-five percent (85%) of Capitation Payments and the allowed medical expenses.

1.3 **Personal Care Coordinator**.

1.3.1 In addition to the amounts described above, and contingent on CalOptima Board of Directors' approval, CalOptima will pay HMO, ____dollars and ____cents ($xx.xx), a per Enrollee, per month amount for PCCs. The commencement date, amount, and duration of such PCC capitation payments, if any, will be established by the action of the CalOptima Board of Directors, and will be deemed incorporated herein by reference. Such payments, if any, may be adjusted in accordance with the PCC Reference Manual and are subject to recovery, termination, or offset as provided in this Contract and in the PCC Reference Manual.

1.3.2 HMO acknowledges and agrees that CalOptima may adjust and/or terminate the PCC Capitation Payments in the event HMO fails to comply with the requirements outlined in the PCC component of the model of care (MOC) profile. HMO acknowledges and agrees that CalOptima, in its sole and absolute discretion, may also offset HMO's future PCC Capitation Payments in the event CalOptima determines that HMO has not complied with the requirements set forth in the PCC component of the MOC Profile.

1.4 **Sequestration**. If CMS reduces payment to CalOptima under the CMS Contract by more than two percent (2%) at any time during the Term, CalOptima may, upon written notice to HMO, reduce payment to HMO under this Attachment C by the same percentage that CMS reduced payment to CalOptima. This provision applies each time CMS reduces payment to CalOptima by more than two percent (2%) during the Term.

1.5 **Pay-for-Performance Program**. CalOptima will develop a pay-for performance program to provide incentive payments to HMO. Payments will be calculated and paid quarterly and annually based on a per Enrollee, per month rate and reflect achievement of specified program goals, which are determined by CalOptima in its sole discretion.

ATTACHMENT D
CLAIMS PROCESSING AND COMPLIANCE OBLIGATIONS

XV. DEFINITIONS

15.1 "**Clean Claim**" means one that can be processed without obtaining additional information from the provider of the service or from a third party. Clean claim shall have the same meaning as "complete claim" as that term is defined in Title 28, CCR Section 1300.71(a)(2). Clean Claim does not include a claim from a Provider who is under investigation for fraud or abuse, or a claim under review for Medical Necessity.

15.2 "**Unclean Claim**" means any claim other than as defined in Section 1.1 of this attachment.

15.3 "**Denied Claim**" means a claim where (a) one or more services will not be paid by HMO and (b) payment is the responsibility of the Enrollee. Examples of claims that are not denials and should not be reported, submitted, or presented to CalOptima as Denied Claims include claims:

15.3.1 For patients who remain enrolled with CalOptima but have transferred to another HMO and HMO is forwarding the claim,

15.3.2 For which payment responsibility belongs to another contracting entity, and HMO is forwarding the claim,

15.3.3 That are duplicates,

15.3.4 That are encounter only/capitated claims and no patient liability is involved, and

15.3.5 That involve reduced payment amounts due to contract terms or allowed Medicare fee schedules.

XVI. GENERAL TERMS

16.1 **HMO Claims Processing**. HMO shall process claims for Provider services according to all CMS requirements and, as applicable, in accordance with the requirements of the Knox-Keene Act. This Attachment D is intended to comply with all DMHC and CMS standards and requirements. Should this Attachment D be out of compliance with any existing or newly enacted DMHC or CMS standard or requirement, the DMHC and/or CMS standard or requirement will supersede this Attachment D. CalOptima will communicate any changes in requirements to HMO in writing.

16.2 If HMO enters into a contract with a Downstream Entity whereby the responsibility for claims processing is delegated to that Downstream Entity, Attachment D provisions shall apply. HMO will have contractual provisions to ensure such Downstream Entity conforms to all DMHC and CMS requirements and oversight provisions as outlined herein and in CalOptima Policies.

16.3 HMO and any applicable Downstream Entity shall be required to have an oversight program for claims processing that includes written policies and procedures, a process for reporting fraudulent or unethical conduct, and an executive accountable for review of claims data and attesting to its accuracy. The oversight program shall include internal auditing of claims functions, and self-reporting as outlined in CalOptima Policies.

XVII. CLAIMS PROCESSING

17.1 **Timely Provider Payments**.

17.1.1 HMO and Downstream Entities, if, and as applicable, must make timely payments to Participating Providers consistent with 42 CFR § 447.45.

17.1.2 HMO shall reimburse Clean Claims, or any portion of any Clean Claim, for Covered Services, as soon as practical, but no later than thirty (30) calendar days after receipt of the claim by HMO, unless the claim or portion thereof is reasonably contested, in which case the claimant shall be notified in writing that the claim is contested or denied within forty-five (45) business days after receipt of the claim by HMO in accordance with CalOptima Policies.

17.1.3 HMO must ensure that ninety percent (90%) of claims from Providers who are in individual or group practice, which can be processed without obtaining additional information from the Provider or from a third party, will be paid within thirty (30) days of the date of receipt of the claim.

17.1.4 HMO must ensure that ninety-nine percent (99%) of all Clean Claims from Providers for Covered Services will be paid within ninety (90) days of the date of receipt of the claim.

17.1.5 Generally, the date of receipt is the date the HMO receives the claim, as indicated by its date stamp on the claim. The date of payment is the date of the check or other form of payment.

3.1.6 **"30-Day" Claim Timeliness**. HMO shall adjudicate nine-five percent (95%) of all Clean Claims from Non-Participating Providers or suppliers within thirty (30) calendar days of receiving the claim. Adjudicate a claim shall be deemed to mean to have processed the claim (paid or denied) and mailed the remittance advice by the thirtieth (30^{th}) calendar day since the earliest receipt by HMO or CalOptima's contracting Providers or Hospitals.

17.1.7 **"60-Day" Claim Timeliness**. HMO shall pay or deny Unclean Claims from Non-Participating Providers or suppliers, claims from Participating Providers or suppliers, and claims from Medicare fiscal intermediaries and carriers within sixty (60) calendar days of receipt of such claims. Processing shall be deemed to mean either to have paid or denied and mailed the remittance advice by the sixtieth (60^{th}) calendar day since the earliest receipt by HMO or CalOptima's contracting Providers or Hospitals, or to have denied the claim, and have mailed the denial letter to the Enrollee by the sixtieth (60^{th}) day. In accordance with federal law and CMS regulations, failure to process such claims within sixty (60) calendar days of receipt automatically constitutes an "adverse" initial determination, which the Enrollee may appeal; thus, a denial notice must be mailed to the Enrollee.

17.1.8 **Payment Accuracy**. When paying Non-Participating Providers, HMO shall employ only those Medicare fee schedules that MA plans are allowed to use by law and shall comply with 42 CFR § 422.214.

17.1.9 **Denied Claims**. Decisions to deny claims that result in liability for the Enrollee must be made in accordance with CMS guidelines. Whenever such decisions are made, the currently CMS approved Notice of Denial of Payment or Integrated Denial Notice must be used, including approved denial reasons. Under no circumstances shall HMO deny a claim for the second time as a consequence of responding to a request for reconsideration from an Enrollee; instead, HMO must direct the Enrollee to submit the request directly to

CalOptima as appropriate.

17.2 **Claims for Emergency and Post-Stabilization Services.**

17.2.1 HMO shall not retroactively deny a claim for Emergency Services because the condition, which appeared to be an Emergency Medical Condition, turned out to be non-emergency in nature. HMO shall ensure that its claims processing actions do not conflict with Hospital actions required to comply with the Emergency Medical Treatment and Active Labor Act ("**EMTALA**").

17.2.2 If there is a disagreement between HMO or any Participating Provider and any Non-Participating Provider regarding Medically Necessity of Covered Services in an emergency, the judgment of the attending physician(s) actually caring for the Enrollee at the treating facility shall prevail. HMO may establish relationships with treating facility whereby the HMO may send a Participating Provider with privileges to assume the attending physician's responsibilities to establish treatment or may arrange to have a Participating Provider under contract with HMO agree to accept the transfer of the Enrollee after the Enrollee has been Stabilized.

3.2.3 HMO shall ensure that an enrollee with an Emergency Medical Condition will be seen on an emergency basis and that Emergency Services will be available and accessible within the Service Area twenty-four (24) hours a day. HMO shall cover Emergency Services without prior Authorization pursuant to Title 28 CCR Section 1300.67(g), Title 22 CCR Section 53216, and Section 1932(b)(2) of the Social Security Act. HMO shall coordinate access to Emergency Services in accordance with 42 CFR § 438.114 and the HMO's emergency department protocol.

3.2.4 HMO may not refuse to cover Emergency Services based on the emergency room Provider, Hospital, or fiscal agent not notifying the Enrollee's PCP managed care organization, prepaid ambulatory health plan, prepaid inpatient health plan or applicable State entity of the Enrollee's screening and treatment within ten (10) calendar days of presentation for Emergency Services. An Enrollee who has an Emergency Medical Condition may not be held liable for payment of subsequent screening and treatment needed to diagnose the specific condition or Stabilize the Enrollee.

3.2.5 HMO may not deny payment for treatment obtained under either of the following circumstances: an Enrollee had an Emergency Medical Condition, including cases in which the absence of immediate medical attention would not have had the outcomes specified in the definition of an Emergency Medical Condition; or the HMO representative instructs the Enrollee to seek Emergency Services. The attending emergency Physician, or the Provider actually treating the Enrollee, is responsible for determining when the Enrollee is sufficiently Stabilized for transfer or discharge, and that determination is binding on the entities as responsible for coverage and payment.

3.2.6 HMO must cover and pay for Post-Stabilization Care Services. HMO is financially responsible for Post-Stabilization Care Services obtained within or outside the organization that are pre-approved by a HMO Provider or other HMO representative. HMO is financially responsible for Post-Stabilization Care Services obtained within or outside the HMO organization that are not pre-approved by a Participating Provider or other HMO representative, but are administered to maintain the Enrollee's Stabilized condition within one (1) hour of a request to the HMO for pre-approval of further Post-Stabilization Care

Services. HMO is financially responsible for Post-Stabilization Care Services obtained from within or outside the HMO that are not pre-approved by a Participating Provider or other HMO representative, but administered to maintain, improve, or resolve the Enrollee's Stabilized condition if the HMO: does not respond to a request for pre-approval within one (1) hour; cannot be contacted; or the HMO representative and the treating physician cannot reach an agreement concerning the Enrollee's care and a Participating Provider is not available for consultation. In this situation, the HMO must give the treating Physician the opportunity to consult with a Participating Provider and the treating Physician may continue with care of the Enrollee until a Participating Provider is reached or one criteria in 42 C.F.R. § 113(c)(3) is met. HMO must limit charges to Enrollees for Post-Stabilization Care Services to an amount no greater than what the HMO would charge the Enrollee if he or she had obtained the services through HMO. HMO financial responsibility for Post-Stabilization Care Services it has not pre-approved ends when: a Participating Provider with privileges at the treating Hospital assumes responsibility for the Enrollee's care; a Participating Provider assumes responsibility for the Enrollee's care through transfer; HMO representative and the treating Physician reach an agreement concerning the Enrollee's care; or; the Enrollee is discharged.

17.2.7 HMO shall reimburse those Physicians providing Emergency Services and Urgent Care services with whom HMO has a contract according to the terms of that contract.

17.2.8 HMO must reimburse a Non-Participating Provider for Emergency Services or Urgent Care services at the prevailing Medicare fee-for-service ("**FFS**") rate as applicable for that service. Where the Covered Service would traditionally be covered under Medicare FFS, the Medicare FFS rate applies. HMO shall ensure that Enrollees maintain balance billing protections as provided in Section 6.4 of this Contract.

3.2.9 In accordance with CalOptima Policies, HMO shall implement the CMS Quality Payment Program known as the Merit-based Incentive Payment System ("**MIPS**"). MIPS adjustments for Part B covered professional services furnished by MIPS-eligible Providers that are not contracted with HMO shall be administered in the same manner as any other changes in the applicable Medicare payment schedules. HMO shall make positive and negative payment adjustments as identified by CMS based on the CMS MIPS adjustment data files.

3.2.9.1 CalOptima or HMO may apply MIPS payment adjustments either at the time the payment is made during the applicable MIPS payment year or as a retrospective adjustment to paid claims.

3.2.9.2 CalOptima or HMO are required to demonstrate payment through reporting or attestation by the end of March on an annual basis.

17.3 **HMO Financial Responsibility**. If CalOptima receives a claim for Covered Services that are the financial responsibility of HMO, CalOptima shall forward such claim to HMO for payment, in accordance with the procedures set forth in Title 28 CCR Section 1300.71, "Claims Settlement Practices." CalOptima shall not pay for services that are HMO's financial responsibility unless HMO fails to make payment within the time allowed by State and federal laws and regulations, and CalOptima is required by law to make such payment. In such cases, CalOptima, after written notice to HMO and reasonable opportunity to cure, will make payment, and HMO shall reimburse CalOptima for such payments. If HMO fails to reimburse CalOptima, CalOptima may offset an

uncontested payment(s) against Capitation Payments or other amounts due from CalOptima to HMO, if any.

17.4 **Collection of Share of Cost**. HMO shall collect Medicare share of cost unless prohibited under this Contract.

17.5 **Capitation Payments**. HMO and/or Downstream Entities shall distribute monthly Capitation Payments to capitated Participating Providers within fifteen (15) calendar days following the date on which Physician receives payment from CalOptima.

17.6 **Claims Adjudication**. Except as provided in Section 3.1.1, HMO shall accept and adjudicate claims for Covered Services provided to Enrollees in accordance with the provisions of Sections 1371, 1371.1, 1371.2, 1371.22, 1371.35, 1371.36, 1371.37, 1371.38, 1371.4 and 1371.8 of the California Health & Safety Code, and Sections 1300.71, 1300.71.38, 1300.71.4, and 1300.77.4 of Title 28 of the CCR and CalOptima Policies. Waiver of any right or obligation specific to the Health and Safety Code and Title 28 related to claims processing and payment shall be prohibited.

17.7 **Dispute Resolution.** HMO shall establish and maintain a fair, fast and cost-effective dispute resolution mechanism to process and resolve provider disputes in accordance with the provisions of Sections 1371, 1371.1, 1371.2, 1371.22, 1371.35, 1371.36, 1371.37, 1371.38, 1371.4 and 1371.8 of the California Health & Safety Code, and Sections 1300.71, 1300.71.38, 1300.71.4, and 1300.77.4 of Title 28 of the CCR and CalOptima Policies.

17.8 **Right of Appeal**. HMO shall afford Providers an unconditional right of appeal and de novo review for claims disputes involving issues of Medical Necessity. Any Provider that submits a claim dispute to HMO's dispute resolution mechanism involving an issue of Medical Necessity or utilization review shall have an unconditional right of appeal for that claim dispute to CalOptima's dispute resolution process for a de novo review and resolution for a period of sixty (60) working days from Physician's Date of Determination.

17.9 **CalOptima Payment On Behalf Of Physician**. If CalOptima receives a copy of an unpaid Clean Claim as part of a Provider grievance that is thirty (30) working days old or more, CalOptima will follow all notification and acknowledgement procedures pursuant to CalOptima Policies. If HMO does not either notify CalOptima that the claim is reasonably contested, as set forth in CalOptima Policies, or pay the Clean Claim within the thirty (30) working day period, CalOptima shall pay the Claim on behalf of Physician, plus interest, as required by the Knox-Keene Act, and deduct the amounts reimbursed, plus processing costs, from the Capitation Payment, in accordance with CalOptima Policies.

17.10 **Quarterly Claims Payment Performance Report.**

17.10.1 HMO shall submit, in a format specified by CalOptima Policies, a quarterly claims payment performance report ("**Quarterly Claims Report**") to CalOptima within thirty (30) calendar days of the close of each calendar quarter. The Quarterly Claims Report shall, at a minimum, disclose HMO's compliance status with Sections 1371, 1371.1, 1371.2, 1371.22, 1371.35, 1371.36, 1371.37, 1371.4, and 1371.8 of the California Health and Safety Code and Sections 1300.71, 1300.71.38, 1300.71.4 and 1300.77.4 of Title 28 of the CCR.

17.10.2 HMO shall ensure that each Quarterly Claims Report is signed by, and includes the written verification of, a principal officer, as defined by Section 1300.45(o) of Title 28 of the CCR,

of HMO, stating that the report is true and correct to the best knowledge and belief of the principal officer.

17.10.3 HMO's Quarterly Claims Report shall include a tabulated record of each Provider dispute it received, categorized by date of receipt, and including the identification of the Provider, type of dispute, disposition and working days to resolution, as to each Provider dispute received. Each individual dispute contained in a Provider's bundled notice of Provider dispute shall be reported as a separate dispute to CalOptima.

17.11 **Forwarding of Misdirected Claims.**

17.11.1 HMO shall have the ability to receive a standard ANSI 837I and ANSI 837P claim file format for retrieving misrouted claims that are the financial responsibility of the HMO. HMO will receive and forward misdirected claims per CalOptima Policy.

17.11.2 HMO shall have the ability to create a standard ANSI 837I and ANSI 837P claim file for forwarding claims that are the financial responsibility of CalOptima within ten (10) working days of receipt of the claim. CalOptima shall receive these files per CalOptima policy and load them into its system to ensure timely claims processing. HMO shall forward any claims that are not its payment responsibility to CalOptima within eight (8) calendar days of receipt, so that a total of only ten (10) working days will elapse prior to the claims being in the proper hands.

17.12 **Assumption of Delegated Functions**. In the event that HMO fails to timely and accurately reimburse its claims (including the payment of interest and penalties), CalOptima may, at its sole discretion, revoke the delegation and assume responsibility from HMO for claims payment, or terminate this Contract as provided for in Article XI. CalOptima's assumption of responsibility for the processing and timely reimbursement of Provider claims may be altered to the extent that HMO has established an approved CAP consistent with Section 1375.4 (b)(4) of the Health and Safety Code and Section 11.3 of the Contract.

17.13 **Recoupment for Assumption of Claims Processing Obligations**. CalOptima, in its sole and absolute discretion, may reduce HMO's Capitation Payments to recoup additional administrative costs for the assumption of the claims processing obligations of HMO, as described in this Article III of Attachment D, as well as any amounts, including interest due, on claims unpaid at the assumption of such obligations by CalOptima.

XVIII. CLAIMS COMPLIANCE

18.1 **Claims Compliance Monitoring**. HMO understands that claims compliance programs are required by CalOptima's Regulators and agrees that delegation is contingent upon HMO's compliance with required monitoring and oversight activities, as outlined in CalOptima Policies. HMO agrees that CalOptima reserves the right to monitor HMO's claims compliance activities, notwithstanding any other audit, compliance, or contractual issue between HMO and CalOptima. In the event HMO demonstrates an inability to meet CalOptima's claims payment standards, CalOptima reserves the right to revoke and assume the delegated responsibilities described above.

18.2 **Claims Non-Compliance**. In the event that CalOptima determines that HMO is not in ninety-five percent (95%) compliance with any of the requirements of Attachment D the following actions will be applied:

18.2.1 Within thirty (30) days of an audit that documents non-compliance, CalOptima will issue a written warning to HMO that describes the non-compliance. HMO will respond within fifteen (15) working days of receiving the non-compliance notification with a written CAP to comply. Such CAP will describe the actions to be taken and the schedule by which those actions will be completed. CalOptima will review the CAP and advise HMO whether or not actions or time schedules are acceptable within fifteen (15) days of receiving it. CalOptima will conduct a follow-up audit of HMO's claims operation within ninety (90) days from the date of serving the non-compliance notification to verify compliance with Attachment D. If CalOptima does not receive a CAP within fifteen (15) calendar days, the consequences outlined in Subsection 4.2.2 of this attachment for continued non-compliance will apply.

18.2.2 If, as a result of CalOptima's follow-up audit, HMO is found to still be non-compliant with Attachment D within fifteen (15) calendar days of making that determination, CalOptima will notify HMO in writing of the continued non-compliance and may elect to provide consultative or other assistance to help establish, maintain and monitor continued administrative compliance or assume "joint administration" of HMO's claims operations, involving itself only with Enrollees' claims and allowing the operation to remain on HMO's premises. The Parties agree to meet and develop a mutually agreeable work plan for added staffing and work stations, the cost of which will be HMO's sole responsibility. CalOptima will develop a CAP with HMO's participation to assure maximum compatibility with HMO's ongoing operations. CalOptima will cooperate with HMO in implementing changes across all risk claims processed at that site, should HMO so request. Within fifteen (15) calendar days of receiving the second notice of non-compliance, HMO will provide a written response stating the specific action to be taken to establish compliance with the help of CalOptima. If CalOptima does not receive a CAP within fifteen (15) calendar days, the consequences outlined in Subsection 4.2.3 for continued non-compliance will apply. Within ninety (90) days from the date of serving the second notice of non-compliance, CalOptima will re-audit HMO's claims process and documents to determine final compliance or non-compliance.

18.2.3 If, as a result of its second follow-up audit, CalOptima reasonably determines that HMO is still non-compliant, CalOptima reserves the right to terminate this Contract for material breach upon ten (10) days' prior written notice and opportunity to cure.

18.2.4 HMO may resume sole administrative responsibility for claims processing if CalOptima determines that HMO has corrected the deficiencies that caused the non-compliance, and, as a result of resuming responsibility for claims processing, demonstrates compliance with the timely provider payments requirements set forth in Section 3.1 of this Attachment D.

18.2.5 With respect to the requirements of Attachment D, HMO will be subject to regular site-audits conducted by CalOptima to monitor all claims requirements.

V. CLAIMS FORWARDING

HMO shall forward any claims that are not its payment responsibility to CalOptima within ten (10) calendar days of receipt.

VI. SELF-MONITORING & REPORTING

HMO shall develop, implement and demonstrate upon request, a claims quality assurance process, including regular, scheduled, automated, or manual reports, self-testing procedures, and internal reporting to HMO's executive management of timeliness, payment accuracy, and denial accuracy (as required herein). Such self-monitoring and internal reporting shall involve use of industry standard tools and shall measure actual performance against the standards for DMHC and CMS compliance. CalOptima strongly recommends check issuance and mailing occur not less frequently than weekly and that HMO's internal reporting intervals match the intervals at which checks are issued, except that weekly reporting would be sufficient if checks are issued more often than weekly. At a point early in the beginning of operations under the Contract and in accordance with industry-wide CMS requirements, CalOptima will require that HMO submit monthly reports to CalOptima using the industry-standard Monthly Report of Claims Processing Timeliness and Overall Percent of Denial Accuracy format. Those reports must be received by CalOptima not later than the fifteenth (15th) calendar day of each month.

VII. AUDITS & AUDIT PREPARATION

Article IV, above, provides detailed, specific processes involving claims non-compliance. Even when HMO does meet compliance standards and successfully concludes any time periods where denials must be submitted to CalOptima for review, CalOptima will continue to schedule (1) periodic audits, (2) random, focused audits, and (3) focused reviews based on appeals and grievance results to monitor HMO's compliance with CMS regulations. Prior to the scheduled arrival of CalOptima's auditor, HMO shall retrieve claims and related documents in accordance with instructions provided to HMO by CalOptima in its letter confirming the appointment.

VIII. SPECIAL STUDIES

8.1 In the event DMHC and/or CMS requires that CalOptima conduct any special compliance study or effort, HMO shall support the study and will be subject to any DMHC and/or CMS specified time schedules or deadlines for corrective actions.

IX. FEDERALLY QUALIFIED HEALTH CENTERS AND RURAL HEALTH CLINICS

9.1 HMO shall meet federal requirements for access to FQHC services, including those in 42 U.S.C. § 1396 b(m). HMO shall reimburse FQHCs and RHCs in accordance with current Laws. If FQHC and RHCs services are not available in the Provider network, HMO shall authorize out-of-network services subject to the prevailing MA payment requirements for out-of-network services.

9.2 HMO shall ensure that its payments to FQHCs and RHCs for services to Enrollees are no less than the sum of the level and amount of payment that the Health Network or CalOptima would make for such services if the services had been furnished by an entity providing similar services that was not an FQHC and RHC. The intent of these provisions is to ensure that HMO pays FQHCs and RHCs amounts consistent with Medicare managed care policies while preserving the opportunity for FQHCs to separately claim supplemental payments under such policies.

X. INDIAN HEALTH CARE PROVIDERS

10.1 HMO shall pay non-network Indian Health Care Providers that are FQHCs for the provision of services to an Indian Enrollee at a rate equal to the rate that HMO would pay to a network FQHC that is not an Indian Health Care Provider, including any supplemental payment from the State to make up the difference between the contract amount and what the Indian Health Care Provider would have received FFS.

10.2 When the amount the Participating Provider Indian Health Care Provider receives from the HMO is less than the amount the Indian Health Care Providers would receive FFS, the State must make a supplemental payment to the Indian Health Care Provider that the Indian Health Care Provider would receive FFS or the applicable encounter rate.

10.3 HMO shall not impose enrollment fees, premiums, or similar charges on Indians served by an Indian Health Care Provider or through referral under contract health services. HMO must exempt from all cost-sharing any Indian who is currently receiving or has ever received an item or service furnished by an Indian Health Care Provider or through referral under contract health services.

10.4 HMO shall reimburse Indian Health Care Providers promptly who provide Covered Services to Indian Enrollees, who are eligible to receive Covered Services, at the most current and applicable outpatient per-visit rate published in the Federal Register by the Indian Health Service, and HMO shall ensure any retroactive outpatient per visit rates are appropriately reimbursed to the Indian Health Care Provider.

ATTACHMENT E
STATUTORY AND REGULATORY COMPLIANCE TERMS

1. **Compliance with State and Federal Laws**. HMO acknowledges that CalOptima is subject to certain State and federal laws, regulations, and instructions governing its MA Program. HMO shall comply with all Laws and DMHC and CMS administrative bulletins, plan letters and instructions. HMO understands that payments made by CalOptima are, in whole or in part, derived from federal funds, and therefore HMO and any Downstream Entities are subject to certain laws that are applicable to individuals and entities receiving federal funds, including the following: (i) Title VI of the Civil Rights Act of 1964; (ii) Sections 503 and 504 of the Rehabilitation Act of 1973; (iii) the Age Discrimination Act of 1975; (iv) the Americans with Disabilities Act of 1990; (v) the Vietnam Era Veteran's Readjustment Assistance Act; and (vi) Title IX of the Education Amendments of 1972. Any provision required to be in this Contract by the CMS Contract, the Knox-Keene Act, Title 28 of the California Code of Regulations, Medicare laws and regulations, DMHC or CMS instructions and reporting requirements and other applicable laws, shall bind CalOptima, HMO, and Downstream Entities, whether or not specifically set forth in this Contract.

2. **Compliance with CalOptima's Contractual Obligations**. All services and other activities furnished by HMO and Downstream Entities must be performed in accordance with CalOptima's contractual obligations to CMS.

3. **Compliance with FWA Requirements**. HMO, and its employees, agents and Downstream Entities performing services under this Contract, shall comply with CalOptima's Compliance Program including, its FWA plan. Prior to performing services under this Contract, HMO shall complete and submit to CalOptima, any CMS-required training and/or CalOptima-required attestations related to such training and other compliance obligations. HMO agrees to comply and will have any Downstream Entity agree to comply with CalOptima standards and policies.

4. **Fraud and Abuse Reporting**. HMO shall, in accordance with all Laws, report to CalOptima all cases of suspected fraud and/or abuse relating to the rendering of Covered Services within five (5) days of the date when HMO first becomes aware of or is on notice of such activity.

5. **CMS Participation Requirements**. HMO represents and warrants that: (i) neither HMO nor any of its HMO Physician, employees or agents furnishing services under this Contract are excluded from participating in any federal or state healthcare program as defined in 42 U.S.C. Section 1320a-7b(f) ("**Federal Health Care Program(s)**"); (ii) HMO has not arranged or contracted (by employment or otherwise) with any employee, contractor or agent that HMO knows or should know are excluded or precluded from participation in Federal Health Care Programs; (iii) no action is pending against HMO or any of its HMO Physicians, employees, or agents performing services under this Contract to suspend or exclude such persons or entities from participation in any Federal Health Care Program; and (iv) HMO will immediately notify CalOptima if it learns that it is or has employed or contracted with a person or entity that is excluded from participation in any Federal Health Care Program. If HMO fails to comply with this Section 5 of this attachment, CalOptima reserves the right to require HMO to pay immediately to CalOptima the amount of any sanctions or other penalties that may be imposed on CalOptima by CMS for violation of this prohibition, and HMO shall be responsible for any resulting overpayments. HMO shall not make payment for a healthcare item or service furnished by an individual or entity that is excluded by the Office of the Inspector General or is included on the Preclusion List. HMO shall provide written notice to the Enrollee who received the services and the excluded Provider or Provider listed on the Preclusion List that payment will not be made, in accordance with CMS requirements. HMO shall ensure that

all Participating Providers that provide Covered Services do not appear on the CMS Preclusion List in order to receive reimbursement for claims or otherwise participate in the Medicare program.

6. **Confidentiality of Enrollee Information**. HMO, its Downstream Entities, and their employees and agents shall comply with the specific confidentiality obligations set forth below.

6.1 HMO, Downstream Entities, and their employees and agents 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 them as a result of services performed under this Contract, except for statistical information not identifying any such person. HMO, Downstream Entities, and their employees and agents shall not use such identifying information for any purpose other than carrying out HMO's obligations under this Contract.

6.2 HMO, Downstream Entities, and their employees and agents shall promptly transmit to CalOptima all requests for disclosure of such identifying information not emanating from the Enrollee. HMO shall not disclose, except as otherwise specifically permitted by this Contract or authorized by the Enrollee, any such identifying information to anyone other than CMS, DMHC, 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.

6.3 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*., Welfare and Institutions Code Section 14100.2, and regulations adopted thereunder. For the purpose of this Contract, all information, records, data, and data elements collected and maintained for the operation of the Contract and pertaining to Enrollees shall be protected by HMO from unauthorized disclosure. HMO may release Medical Records in accordance with Laws pertaining to the release of this type of information. HMO is not required to report requests for Medical Records made in accordance with Laws.

6.4 With respect to any identifiable information concerning an Enrollee under this Contract that is obtained by HMO or its Downstream Entities from CalOptima's Regulators, HMO will, at the termination of this Contract, return all such information to CalOptima's Regulators if required by them, or maintain such information according to written procedures provided to HMO by CalOptima and/or CalOptima's Regulators for this purpose.

7. **Offshore Subcontracts**. HMO shall provide, and ensure that Downstream Entities provide, to CalOptima information and attestations related to the provision of any services under this Contract in a country other than the United States ("**Offshore Subcontractor**") to enable CalOptima to comply with CMS reporting obligations. Such information shall be submitted to CalOptima prior to engaging any Offshore Subcontractor for purposes of this Contract, and such Offshore Subcontractors are subject to approval by CalOptima.

8. **Required Disclosures**. In accordance with 42 CFR Section 1002.3, HMO shall immediately notify CalOptima in the event any sanctioned person (as defined in 42 CFR Section 1001.1001(a)(1)) owns or controls HMO.

9. **Equal Opportunity**. HMO and Downstream Entities shall comply with the following Equal Opportunity requirements set forth below.

9.1 HMO and its Downstream Entities 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. HMO and its Downstream Entities will take affirmative action to ensure that qualified applicants are employed, and that employees are treated during employment, without regard to their race, color, religion, sex, national origin, physical or mental handicap, disability, age, or status as a disabled veteran or veteran of the Vietnam era. Such action shall include the following: Employment, upgrading, demotion or transfer; recruitment or recruitment advertising; layoff or termination; rates of pay or other forms of compensation; and career development opportunities and selection for training, including apprenticeship. Physician and its Downstream Entities agree to post in conspicuous places, available to employees and applicants for employment, notices to be provided by the federal government, 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 HMO and its Downstream Entities' 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.

9.2 HMO and its Downstream Entities will, in all solicitations or advancements for employees placed by or on behalf of HMO and its Downstream Entities, 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.

9.3 HMO and its Downstream Entities will send to each labor union or representative of workers with which it has a collective bargaining agreement or other contract or understanding a notice, to be provided by the federal government or the State, advising the labor union or workers' representative of HMO and its Downstream Entities' commitments under the provisions herein and shall post copies of the notice in conspicuous places available to employees and applicants for employment.

9.4 HMO and its Downstream Entities 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.

9.5 HMO and its Downstream Entities 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 HMO 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.

9.6 In the event of HMO and its Downstream Entities' noncompliance with the requirements of the provisions herein or with any federal rules, regulations, or orders which are referenced in this Article IX, this Contract may be cancelled, terminated, or suspended in whole or in part, and HMO and its Downstream Entities may be declared ineligible for further State and Federal 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.

9.7 HMO and its Downstream Entities will include the provisions of Sections 10.1 through 10.7 of this attachment 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. Section 4212) of the Vietnam Era Veteran's Readjustment Assistance Act, so that such provisions will be binding upon each Downstream Entity. Physician and its Downstream Entities will take such action with respect to any subcontract or purchase order as the Director of the Office of Federal Contract Compliance Programs or CMS may direct as a means of enforcing such provisions, including sanctions for noncompliance; provided, however, that in the event HMO and/or its Downstream Entities become involved in, or are threatened with litigation by a other Downstream Entity or vendor as a result of such direction by CMS, HMO and its Downstream Entities may request in writing to CMS, 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.

10. **Non-Discrimination**. HMO and Downstream Entities shall comply with the non-discrimination requirements set forth below.

10.1 During the performance of this Contract, neither HMO nor any Downstream Entities shall unlawfully discriminate, harass, or allow harassment against any employee or applicant for employment because of sex, race, religion, color, national origin, ancestry, religious creed, physical disability, (including Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS), AIDS-Related Complex (ARC)), medical condition (including cancer), mental disability, marital status, age (over 40), or the use of family and medical care leave and pregnancy disability leave. HMO and Downstream Entities shall insure that the evaluation and treatment of their employees and applicants for employment are free of such discrimination and harassment. HMO and Downstream Entities shall comply with the provisions of the Fair Employment and Housing Act (Government Code, Section 12900, *et seq*.) and the applicable regulations promulgated thereunder (Title 2 CCR Section 7285.0, *et seq*.). The applicable regulations of the Fair

Employment and Housing Commission implementing Government Code, Section 12990, set forth in Chapter 5 of Division 4 of Title 2 of the CCR are incorporated into this Contract by reference and made a part hereof as if set forth in full. HMO and Downstream Entities shall give written notice of their obligations under this clause to labor organizations with which they have a collective bargaining or other agreement. HMO shall include the non-discrimination and compliance provisions of this Section 10.1 in all Downstream Entity subcontracts to perform work under this Contract.

10.2 HMO and all Downstream Entities shall abide by 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 1972 (regarding education programs and activities); Title 45 CFR Part 91 and the Age Discrimination Act of 1975 (discrimination based on age); and all other laws regarding privacy and confidentiality. Neither the Physician nor Downstream Entities shall discriminate against Enrollees because of race, color, creed, religion, ancestry, marital status, sexual orientation, national origin, age, sex, or physical or mental handicap in accordance with Title VI of the Civil Rights Act of 1964, 42 U.S.C., Section 2000d (race, color, national origin); 45 CFR Part 84 (physical or mental handicap); Government Code Section 11135 (ethnic group identification, religion, age, sex, color, physical or mental handicap); Civil Code Section 51 (all types of arbitrary discrimination); rules and regulations promulgated pursuant thereto, or as otherwise provided by Laws.

10.3 For the purpose of this Contract, if based on any of the foregoing criteria, the following constitute unlawful discriminations: (i) denying any Enrollee any Covered Services or availability of a facility; (ii) providing to an Enrollee any Covered Service that is different or is provided in a different manner or at a different time from that provided to other similarly situated Enrollees under this Contract, except where medically indicated; (iii) subjecting an Enrollee to segregation or separate treatment in any manner related to the receipt of any Covered Service; (iv) restricting an Enrollee in any way in the enjoyment of any advantage or privilege enjoyed by others receiving any Covered Service; or (v) treating an Enrollee differently from others similarly situated in determining compliance with admission, enrollment, quota, eligibility, or other requirements or conditions that individuals shall meet in order to be provided any Covered Service or assigning the times or places for the provision of Covered Services.

10.4 HMO shall take affirmative action to ensure that all Enrollees are provided Covered Services without unlawful discrimination, except where medically indicated. For the purposes of this Section 10.4, physical handicap includes the carrying of a gene that may, under some circumstances, be associated with disability in that person's offspring, but which causes no adverse effects on the carrier. Such genetic handicap shall include, but not be limited to, Tay-Sachs trait, sickle cell trait, thalassemia trait, and X-linked hemophilia.

10.5 Physician shall act upon all complaints alleging discrimination against Enrollees in accordance with CalOptima's Policies and shall forward copies of all such grievances to CalOptima within five (5) days of receipt of same.

11. **Smoke Free Workplace**. Public Law 103-227, also known as the Pro Children Act of 1994 ("**Pro Children Act**"), requires that smoking not be permitted in any portion of any indoor facility owned

or leased or contracted for by an entity and used routinely or regularly for the provision of health, day care, early childhood development services, education, or library services to children under the age of 18, if the services are funded by federal programs either directly or through state or local governments, by federal grant, contract, loan, or loan guarantee. The law also applies to children's services that are provided in indoor facilities that are constructed, operated, or maintained with such federal funds. The law does not apply to children's services provided in private residences; portions of facilities used for inpatient drug or alcohol treatment; service providers whose sole source of applicable federal funds is Medicare or Medicaid; or facilities where WIC coupons are redeemed. Failure to comply with the provisions of the law may result in the imposition of a civil monetary penalty of up to $1,000 for each violation and/or the imposition of an administrative compliance order on the responsible party. By signing this Contract, HMO certifies that it will comply with the requirements of the Pro Children Act and will not allow smoking within any portion of any indoor facility used for the provision of services for children as defined by the Pro Children Act. Physician further agrees that it will insert this certification into any subcontracts entered into that provide for children's services as described in the Pro Children Act.

12. **Air or Water Pollution Requirements**. Any federally funded agreement and/or subcontract in excess of $100,000 must comply with the following provisions unless said agreement is exempt under 40 CFR 15.5. HMO 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.

13. **Lobbying Restrictions and Disclosure Certification**. Any federally funded contracts in excess of $100,000 per Section 1352 of the 31, U.S.C. must comply with the following lobby restrictions and disclosures.

13.1 Each person (or recipient) who requests or receives a contract, subcontract, grant, or sub-grant, which is subject to 31 U.S.C. Section 1352 and which exceeds $100,000 at any tier, shall file a certification (in the form set forth in **Attachment E-1**, consisting of one page, entitled "Certification Regarding Lobbying") that the recipient has not made, and will not make, any payment prohibited by Subsection 13.6 of this attachment.

13.2 Each recipient shall file a disclosure (in the form set forth in **Attachment E-2**, entitled "Standard Form-LLL 'Disclosure of Lobbying Activities'") if such recipient has made or has agreed to make any payment using non-appropriated 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 Section 13.6 of this attachment if paid for with appropriated funds.

13.3 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 Section 13.2 of this attachment. An event that materially affects the accuracy of the information reported includes: (i) 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; (ii) a change in the person(s) or individuals(s) influencing or attempting to influence a covered federal action; or (iii) 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.

13.4 Each person (or recipient) who requests or receives, from a person referred to in Section 13.1 of this attachment, a contract, subcontract, grant or sub-grant 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.

13.5 All disclosure forms (but not certifications) shall be forwarded from tier to tier until received by the person referred to in Section 13.1 of this attachment.

13.6 31 U.S.C. Section 1352 provides in part that no appropriated funds may be expended by the recipient of a federal contract, grant, loan, or cooperative agreement to pay any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with any of the following covered federal actions: the awarding of any federal contract, the making of any federal grant, the making of any federal loan, entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any federal contract, grant, loan, or cooperative agreement.

14. **Debarment Certification**. HMO agrees to comply with applicable Federal suspension and debarment regulations including 7 CFR § 3017, 45 CFR §76, 40 CFR § 32, or 34 CFR § 85.

14.1 HMO certifies to the best of its knowledge and belief, that it and its principals:

(i) Are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded by any Federal department or agency;

(ii) Have not within a three (3)-year period preceding this Contract have been convicted of or had a civil judgment rendered against them for commission of fraud or a criminal offense in connection with obtaining, attempting to obtain, or performing a public (Federal, State or local) transaction or contract under a public transaction; violation of Federal or State antitrust statutes or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, or receiving stolen property;

(iii) Are not presently indicted for or otherwise criminally or civilly charged by a governmental entity (federal, State or local) with commission of any of the offenses enumerated in sub-provision (ii) herein;

(iv) Have not within a three (3)-year period preceding this Contract had one or more public transactions (Federal, State or local) terminated for cause or default;

(v) Shall not knowingly enter into any lower tier covered transaction with a person who is proposed for debarment under Federal regulations (i.e., 48 CFR 9, subpart 9.4), debarred, suspended, declared ineligible, or voluntarily excluded from participation in such transaction, unless authorized by the State; and

(vi) Will include a clause entitled, "Debarment and Suspension Certification'' that essentially sets forth the provisions herein, in all lower tier covered transactions and in all solicitations for lower tier covered transactions.

14.2 If HMO is unable to certify to any of the statements in this certification, the Physician shall submit an explanation to CalOptima.

14.3 The terms and definitions in this Section 14 have the meanings set out in the Definitions and Coverage sections of the rules implementing Federal Executive Order 12549.

14.4 If HMO knowingly violates this certification, in addition to other remedies available to the federal government, CalOptima may terminate this Contract for cause or default.

15. **Downstream Entity Contracts**. If any services under this Contract are to be provided by a Downstream Entity subcontracted by HMO, HMO shall ensure that such subcontracts comply with 42 CFR Sections 422.504, 423.505 and 438.6(l). Such subcontracts shall include all language required by CMS as provided in Attachment F**.**

16. **Other Statutory and Compliance Terms**. HMO shall not contract with, or otherwise pay for any items or services (other than an emergency item or service, not including items or services furnished in an emergency room of a Hospital):

16.1 Furnished by HMO by any individual or entity during any period when the individual or entity is excluded from participation under Titles V, XVIII, or XX, or under Title XIX pursuant to sections 1128, 1128A, 1156 or 1842(j)(2);

16.2 Furnished at the medical direction or the prescription of a physician, during the period when such physician is excluded from participation under Titles V, XVIII, or XX, or under Title XIX pursuant to sections 1128, 1128A, 1156, or 1842(j)(2) and when the person furnishing such item or service knew, or had some reason to know, of the exclusion (after a reasonable time period and after reasonable notice has been furnished to the person);

16.3 Furnished by an individual or entity to whom the State has suspended payments to during any period when there is a pending investigation of a credible allegation of fraud against the individual or entity, unless the State determines there is good cause not to suspend such payments;

16.4 HMO may not pay for an item or service with respect to any amount expended for which funds may not be used under the Assisted Suicide Funding Restriction Act of 1997

ATTACHMENT E-1
CERTIFICATION REGARDING LOBBYING

STATE OF CALIFORNIA
DEPARTMENT OF HEALTH CARE SERVICES
CERTIFICATIN 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 HMO	Printed Name of Person Signing for HMO
Contract / Grant Number	Signature of Person Signing for HMO
Date	Title

After execution by or on behalf of HMO, please return to:

CalOptima
Attn: Regulatory Affairs
505 City Parkway West
Orange, California 92868

ATTACHMENT E-2

CERTIFICATION REGARDING LOBBYING

Approved by OMB

Complete this form to disclose lobbying activities pursuant to 31 U.S.C. 1352
0348-0046 (See reverse for public burden disclosure)

<table>
<tr><td>1. Type of Federal Action:
contract
grant
cooperative agreement loan
loan guarantee
loan insurance</td><td colspan="2">2. Status of Federal Action:
bid/offer/application initial
award post-award</td><td>3. Report Type:
initial filing
material change

For Material Change Only:
Year _____ quarter_____
date of last report</td></tr>
<tr><td colspan="2">4. Name and Address of Reporting Entity:
Prime Subawardee Tier, if known:</td><td colspan="2" rowspan="2">5. If Reporting Entity in No. 4 is Subawardee,
Enter Name and Address of Prime:

Congressional District, If known:</td></tr>
<tr><td colspan="2">Congressional District, If known:</td></tr>
<tr><td colspan="2">6. Federal Department/Agency:</td><td colspan="2">Federal Program Name/Description:
CDFA Number, if applicable:</td></tr>
<tr><td colspan="2">8. Federal Action Number, if known:</td><td colspan="2">9. Award Amount, if known:</td></tr>
<tr><td colspan="2">10. a. Name and Address of Lobbying Entity
(If individual, last name, first name, MI):
(attach Continuation Sheets(s)</td><td colspan="2">b. Name and Address of Lobbying Entity
(If individual, last name, first name, MI):
SF-LLL-A, If necessary)</td></tr>
<tr><td colspan="2">Amount of Payment (check all that apply):
$ actual planned</td><td colspan="2" rowspan="3">13. Type of Payment (check all that apply):
a. retainer
b. one-time fee
c. commission
d. contingent fee
e. deferred
f. other, specify:</td></tr>
<tr><td colspan="2">Form of Payment (check all that apply):
a. cash
b. in-kind, specify: Nature</td></tr>
<tr><td colspan="2">Value</td></tr>
</table>

14. Brief Description of Services Performed or to be Performed and Dates(s) of Service, including Officer(s), Employee(s), or Member(s) Contracted for Payment indicated in item 11: (Attach Continuation Sheet(s) SF-LLL-A, If necessary)	
15. Continuation Sheet(s) SF-LLL-A Attached: Yes No	
16. Information requested through this form is authorized by Title 31, U.S.C., Section 1352. This disclosure of lobbying activities is a material representation of fact upon which reliance was placed by the tier above when this transaction was made or entered into. This disclosure is required pursuant to Title 31, U.S.C., Section 1352. This information will be reported to the Congress semiannually and will be available for public inspection. Any person who fails to file the required disclosure shall be subject to a civil penalty of not less than $19,000 and not more than $100,000 for each such failure.	Signature: Print Name: Title: Telephone No.: Date:
Federal Use Only	

INSTRUCTIONS FOR COMPLETION OF SF-LLL, DISCLOSURE OF LOBBYING ACTIVITIES

This disclosure form shall be completed by the reporting entity, whether subawardee or prime federal recipients at the initiation or receipt of a covered federal action, or a material change to a previous filing, pursuant to Title 31, U.S.C., Section 1352. The filing of a form is required for each payment or agreement to make payment to any lobbying entity for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with a covered federal action. Use the SF-LLL-A Continuation Sheet for additional information if the space on the form is inadequate. Complete all items that apply for both the initial filing and material change report. Refer to the implementing guidance published by the Office of Management and Budget for additional information.

Identify the type of covered federal action for which lobbying activity is and/or has been secured to influence the outcome of a covered federal action.

Identify the status of the covered federal action.

Identify the appropriate classification of this report. If this is a follow-up report caused by a material change to the information previously reported, enter the year and quarter in which the change occurred. Enter the date of the last previously submitted report by this reporting entity for this covered federal action.

Enter the full name, address, city, state, and ZIP code of the reporting entity. Include Congressional District, if known. Check the appropriate classification of the reporting entity that designates if it is, or expects to be, a prime or subaward recipient. Identify the tier of the subawardee, e.g., the first subawardee of the prime is the 1st tier. Subawards include but are not limited to subcontracts, subgrants, and contract awards under grants.

If the organization filing the report in Item 4 checks "Subawardee," then enter the full name, address, city, state, and ZIP code of the prime federal recipient. Include Congressional District, if known.

Enter the name of the federal agency making the award or loan commitment. Include at least one organizational level below agency name, if known. For example, Department of Transportation United States Coast Guard.

Enter the federal program name or description for the covered federal action (Item 1). If known, enter the full Catalog of Federal Domestic Assistance (CDFA) number for grants, cooperative agreements, loans, and loan commitments.

Enter the most appropriate federal identifying number available for the federal action identified in Item 1 (e.g., Request for Proposal (RFP) number; Invitation for Bid (IFB) number; grant announcement number; the contract grant, or loan award number; the application/proposal control number assigned by the federal agency). Include prefixes, e.g., "RFP-DE-90401."

For a covered federal action where there has been an award or loan commitment by the federal agency, enter the federal amount of the award/loan commitment for the prime entity identified in Item 4 or 5.

10. (a) Enter the full name, address, city, state, and ZIP code of the lobbying entity engaged by the reporting entity identified in Item 4 to influence the covered federal action.

10. (b) Enter the full names of the Individual(s) performing services and include full address if different from 10.(a). Enter last name, first name, and middle initial (MI).

Enter the amount of compensation paid or reasonably expected to be paid by the reporting entity (Item 4) to the lobbying entity (Item 10). Indicate whether the payment has been made (actual) or will be made (planned). Check all boxes that apply. If this is a material change report, enter the cumulative amount of payment made or planned to be made.

Check the appropriate box(es). Check all boxes that apply. If payment is made through an in-kind contribution, specify the nature and value of the in-kind payment.

Check the appropriate box(es). Check all boxes that apply. If other, specify nature.

Provide a specific and detailed description of the services that the lobbyist has performed, or will be expected to perform, and the date(s) of any services rendered. Include all preparatory and related activity, not just time spent in actual contact with federal officials, identify the federal official(s) or employee(s) contacted or the officer(s), employee(s), or Member(s) of Congress that were contacted.

Check whether or not a SF-LLL-A Continuation Sheet(s) is attached.

The certifying official shall sign and date the form, print his/her name, title, and telephone number.

Public reporting burden for this collection of information is estimated to average 30 minutes per response, including time for reviewing instruction, searching existing data sources, gathering and maintaining the data needed, and completing and renewing the collection of information. Send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to the Office of Management and Budget, Paperwork Reduction Project, (0348-0046), Washington, DC 20503.

ATTACHMENT F
SUBCONTRACT REGULATORY TERMS

A. **General Terms**: Language addressing the following matters shall be included in Downstream subcontracts:

1. The right of CalOptima's Regulators to monitor, audit, evaluate, inspect and have access to books, records and other information as provided in this Contract.
2. CalOptima's Regulators' right to inspect, evaluate, and audit any pertinent information related to the Contract for a period of ten (10) years from the final date of the contract period or from the date of completion of any audit as provided in this Contract.
3. Prohibitions against holding Enrollees liable for payment of any fees that are the obligation of CalOptima or the HMO, as applicable.
4. The services are in accordance with CalOptima's obligations to CMS and applicable CalOptima Policies.
5. The obligations of Downstream Entities to protect Enrollee privacy and confidentiality including health records, as provided in this Contract.
6. The obligation to comply with all federal and state laws, regulations and CMS instructions, including those laws that must be incorporated into such Downstream subcontracts as indicated in this Contract.
7. Language related to the obligations to submit timely and accurate Encounter Data and other data and reports required by CalOptima and CalOptima's Regulators as provided in this Contract and in CalOptima's Policies.
8. All requirements included in Attachment E not expressly addressed herein.

B. **Delegation Terms**. If, and to the extent that sub-delegation is permitted by CalOptima and HMO obtains CalOptima's approval as provided in this Contract, Downstream Entity subcontracts must include:

1. Language that specifies (i) the delegated activities and reporting requirements; (ii) that provides for revocation of the delegated activities and other remedies in the event CalOptima or CalOptima's Regulators find that the delegated party as not performed satisfactorily; (iii) that the performance of the parties is monitored by CalOptima on an ongoing basis; and (iv) that CalOptima may impose corrective action as necessary.
2. If the subcontract relates to credentialing of medical providers, language that the credentials of medical professionals affiliated with the party or parties will either be reviewed by CalOptima or the credential process will be reviewed and approved by CalOptima and that CalOptima must audit the process on an ongoing basis.
3. If the subcontract delegates selection of providers it must include language that CalOptima retains the right to approve, suspend or terminate any such arrangement and that CalOptima shall provide a written statement to a provider of the reason or reasons for the termination with cause.

C. **Medical Provider Downstream Subcontract Terms**.

All subcontracts or arrangements with medical providers shall include provisions addressing:

1. The term of the contract, including the beginning and ending dates as well as methods of extension, renegotiation and termination and full disclosure of the method and amount of compensation or other consideration.

2. The obligation to pay contracted medical providers under the terms of the contract and prompt payment provision, the terms of which are developed and agreed to by the parties.

3. The obligations to provide services in a culturally competent manner to all Enrollees, including those with limited English proficiency or reading skills, and diverse culturally and ethnic background and provide interpreter services for Enrollees at all provider sites.

4. The obligation to (i) abide by all federal and state laws and regulations regarding confidentiality and disclosure of medical records, or other health and enrollment information; (ii) to ensure that medical information is released in accordance with applicable federal or state law, or pursuant to court orders or subpoenas; (iii) to maintain Enrollee records and information in an accurate and timely manner; and (iv) to ensure timely access by Enrollees to the records and information that pertain to them.

5. The obligation to hold CalOptima, CalOptima's Regulators and Enrollees harmless in the event that HMO cannot or will not pay for services performed by the Downstream Entity and for Medicare Part A and B cost sharing. Specifically, Medicare Parts A and B services must be provided at zero cost-sharing to Enrollees.

6. Medical providers' EMTALA obligations and that they must not create any conflicts with hospital actions required to comply with EMTALA.

7. Language prohibiting providers, including PCPs, from closing or otherwise limiting their acceptance of Enrollees as patients unless the same limitations apply to all commercially insured Enrollees.

8. Language that prohibits the Downstream Entity from refusing to contract or pay an otherwise eligible health care Provider for the provision of Covered Services solely because such Provider has in good faith: (a) Communicated with or advocated on behalf of one or more of his or her prospective, current or former patients regarding the provisions, terms or requirements of the 'Downstream Entity's health benefit plans as they relate to the needs of such Provider's patients; or (b) communicated with one or more of his or her prospective, current or former patients with respect to the method by which such Provider is compensated by the Downstream Entity for services provided to the patient.

9. Language that states the Provider is not required to indemnify the HMO for any expenses and liabilities, including judgments, settlements, attorneys' fees, court costs and any associated charges, incurred in connection with any claim or action brought against the HMO based on its management decisions, utilization review provisions or other policies, guidelines or actions.

10. The obligation of the medical provider to assist CalOptima in the transfer of care, including in the transfer of care in the event of sub-subcontract termination for any reason.

11. Acknowledgement that assignment or delegation of the subcontract will be void unless prior written approval is obtained from CMS and CalOptima.

12. 'The Provider's right to submit a grievance and a description of the formal process to resolve the Provider's grievances.

13. The obligation to participate and cooperate in HMO's Quality Improvement System.

14. Language addressing requirements related to payment of Non-Participating Provider emergency and post-stabilization services.

ATTACHMENT G
CMS SPECIFIC PROGRAM PERFORMANCE REQUIREMENTS

1. HCC Coding Requirements and Performance Improvement Activities

1.1 CMS pays CalOptima health-based capitation to compensate CalOptima for services rendered to Enrollees. CMS utilizes encounter data to assign Hierarchical Condition Categories ("**HCC**") to Enrollees. The Enrollee's HCC determines the payment amount received by CalOptima accounting for the variation in expenditures for Medicare Enrollees based on an Enrollee's health status.

1.2 HMO shall submit Enrollee-specific accurate encounter and service data. Encounters are to be submitted no less than monthly using the ANSI 837P and/or 837I format version 5010 as appropriate, or current format as required by CalOptima.

1.3 HMO shall support and aid CalOptima's review of encounters, including to production and/or access of supporting medical records.

1.4 To enhance encounter submission accuracy and completeness, CalOptima has initiated performance improvement activities ("**PIAs**"). These PIAs include Enrollee medical and behavioral health assessments provided in the home or a residential facility.

1.5 HMO has the option to perform these PIAs provided HMO can demonstrate that HMO's PIAs meet all CalOptima standards and guidelines. Should HMO not perform the PIAs or HMO's PIAs not meet CalOptima standards and guidelines as determined by CalOptima, CalOptima shall perform these activities on behalf of HMO and the cost for these PIAs shall be charged to or shared with HMO. CalOptima will provide sixty (60) days' notification prior to taking any such action.

2. ESRD Waiver Responsibilities

2.1 HMO shall demonstrate to CalOptima that HMO administers a CalOptima-approved complex case management program for all End Stage Renal Disease (ESRD) Enrollees, which is in accordance with CMS requirements and CalOptima Policies and standards.

2.2 CalOptima shall advise HMO if its ESRD complex case management program does not meet CMS requirements and CalOptima Policies and clinical standards. If HMO cannot meet requirements as provided by CalOptima, CalOptima shall have the option to de-delegate the HMO for the management of ESRD Enrollees and retain a portion of the Capitation Payment for ESRD Enrollees commensurate with the costs for providing or outsourcing such services.

2.3 CalOptima shall provide notification to HMO of the intent to de-delegate. HMO shall have the opportunity to submit a corrective action plan to CalOptima in accordance with CalOptima policy.

3. Appeals Rights

HMO may appeal CalOptima's decision to take the actions outlined above, by filing a complaint pursuant to CalOptima Policies. If HMO is dissatisfied with the result of any appeal; it shall proceed in accordance with CalOptima's legal claims and judicial review policy.

MEDICARE ADVANTAGE – PHYSICIAN GROUP SERVICES CONTRACT

BETWEEN

ORANGE COUNTY HEALTH AUTHORITY DBA CALOPTIMA

AND

_____

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MEDICARE ADVANTAGE PHYSICIAN GROUP SERVICES CONTRACT

This Medicare Advantage Physician Group Services Contract ("**Contract**") is January 1, 2023 ("**Effective Date**") by and between Orange County Health Authority, a public agency dba CalOptima ("**CalOptima**"), and _____ ("**Physician Group**"), a California professional medical corporation organized under the laws of the State of California. CalOptima and Physician Group may each be referred to herein as a "**Party**" and collectively as the "**Parties**".

RECITALS

A. CalOptima is a County Organized Health System ("**COHS**") organized under Welfare & Institutions Section 14087.54 and Orange County Ordinance No. 3896.

B. CalOptima is licensed as a health care service plan by the California Department of Managed Health Care ("**DMHC**") under the Knox-Keene Health Care Service Plan Act of 1975 and its implementing regulations (collectively the "**Knox-Keene Act**") and authorized to offer a Medicare Advantage ("**MA**") plan pursuant to Title 42 of the United States Code, Chapter 7, Subchapter XVIII, Part C and its implementing regulations for individuals covered under the federal Medicare program.

C. CalOptima, as a dual–eligible special needs plan ("**DSNP**"), may only enroll those dual eligible individuals who meet all applicable Medicare Advantage eligibility requirements, and who are eligible to be enrolled in CalOptima's Medi-Cal Managed Care plan, as described in the contract between CalOptima and the California Department of Health Care Services ("**DHCS**").

D. Physician Group is a duly licensed California professional medical corporation that employs or has entered into contracts with physicians who are licensed to practice medicine in the State of California ("**State**"), and other Providers who are appropriately licensed in the State.

E. CalOptima and Physician Group desire to enter into the Contract whereby Physician Group will perform delegated administrative services and furnish health care items and services as described herein to certain Enrollees enrolled in CalOptima's MA plan.

F. Unless defined elsewhere in the Contract, the defined terms used in this Contract shall have the meanings set forth in Attachment A.

NOW, THEREFORE, in consideration of the promises and the mutual covenants herein stated, it is agreed by and between the Parties as follows:

I. PHYSICIAN GROUP SERVICE OBLIGATIONS

1.1 **Covered Services**. Physician Group shall provide Covered Services to Enrollees selecting, and assigned to, Physician Group in accordance with all provisions of this Contract and CalOptima Policies. The Covered Services that are to be provided by and are the financial responsibility of Physician Group are described in Attachment B. Physician Group specifically agrees to accept financial risk and responsibility for injectables pursuant to Health & Safety Code Section 1375.8.

1.1.1 Physician Group shall provide Covered Services: (i) in the same manner, in accordance with the same standards, and within the same time availability as offered to non-CalOptima

patients; (ii) in accordance with professionally recognized standards of practice, (iii) in a culturally competent manner to all Enrollees, including those with limited English proficiency or reading skills and from diverse cultural and ethnic backgrounds; and (iv) not discriminate in the provision of such Covered Services because of an Enrollee's race, ethnicity, color, national origin, religion, sex, sexual orientation, age, medical or claims history, mental or physical disability, genetic information, or source of payment.

1.1.2 Physician Group is prohibited from closing or otherwise limiting its acceptance of Enrollees as patients unless the same limitations apply to all of its commercially insured patients.

1.1.3 Physician Group shall use its best efforts, where consistent with sound medical practice, to ensure that Covered Services are provided only by Group Physicians and/or other Participating Providers, except in cases of Emergency Services or Urgent Care Services, or if no such Group Physician or Participating Provider is available to perform the appropriate Covered Services.

1.1.4 Physician Group shall be liable for the provision and payment of all Covered Services notwithstanding a delay in payment of the Capitation Payment.

1.1.5 Physician Group acknowledges that the determination of whether a service or supply was/is a Covered Service delegated to Physician Group rests with CalOptima, subject to the Evidence of Coverage and Appeals procedures established by the DMHC and CMS.

1.1.6 CalOptima may incorporate any change in Covered Services mandated by Laws into the Contract effective the date the change goes into effect. Whenever possible, CalOptima shall give the Physician Group thirty (30) calendar days' prior notice of any such change to the Contract. CalOptima shall determine the effective date of the change in Covered Services. Attachment B shall not be amended during the current Term without mutual consent of the Parties, except as may be required for continued compliance with Laws.

1.1.7 Decisions concerning whether to provide or authorize Covered Services under this Contract shall be based solely on Medical Necessity. Physician Group shall not deny Authorization for a Covered Service that the Enrollee or the Provider demonstrates is Medically Necessary. The actual provision of any Covered Service is subject to the professional judgment of the PCP or other physicians and/or Providers participating with Physician Group as to the Medical Necessity of the Covered Service, except that each Physician shall provide assessment and evaluation services ordered by a court or legal mandate. Physician Group acknowledges that disputes between the Physician Group and Enrollees about Medical Necessity can be appealed pursuant to CalOptima Policies and Laws.

1.1.8 Physician Group may not arbitrarily deny or reduce the amount, duration, or scope of a required Covered Service solely because of the diagnosis, type of illness, or condition. Physician Group may place appropriate limits on a service on the basis of criteria such as Medical Necessity or for utilization control, provided the services furnished can reasonably be expected to achieve their purpose and such a limitation complies with Laws.

1.2 **Confidentiality**. Physician Group and CalOptima agree to safeguard the confidentiality of Enrollee information and comply with all Laws (including, but limited to, the Health Insurance Portability and Accountability Act ("HIPAA"), 42 CFR Section 431.300 *et seq*., California Welfare and Institutions Code Section 14100.2, California Civil Code Section 56 *et seq.*, and the California

Information Practices Act, Civil Code Section 1798) regarding the confidentiality and disclosure of Enrollee names, health, enrollment and personal information (including medical and Behavioral Health information contained in Medical Records). Physician Group shall provide counseling to Enrollees on their right to confidentiality and obtain Enrollee consent prior to releasing confidential information unless such consent is not required pursuant to Title 22 CCR Section 51009.

1.3 **Emergency Services and Urgent Care**. Physician Group shall insure that it provides and pays for all Emergency Services and Urgent Care, including those services provided by Non-Participating Providers, without prior Authorization, twenty-four (24) hours each day, seven (7) days a week, in accordance with Laws and CalOptima Policies. Physician Group shall coordinate access to Emergency Services in accordance with CalOptima's emergency department protocol. Physician Group shall ensure adequate follow-up care for those Enrollees who have been screened in the emergency room and require non-Emergency Services. Physician Group may not specify what constitutes an Emergency Medical Condition on the basis of lists of diagnoses or symptoms.

1.4 **Days to Appointment**. Physician Group shall ensure that appointments for non-Emergency Services and non-Urgent Care Covered Services are scheduled within ten (10) business days of the Enrollee's request for PCP and fifteen (15) business days of Enrollee's request for Specialist Physician; that health assessments and general physical examinations and all preventative Covered Services are scheduled within thirty (30) calendar days of Enrollee's request for an appointment, and that, if Physician Group supplies maternity Covered Services, Physician Group shall ensure that the most current standards and guidelines of the American College of Obstetricians and Gynecologists are utilized as the minimum measure of quality for perinatal services. Physician Group shall also have a process in place for follow-up on Enrollee missed appointments.

1.5 **Twenty-Four (24) Hour Physician Group Coverage**. Physician Group shall ensure that it has, at a minimum, two Group Physicians as follows: One (1) Group Physician who is available twenty-four (24) hours a day to authorize Medically Necessary, Post-Stabilization Care Services and coordinate transfer of stabilized Enrollees in an emergency department, if necessary, and one (1) Group Physician available twenty-four (24) hours a day, seven (7) days a week to resolve disputed requests for Authorizations.

1.6 **Clinical Laboratory Improvement Amendments**. Physician Group shall only use laboratories with a Clinical Laboratory Improvement Amendments ("**CLIA**") certificate of waiver or a certificate of registration along with a CLIA identification number.

1.7 **CalOptima Formulary Compliance**. Participating Providers shall comply with the CalOptima Formulary and its associated drug utilization and disease management guidelines and protocols. Requests for items not included in the CalOptima Formulary shall require prior Authorization by CalOptima. The prescribing Physician shall be responsible for obtaining Authorization through CalOptima and/or its designated pharmacy benefit management contractor ("**PBM**"), as appropriate. The prescribing Physician shall provide CalOptima and/or the PBM with all information necessary to process Authorization requests.

1.8 **Enrollee Access**. Physician Group and its Downstream Entities shall comply with all Laws and CalOptima Policies governing Enrollee access to Covered Services.

1.8.1 If Physician Group is unable to provide necessary Covered Services to a particular Enrollee, Physician Group must adequately and timely cover these services with Non-Participating Providers for the Enrollee, for as long as Physician Group is unable to provide them. Physician Group shall make prior arrangements with Non-Participating Providers

for the provision of such services, shall be fully responsible for arranging and paying for such services, and shall comply with all applicable CalOptima Policies with regard to the payment and Authorization of Non-Participating Providers.

1.8.2 Physician Group shall ensure that PCPs as well as Specialty Physicians are located so as to assure sufficient geographic and physical access of Enrollees to such providers as required by Laws and CalOptima Policies.

1.8.3 Physician Group shall ensure that each Enrollee has a PCP who is available and physically present at the service site for sufficient time to ensure access for the assigned Enrollee when medically required. This requirement does not preclude an appropriately licensed professional from being a substitute for the PCP in the event of the PCP's vacation, illness, or other unforeseen circumstances.

1.8.4 Physician Group shall ensure female Enrollees have direct access to a women's health specialist within the network to provide women's routine and preventative health care services. Such access may be in addition to the Enrollee's PCP.

1.8.5 Physician Group shall cover family planning services for all Enrollees whether they are provided by a Participating Provider or Non-Participating Provider.

1.8.6 Physician Group shall reasonably accommodate Enrollees and ensure programs and services are as accessible (including a sufficient number of Providers and geographic access) to an Enrollee with disabilities as they are to an Enrollee without disabilities in accordance with CalOptima Policies. Physician Group's facilities shall comply with the requirements of Title III of the Americans with Disabilities Act of 1990 ("**ADA**") and shall ensure access for the disabled, including, but not limited to, ramps, elevators, restrooms, designated parking spaces, and drinking water provisions. Physician Group shall have policies to ensure that physical, communication and programmatic barriers do not inhibit Enrollees with disabilities from obtaining all Covered Services, including addressing reasonable accommodations required by the CMS Contract and CalOptima Policies. Physician Group will comply with CalOptima Policies and work plan requirements related to ADA compliance relevant to services under this Contract.

1.9 **Provider Network Maintenance**. Physician Group agrees to employ or contract with a sufficient number of Physicians and other Providers representing the range of medical specialties necessary, in the determination of CalOptima, CMS, and the DMHC to ensure Enrollees of reasonable access to the full range of Covered Services.

1.9.1 During the Term, all Participating Providers of Covered Services must: (i) be and remain qualified in accordance with current applicable legal, professional, and technical standards; (ii) be and remain appropriately licensed, certified or registered; (iii) be and remain in good standing with Medicare and not be terminated or suspended from participation in the Medicare and/or Medi-Cal programs; and (v) have a valid NPI number, as applicable. Physician Group shall ensure that PCPs are located so as to assure sufficient geographic and physical access of Enrollees to such Physicians under Laws and CalOptima Policies.

1.9.2 Physician Group shall ensure that Participating Providers have the requisite training and experience in dealing with the medical problems frequently encountered in elderly, disabled, and special needs individuals.

1.9.3 Physician Group shall use primary source verification to confirm the board certification in each clinical specialty area for which the Physician is being credentialed if the Physician lists such board certification on credentialing applications.

1.9.4 Physician Group acknowledges that the requirements of this Section 1.9 apply to each individual Provider who is affiliated with and/or part of any medical group, independent physician associations ("**IPA**"), and/or other organization or entity that contracts with Physician Group to furnish Covered Services to Enrollees.

1.9.5 Physician Group will maintain accurate records, including records detailing the status, membership, and qualifications of the Participating Providers in the Physician Group's network.

1.9.6 If a Provider who seeks to become a Participating Provider is denied a contract with Physician Group or a Participating Provider is suspended or terminated for cause, Physician Group shall provide the Provider with written notice of the reason for the action, as required by Laws, including any standards and profiling data Physician Group used to evaluate the provider, the number and mix of similar health care Providers that Physician Group needs (if applicable), and notice of the Provider's right to appeal the action, including notice of the process and timing to request a hearing. In the event Physician Group terminates a contract with a Participating Provider for deficiencies in the quality of care provided, Physician Group shall give notice of the action to CalOptima, as provided by CalOptima Policies, and to the appropriate licensing and disciplinary bodies, as provided by law.

1.9.7 In the event that a Provider, including a PCP, is terminated or leaves the Physician Group for any reason, Physician Group shall give written notification of termination of such Provider to CalOptima within fifteen (15) days after receipt or issuance of the termination notice.

1.9.8 In the event that a Provider, including a PCP, is terminated or leaves the Physician Group for any reason, Physician Group shall ensure that there is no disruption in services provided to Enrollees who are receiving treatment for a chronic or ongoing medical condition in accordance with applicable Laws.

1.9.9 Physician Group shall notify CalOptima at least sixty (60) days before any significant change in Physician Group's provider network that renders Physician Group unable to provide one or more Covered Services within CalOptima's access to care standards. If such notice is not possible because the providers terminate their participation with less than sixty (60) days' notice or Physician Group terminates the providers without prior notice as a result of their endangering the health and safety of Enrollees, providers committed criminal or fraudulent acts, or providers engaged in grossly unprofessional conduct, then Physician Group shall notify CalOptima immediately upon receipt of notice of the termination, or sending notice to the providers of a Physician Group-initiated termination.

1.9.10 Physician Group shall ensure that no Provider who fails to meet the requirements of this section furnishes items and/or services to Enrollees, submits claims and/or receives reimbursement for any Covered Services.

1.9.11 Physician Group agrees that each Participating Provider with whom Physician Group contracts to provide Covered Services will be required to execute a contract with Physician Group. Such an agreement will require all Participating Providers to comply with those

aspects of this Contract relating to activities of Participating Providers and with Laws, including the standards of accrediting and regulatory agencies governing CalOptima's MA Program, and any and all provisions required by MA regulations. The Physician Group agreement with Participating Providers shall be made available to CalOptima and its regulatory agencies for inspection and copying upon request. Physician Group shall ensure that all contracts with Participating Providers allow for termination of the contract for failure to meet the requirements of this Section 1.9.

1.10 **Enrollment**. Physician Group shall accept as Enrollees all persons indicated as Enrollees by the CalOptima information system and transmitted to Physician Group and shall comply with requirements to provide notices to Enrollees in accordance with CalOptima Policies.

1.11 **Primary Care Physician**. Physician Group agrees that each Enrollee will select or be assigned a PCP. Enrollee must request a PCP assignment from CalOptima's Customer Service department. If the Enrollee has not selected a PCP, CalOptima shall assign the PCP per its policies. Physician Group agrees that it will ensure that the PCP shall be responsible for the provision, coordination, referral, and Authorization of Covered Services in accordance with the utilization management ("**UM**") program and prevailing standards of medical practice so that there is a Physician who has ultimate responsibility for the Enrollee's care management.

1.12 **Physician Group Medical Director**. Physician Group shall designate a Group Physician as Medical Director for purposes of this Contract. The Physician Group Medical Director will be a member of the Physician Group's quality management and UM committee(s) and will be the individual to whom CalOptima communicates regarding provision of professional medical care and quality and/or appropriate utilization of medical services. The Physician Group Medical Director will be the individual responsible for representing Physician Group in the resolution of any Grievances presented to CalOptima by Enrollees related to the provision of medical care.

1.13 **Care Coordination**. CalOptima shall retain the responsibility for the initial HRA and an HRA annually thereafter in accordance with CalOptima Policies, but any update during the course of the year due to change in Enrollee's condition/circumstance would be the responsibility of the Physician Group, per policy. Physician Group shall offer care coordination and case management services to all Enrollees, which shall: (i) include coordination of care across the full continuum of service providers as appropriate to Covered Services under this Contract; (ii) ensure that care coordination services reflect a person-centered, outcome-based approach, consistent with the Model of Care and CalOptima Policies; (iii) follow Enrollee direction about level of involvement of his or her caregivers or medical providers; (iv) include the assignment of a qualified Care Coordinator to each Enrollee needing or requesting one; and (v) reflect access to appropriate community resources with a focus on providing services in the least restrictive setting and transitions between the facilities and the community.

1.14 **Model of Care**. Physician Group shall furnish Covered Services in compliance with CalOptima's Model of Care, including the PCC component, HRA, ICP and ICT requirements.

1.14.1 CalOptima will complete and communicate the HRA to Physician Group. Physician Group shall, upon notification by CalOptima of the need to follow-up on the results of an HRA administered by CalOptima, perform and provide any follow-up required by CalOptima.

1.14.2 Physician Group shall develop an ICP for each Enrollee and engage Enrollees and/or their representative in the design of the ICP in accordance with CalOptima Policies.

1.14.3 Physician Group shall offer an ICT for each Enrollee, as necessary, which will be developed around the Enrollee and integrate medical and LTSS and the coordination of Behavioral Health services. Enrollees shall not be required to participate in the ICT and may opt-out at any time. Enrollees may not be dis-enrolled from the ICT for lack of participation on the ICT. The ICT shall comply with CalOptima Policies.

1.14.4 PCPs and/or the Care Coordinator, in collaboration with CalOptima, will provide basic case management services to Enrollees in accordance with CalOptima's Policies. If the Enrollee has been identified as potentially benefiting from complex case management services, Physician Group shall provide such services to the Enrollee.

1.14.5 Physician Group shall ensure the provision of discharge planning when an Enrollee is admitted to a Hospital or institution and continues into the post-discharge period. Discharge planning shall include ensuring that the necessary care, services, and supports are in place in the community for the Enrollee once he or she is discharged, including scheduling an outpatient appointment and/or conducting follow-up with the Enrollee or caregiver. Physician Group shall comply with CalOptima Policies addressing minimum criteria requirements for discharge planning.

1.15 **Behavioral Health Services Referrals**. Physician Group shall furnish and/or coordinate Behavioral Health services as specified in CalOptima Policies and this Contract.

1.15.1 For Specialty Mental Health Services, Physician Group shall refer Enrollees to CalOptima as the Administrative Service Organization contracted to provide assessment, referral and Authorization services.

1.15.2 For Outpatient Mental Health Services that are within a Physician Group' PCP's scope of practice, Physician Group shall manage according to current appropriate treatment guidelines. If the Outpatient Mental Health Services are outside its PCPs' scope of practice, Physician Group shall refer Enrollees to CalOptima's contracted behavioral health provider.

1.15.3 For Enrollees requiring alcohol or substance use disorder treatment, Physician Group shall manage according to the appropriate PCP treatment guidelines. If the alcohol or substance use disorder treatment are outside its PCPs' scope of practice, Physician Group shall refer Enrollees to CalOptima's contracted behavioral health provider. Coordination of care through the ICT will occur as is specified in CalOptima Policies and this Contract.

1.16 **LTSS Referrals**. Physician Group shall refer Enrollees to CalOptima for LTSS pursuant to CalOptima Policies.

1.17 **Facility Site and Medical Record Reviews**. Physician Group shall participate in, and comply with requirements for, PCP site and medical reviews, including facility site physical accessibility reviews, in accordance with CalOptima Policies and guidance issued by CalOptima's Regulators, including requirements, if any, related to collaborative programs.

1.18 **Transfers**. Physician Group agrees to assist CalOptima in facilitating the transfer of care of Enrollees if determined medically acceptable by attending Physicians and the CalOptima Medical Director. Physician Group will be responsible for the cost of Covered Services provided if Physician Group refuses to accept such transfer.

1.19 **Delegation by CalOptima to Physician Group**. Physician Group agrees to accept delegated responsibility for those activities listed in the Delegation Agreement and to perform the delegated activities in a manner consistent with the Delegation Criteria. Physician Group warrants that it meets CalOptima's Delegation Criteria and acknowledges that delegation to another entity does not alter Physician Group's ultimate obligations and responsibilities set forth in this Contract. Physician Group agrees to notify CalOptima of any change in its ability to meet the Delegation Criteria within twenty-four (24) hours from the date it fails to meet such Delegation Criteria. At CalOptima's request, Physician Group shall identify the Compliance Officer or other appropriate health network representative to be the liaison expressly responsible for oversight of delegated obligations.

1.19.1 Physician Group acknowledges that it is CalOptima's responsibility to oversee, monitor and evaluate Physician Group's ongoing eligibility for delegation according to the Delegation Criteria and performance of the delegated activities according to the Delegation Criteria. Physician Group agrees to cooperate with CalOptima's oversight, monitoring, and evaluation of Physician Group's eligibility and performance of delegated activities, including the provision of reasonable access during regular business hours to the Enrollee inquiry files, credentialing files, clinical and Medical Records of Enrollees, and all other information requested by CalOptima. Physician Group shall comply with corrective actions imposed by CalOptima and/or CalOptima's Regulators in the time and manner required by them.

1.19.2 Physician Group acknowledges and agrees that CalOptima retains final authority and responsibility for activities delegated under this Contract. Activities not expressly delegated herein and in the Delegation Agreement by CalOptima or for which delegation is terminated are the responsibility of CalOptima.

1.19.3 Physician Group agrees to provide CalOptima with periodic reports on delegated activities performed by Physician Group as provided in the Delegation Criteria or specified in CalOptima Policies.

1.19.4 In the event CalOptima, DMHC, or CMS is dissatisfied with the performance of delegated functions and activities by Physician Group or its Downstream Entities, CalOptima may, in its sole discretion, modify Physician Group's delegated status (in respect to all or a particular delegated activity), including from fully delegated to delegated with corrective action, or may immediately revoke all or part of the delegated activities. In the event Physician Group breaches its obligation to perform any delegated obligations, CalOptima shall have all remedies set forth in this Contract, including the right to revoke delegation of such function(s) and impose financial and other penalties. Moreover, CalOptima shall have the right to require Physician Group to terminate any Downstream Entity for good cause, including breach of its obligations to perform any delegated duties. Nothing herein is intended to limit CalOptima's remedies as provided for in this Contract or at law.

1.19.5 Physician Group acknowledges and agrees that CalOptima, in its sole and absolute discretion, may reduce Physician Group's Capitation Payments to recoup additional administrative costs where CalOptima revokes or modifies activities or functions delegated to Physician Group under this Contract.

1.20 **Delegation and Subcontracting of Administrative Services by Physician Group**. Except as otherwise limited by this Contract and/or CalOptima Policies, Physician Group may sub-delegate Administrative Services required of Physician Group to a management services organization

("**MSO**"), medical group and/or IPA. Delegation shall not absolve Physician Group of oversight responsibilities or its obligations under this Contract. All requests for delegation of Administrative Services (i) must be in writing; (ii) are subject to successful completion of CalOptima's readiness assessment requirements; and (iii) must be approved by CalOptima in advance of undertaking the Administrative Services. Physician Group shall obtain written approval of delegation from CalOptima pursuant to the process detailed in CalOptima Policies.

1.21 **Subcontracts**. Physician Group is required to inform CalOptima of the name and business addresses of all subcontracted Downstream Entities. Physician Group is required to ensure that all such subcontracts are in writing and include all provisions required by this Contract to be incorporated into subcontracts. Physician Group acknowledges that CalOptima's FDR subcontracts are subject to the review and approval of CMS.

1.22 **Payment to Providers**. CalOptima hereby delegates claims processing functions to Physician Group. Physician Group shall review, adjudicate, and pay (as appropriate) all claims in accordance with the benefits set forth in the Evidence of Coverage, the requirements established by Laws, and the terms of this Contract. In making payments to Providers, Physician Group shall comply with the provisions of Attachment D, including requirements related to payment of Non-Participating Provider Emergency Services and Urgent Care claims.

1.23 **Documentation and Data Submission Integrity**. Physician Group and its Downstream Entities shall not submit false claims or financial reports, encounter data, and other information to CalOptima, CMS or DMHC, whether by commission or omission. Physician Group and applicable Downstream Entities shall implement and maintain policies and procedures that address correct completion of claims, financial reports, encounter data, and other documentation requirements and penalties for falsifying such reports and other information that require all new and current employees and/or agents compiling or providing this information to sign a statement of attestation that will acknowledge understanding and compliance with said Physician Group policy.

1.24 **Advance Directives**. Physician Group shall maintain written policies and procedures related to Advanced Directives in compliance with Laws. Providers shall document Advance Directives in patient records in accordance with Laws. Physician Group shall not discriminate against any Enrollee on the basis of that Enrollee's Advance Directive status. Nothing in this Contract shall be interpreted to require an Enrollee to execute an Advance Directive or agree to orders regarding the provision of life-sustaining treatment as a condition of receipt of services.

1.25 **Enrollee Appeals**. Enrollees will be notified of all applicable MA and/or Medicare Appeal rights, the form and content of which is approved by CMS. . Medicare Appeal rights and protections will be maintained and enhanced for Medicare services. Physician Group agrees to cooperate with CalOptima in resolving Appeals related to Physician Group or Physician Group's Participating Providers and will comply with CalOptima Policies related to Appeals.

1.26 **Organization Determination Process**. Physician Group agrees to comply with CMS regulations and instructions and CalOptima Policies pertaining to timely organization determination by Physician Group with regard to the provision, denial, reduction, or suspension of a Covered Service to an Enrollee. "**Organization determination**" is defined as a decision to provide or deny service based on CMS and CalOptima criteria. Such determinations shall be made in accordance with procedures and instructions set forth in the CalOptima Policies and Laws. Physician Group shall immediately notify CalOptima of any request for an expedited initial organization determination and submit to CalOptima on a monthly basis a report which tracks the requests for standard and

expedited organization determinations and the timeframe within which Enrollees were informed of decisions made by Physician Group.

1.27 **Expedited Review Process**. Physician Group shall comply with CMS regulations and CalOptima Policies pertaining to expedited initial organization determinations of Enrollee's medical care and reconsideration (Appeals) thereof in the time sensitive situations. Time sensitive situations are those outlined by CMS which include medical conditions that require initial determinations to be made within seventy-two (72) hours upon Physician Group receiving a request for an expedited review from a Provider, Enrollee, or CalOptima.

1.28 **Linguistic and Cultural Sensitivity**. Physician Group shall comply with all requirements related to the provision of linguistic and culturally sensitive services in accordance to this Contract, CalOptima's Cultural and Linguistic Services Program, and CalOptima Policies. Physician Group shall address the special health needs of Enrollees who are of any minority, are homeless, are disabled (both congenital and acquired disabilities), or are part of other special populations served by the CalOptima MA Program, including the capacity to communicate with Enrollees in languages other than English, when necessary, as well as those Enrollees who are deaf, hard-of-hearing, and/or visually impaired. Physician shall, in policies, administration, and services, practice the values of: (a) honoring the Enrollees' beliefs, traditions and customs; (b) recognizing individual differences within a culture; (c) creating an open, supportive, and responsive organization in which differences are valued, respected and managed; (d) through cultural diversity training, foster in staff and Participating Providers attitudes and interpersonal communication styles that respect Enrollees' cultural backgrounds and are sensitive to their special needs; and (e) referring Enrollees to linguistically and culturally sensitive programs. Pursuant to CalOptima Policies, Physician Group shall provide translation of written materials in the Threshold Languages as provided by CalOptima Policies. Written materials to be translated include, but are not limited to, signage, the Enrollee services guide, Enrollee information, Explanation of Coverage, Enrollee forms, Enrollee notices, and Enrollee welcome packages.

1.29 **Provision of Interpreters**. Oral interpreters, signers, and bilingual Provider services shall be provided in all languages spoken by all MA Enrollees. Physician Group shall provide linguistic interpreter/translator services for Enrollees as necessary at all Physician Group sites to ensure the availability of effective communication regarding treatment, diagnosis, medical history, and health education to Enrollees. Physician Group shall provide twenty-four (24)-hour access to interpreter services for all Enrollees. Upon an Enrollee or Participating Provider request for interpreter services in a specific situation where care is needed, Physician Group shall make all reasonable efforts to provide an interpreter in time to assist adequately with all necessary Covered Services, including Urgent Care Services and Emergency Services, as required by Laws. Physician Group shall routinely document all such efforts and make this documentation available to CalOptima at its request. Interpreters shall be used where needed where technical, medical, or treatment information is to be discussed. Physician Group shall not require an Enrollee to use friends or family as interpreters. However, a family member or friend may be used when the use of the family member or friend: (i) is requested by the Enrollee; (ii) will not compromise the effectiveness of service; (iii) will not violate Enrollee's confidentiality; and (iv) the Enrollee is advised that an interpreter is available at no cost to the Enrollee. Physician Group shall maintain a contract with an interpreter service agency that is on "on call" status to provide interpreter services.

1.30 **Identification of Physician Group and Group Physicians**. Physician Group agrees that CalOptima may list the Physician Group's name, address, and telephone number and that of its Group Physicians and Downstream Entities in CalOptima's roster of Participating Providers that is given to Enrollees and prospective Enrollees, and CalOptima may use such names for

advertising/marketing purposes. However, CalOptima is not obligated to list the name of any particular Group Physician in the roster of Participating Providers. The use of Physician Group's trademarks or logos by CalOptima is prohibited without Physician Group's prior written approval.

1.31 **Liaisons**. Physician Group shall designate an individual(s) who will assume the day-to-day responsibilities with regard to Physician Group's obligations under this Contract and to serve as liaison with CalOptima. Physician Group will also designate an individual(s) to be responsible for answering Enrollee inquiries and responding promptly to any Enrollee grievance in accordance with CalOptima's grievance procedures and Laws.

1.32 **Provider Private Contract**. Physician Group understands that CalOptima is prohibited by CMS from paying capitation to, or including in its provider network, any provider that has entered into a private contract with a Medicare beneficiary for the provision of Covered Services. Physician Group shall notify CalOptima immediately in the event that any Group Physician has a private contract with a Medicare beneficiary. In such an event, CalOptima reserves the right to exclude any such Group Physician from its provider network. In addition, Physician Group agrees that CalOptima shall have the right to offset the amount of any reimbursement that was paid either directly or indirectly to such Provider(s) against Capitation Payments or other amounts due from CalOptima to Physician Group, if any.

1.33 **Disclosure of Physician Group PIPs**. In the event that Physician Group implements and maintains a physician incentive plan ("**PIP**"), Physician Group and its Downstream Entities must comply with all applicable requirements governing PIPs, including such requirements appearing at 42 CFR Parts 417, 422, 434, 438.6(h), and 1003.

1.33.1 Physician Group shall ensure that no specific payment is made directly or indirectly under a PIP to a Physician or Physician Group as an inducement to reduce or limit Medically Necessary services furnished to an Enrollee.

1.33.2 On an annual basis, Physician Group and its Downstream Entities must submit to CalOptima all information required to be disclosed to CMS and the DMHC in the manner and format specified by them.

1.33.3 Physician Group must provide information on its PIP to any Enrollee upon request as provided in 42 CFR Section 422.208.

1.33.4 In the event that CalOptima's Regulators find that Physician Group (or its Downstream Entities) has failed to comply with the requirements governing physician incentive plans and CalOptima's Regulators offset, recoup and/or otherwise seek recovery of federal financial participation ("**FFP**") amounts from CalOptima, Physician Group agrees that CalOptima may recover such FFP amounts attributable to Physician Group from Physician Group, including through recoupment or offset to future Capitation Payments or other amounts due from CalOptima to Physician Group, if any.

1.34 **Provider Grievance Process**. Physician Group shall establish and maintain a Provider dispute resolution process that at all times complies with the requirements of Laws. Physician Group shall provide CalOptima with all necessary information and reports regarding the provider dispute resolution process as required by CalOptima to meet its obligations under the CMS Contract and Laws. If Physician Group fails to maintain a process that complies with the requirements stated in Laws and CalOptima Policies, then following written notice of such deficiency from CalOptima to

Physician Group, CalOptima may revoke the delegation and assume responsibility for the administration of Physician Group's Provider dispute resolution process.

1.35 **Provider Education**. Physician Group acknowledges that CMS requires that CalOptima furnish to Participating Providers certain training, education, and orientation related to the MA Program in order to operate in full compliance with this Contract and Laws. Such training and education may address the MA Program, Enrollee rights, cultural competency and clinical protocols, evidence-based guidelines and cultural awareness and sensitivity instruction. Physician Group and its Participating Providers shall participate in such training, education, and orientation programs, as required by CalOptima, and shall attest to compliance with training requirements as required by CalOptima.

1.36 **State Licensure**. If Physician Group is licensed by the DMHC as a heath care service plan for purposes of the MA Program, it shall maintain such licensure in accordance with the Knox-Keene Act, as amended, and have no adverse actions with regard to enforcement or quality management.

1.37 **CalOptima's Regulator Requirements**. The MA Program is subject to oversight by CalOptima's Regulators, which mandate that CalOptima and its FDRs comply with certain terms and conditions in rendering services to Enrollees and that certain terms be incorporated in FDR subcontracts. Physician Group acknowledges that it will comply with CalOptima's Regulators' requirements set forth in Attachment E.

1.38 **COB Obligations of Physician Group**. Physician Group agrees to coordinate with CalOptima for proper determination of COB and to bill and collect from other payers and third-party liens such charges for which the other payer is responsible pursuant to CalOptima Policies. Physician Group agrees to establish procedures to effectively identify, at the time of service and as part of its claims payment procedures, individuals and services for which there may be a financially responsible party other than the CalOptima MA Program.

1.39 **CMS Lien Rights.** Physician Group shall coordinate benefits either operating a cost avoidance method of paying claims, when the existence of private health coverage is known at the time the claim is processed, or using the method of post-payment recovery of the cost of services, if the coverage is identified retroactively, as set forth in CalOptima Policies. Nothing herein shall be interpreted to, in any manner, impair any lien rights retained by the U.S. Department of Health and Human Services ("**HHS**") through CMS. Physician Group shall make no claim for the recovery of the value of Covered Services rendered to an Enrollee when such recovery would result from an action involving tort liability of a third party, recovery from the estate of deceased Enrollee, Workers' Compensation, or casualty liability insurance awards and uninsured motorist coverage. Physician Group shall identify and notify CalOptima, within five (5) calendar days of discovery of potential third-party liability ("**TPL**") claims, and provide information relative to potential TPL claims, in accordance with CalOptima Policies.

1.40 **Provider Training.** Physician Group shall ensure that all network Providers receive training regarding the MA Program in order to operate in full compliance with all Laws, including rights and responsibilities pertaining to grievance and appeals procedures and timelines under this Contract. Physician Group shall ensure that network Provider training relates to MA services, policies, procedures and any modifications to existing services, policies or procedures. Training shall include methods for sharing information among network Providers, Enrollees, and/or other healthcare professionals. Physician Group shall conduct training for all network Providers within thirty (30) working days after the Physician Group places a newly contracted Provider on active status. Physician Group shall ensure that network Provider training includes information on all

Enrollee rights, including the right to full disclosure of health care information and the right to actively participate in health care decisions. Physician Group will maintain policies and procedures on advance directives pursuant to 42 CFR §§ 422.128, 438.3(j), and 489.102, and will educate its network Providers concerning its policies and procedures on Advance Directives. Physician Group shall ensure that ongoing training is conducted when deemed necessary by either the Physician Group or CMS.

II. PHYSICIAN GROUP FINANCIAL OBLIGATIONS

2.1 **Financial Security Requirements**. Physician Group must establish and maintain during the Term financial security requirements as specified in Article 9 of Chapter 2 of Division 1 of Title 28 of the California Code of Regulations (SB 260 Regulations), and in compliance with CalOptima Policies. Physician Group must establish and maintain, throughout the Term, financial security reserves, in the form of time certificates of deposit, irrevocable standby letters of credit, surety bonds naming CalOptima as beneficiary, and/or other forms of financial instruments acceptable by CalOptima, as required in CalOptima Policies.

2.2 **Financial Viability Standards and Reporting**. Physician Group must establish and maintain a minimum reserve of twenty-five percent (25%) of one month's Capitation Payment. Physician shall have thirty (30) days upon receiving notice from CalOptima to cure any deficit. Physician Group shall maintain a cash-to-claims ratio of no less than 0.75 at all times during the Term. Physician Group shall substantiate compliance with this requirement by submitting all applicable reports to the DMHC that are required under Title 28 CCR Section 1300.75.4.2.

2.3 **Medical Loss Ratio**. Physician Group shall ensure that it maintains a minimum acceptable loss ratio (as defined by CalOptima Policies) of eight five percent (85%). Physician Group shall comply with CalOptima requirements related to limitations on administrative costs, as set forth in CalOptima Policies.

2.4 **Termination of Physician Group Health Network**. If this Contract terminates or expires for any reason, CalOptima may require that Physician Group take certain actions and/or CalOptima may take certain actions to ensure that all items and services for which Physician Group is delegated financial risk under this Contract are reimbursed by Physician Group, including the following: (i) require Physician Group to reserve sufficient funds to pay any claims run out; (ii) offset Physician Group's future Capitation Payments or other amounts due from CalOptima to Physician Group under this Contract or any other agreement, if any, in order to pay Physician Group's claims; and/or (iii) withhold or offset Physician Group's Capitation Payments or other amounts due from CalOptima to Physician Group, including to pay-for-performance, quality incentives, and shared risk pool surpluses, if any, in order to pay amounts owed by Physician Group to Providers.

2.5 **Conversion of Health Network Model**. If CalOptima approves a change in the delegated model of Physician Group at any time during the Term, CalOptima may require additional financial protections as a condition precedent to such approval, including: (i) require Physician Group to reserve sufficient funds to pay any claims run out related to claims which are the financial responsibility of Physician Group under the existing delegated relationship; (ii) require Physician Group to meet additional financial security requirements, including the maintenance of financial deposits; and/or (iii) withhold or offset Physician Group's Capitation Payments or other amounts due from CalOptima to Physician Group, including pay-for-performance, quality incentives and shared risk pool surpluses, if any, in order to pay amounts owed by Physician Group to Providers.

2.6 **Cooperation with DMHC**. Physician Group shall fully cooperate and comply with the DMHC's review and audit process and permit DMHC to obtain and evaluate supplemental financial information related to Physician Group, in accordance with Title 28 CCR Section 1300.75.4.7. Physician Group shall also fully cooperate and participate in DMHC's Corrective Action Plan process, in accordance with Title 28 CCR Section 1300.75.4.8.

III. CALOPTIMA OBLIGATIONS

3.1 **CalOptima Services**. CalOptima agrees to provide certain Enrollee and Administrative Services, including processing Enrollee applications, maintaining eligibility records and a system of verifying eligibility, processing enrollments and dis-enrollments, responding to Enrollee complaints and grievances, informing Enrollees of CalOptima Policies, providing Enrollees with membership cards and informational material, and informing Enrollees of Health Networks.

3.2 **Enrollment**. CalOptima agrees to process all enrollment applications and ensure that each Enrollee selects or is assigned to Health Networks in accordance with CalOptima Policies. CalOptima reserves the right to assign Enrollees to a Health Networks other than that selected by Enrollee.

3.3 **Model of Care and Health Risk Assessment**. CalOptima shall maintain a Model of Care, as required by CalOptima's Regulators. CalOptima shall ensure that, upon enrollment in the CalOptima MA Program, each Enrollee receives an initial HRA and an HRA annually thereafter in accordance with CalOptima Policies and that results of the HRA are shared with Physician Group in order to coordinate Enrollee care. Physician Group is responsible for interim updates to the HRA.

3.4 **Authorization Process**. CalOptima shall provide a written Authorization process for Covered Services pursuant to CalOptima Policies.

3.5 **Enrollee Grievance Process**. CalOptima will inform Enrollees that they may file a grievance through CalOptima or the CMS Ombudsman Program for complaints related to Medicare-covered benefits and services. Enrollees may also file a grievance through 1-800 Medicare.

3.6 **Enrollee Appeals**. Enrollees will be notified of all applicable MA Medicare Appeal rights through a single notice prior approved by CMS.

3.7 **CalOptima Formulary**. CalOptima shall publish and maintain the CalOptima Formulary pursuant to CalOptima Policies.

3.8 **Training and Education**. CalOptima agrees to provide Participating Provider education, training, and orientation in accordance with CMS requirements, including training regarding the CalOptima MA Program, Enrollee rights, clinical protocols, evidence-based practice guidelines, and CalOptima's cultural awareness and sensitivity instruction and cultural competency training, as applicable.

3.9 **Marketing**. Physician Group acknowledges that CalOptima will be responsible for marketing the CalOptima MA Program to Medicare beneficiaries. Physician Group acknowledges that it shall not conduct any marketing activities except as expressly approved in advance and in writing by CalOptima.

3.10 **Administration of Funds**. CalOptima will administer the funds and payments called for in this Contract to Physician Group in accordance with provisions outlined in Article VI.

3.11 **No Refusal to Pay or Contract Based on Physician Group Communications with Enrollees**. CalOptima will not refuse to contract or pay an otherwise eligible health care Provider for the provision of Covered Services solely because such Provider has, in good faith, communicated with or advocated on behalf of one or more of his or her prospective, current, or former patients regarding: (i) the provisions, terms or requirements of CalOptima's health care plans as they relate to the needs of such Provider's Enrollees; or (ii) the method by which such Provider is compensated by CalOptima for Covered Services rendered to the Enrollee.

3.12 **CalOptima Policies**. CalOptima will provide Physician Group with CalOptima Policies as necessary for Group to provide Covered Services to Enrollees. Those CalOptima Policies shall describe all benefit plans, including copayments, limitations, and exclusions offered by CalOptima to Enrollees. The Provider Manual will be made available to Physician Group to disseminate to Physicians.

3.13 **Listing of CalOptima**. CalOptima agrees that Physician Group may list its name, address, telephone number, and a description of the CalOptima MA Program, along with CalOptima's name, in Physician Group's promotional materials and advertisements. The use of CalOptima's trademarks and logos by Physician Group is prohibited without CalOptima's prior written approval.

3.14 **CalOptima Oversight**. CalOptima shall monitor Physician Group's performance under this Contract on an ongoing basis. CalOptima may conduct regularly scheduled audits as well as an annual evaluation of the delegated functions to determine Physician Group's continued compliance with the Delegation Criteria. CalOptima may impose corrective action plans on Physician Group and/or its Downstream Entities, as necessary.

3.15 **CalOptima Accountability**. The delegation of the functions and responsibilities stated in this Contract and the Delegation Agreement does not relieve CalOptima of any of its accountability to CMS and obligations to its Enrollees under Laws. CalOptima is authorized to perform and remains liable for the performance of such obligations, notwithstanding any delegation of some or all of those obligations to Physician Group.

3.16 **COB Obligations of CalOptima**. CalOptima will cooperate in providing COB information to Physician Group by collecting appropriate data from the Enrollee at the point of enrollment and supplying such data to Physician Group.

3.17 **Enrollee Rights**. CalOptima shall ensure that Enrollee rights are fully respected and observed in accordance with Laws and CalOptima Policies. CalOptima shall notify Enrollees of their rights and protections at least annually and in a manner that accounts for cultural considerations, functional status, and language needs.

3.18 **Enrollee Grievances**. CalOptima retains responsibility for the Enrollee grievance process. Physician Group will comply with CalOptima Policies related to Enrollee grievances, including timely reporting to CalOptima and resolution of Enrollee grievances. Enrollees may file an internal Enrollee grievance at any time with CalOptima or Physician Group, including grievances related to reasonable accommodations and access to services under the ADA.

IV. QUALITY IMPROVEMENT PROGRAM AND CREDENTIALING

4.1 **CalOptima's Quality Improvement Program**. Physician Group shall comply with, and participate in, CalOptima's Quality Improvement Program ("**QIP**"). Physician Group shall immediately notify CalOptima of those Enrollees and cases that fall within the catastrophic and

targeted case management guidelines and shall cooperate with CalOptima's case management program for catastrophic and targeted cases. Physician Group and its Downstream Entities shall fully cooperate with CalOptima with regard to the HEDIS measurements and HEDIS audits, guideline development, preventive services utilization, disease/risk management, clinical service monitoring, and quality improvement studies and initiatives. Physician Group shall comply with and accept as final the decisions of the CalOptima QIP and, pending resolution of any dispute through the dispute resolution process, comply with the decisions of the CalOptima Quality Improvement Committee.

4.2 **Quality Improvement Functions – Delegation to Physician Group**. Physician Group shall establish, maintain and operate a Quality Improvement ("**QI**") program, in accordance with the delineation of responsibilities in the Delegation Agreement, which shall include preparation of an annual QI program plan, semi-annual work plan, and annual evaluation of effectiveness of the QI program, and report to CalOptima's QI department using the Health Industry Collaboration Effort Reporting Tool. All of the foregoing elements of the QI program shall be consistent with current industry standards, and meet CMS, National Committee for Quality Assurance ("**NCQA**"), The Joint Commission, and CalOptima QIP requirements.

4.2.1 Physician Group shall adopt a detailed written QI plan, which shall include: (i) well defined goals and objectives; (ii) a well-defined scope that considers all different types and levels of care and service provided to Enrollees; and (iii) clearly defined accountability and responsibility for the QI program.

4.2.2 The Board of Directors of the Physician Group or a multi-disciplinary QI committee designated by the Board of Directors of Physician Group shall oversee the QI program. This committee shall be separate from the utilization review committee (though members may be the same) and have a separate agenda. The QI committee shall meet at least on a quarterly basis. Physician Group shall maintain attendance records and meeting minutes related to the QI program. The QI committee shall have adequate representation from all categories of the Physician Group such as Physicians and non-Physician practitioners.

4.2.3 QI Program activities shall be reported in writing to Physician Group's Board of Directors at least on a quarterly basis. These reports shall be available to CalOptima upon request.

4.2.4 Physician Group's QI program shall include involvement and participation in network-wide studies/projects initiated by CalOptima. Physician Group shall facilitate quality studies and assist in collection of comparative data collected from all Participating Providers using objective parameters (e.g., the current version of HEDIS).

4.2.5 Physician Group shall develop an annual QI work plan, which includes the following: (i) goals, scope, and planned projects for the year; (ii) planned monitoring of identified issues and tracking these issues over time; (iii) planned studies/audits suggested by CalOptima or Physician Group; and (iv) an annual evaluation of the QI program/plan.

4.2.6 Physician Group shall have a written procedure for responding to the findings of QI activities, such as collecting data, analyzing results, implementing corrective action plans, and reassessing the same data for improvement.

4.2.7 Requirements for the Physician Group's QI program shall be established by the Physician Group's QI committee and requirements may change based on changes in industry standards. CalOptima's QI committee shall notify Physician Group of any additional

changes in QI standards and requirements that shall be incorporated in Physician Group's QI program. Physician Group shall not be required to change QI program requirements more frequently than once per year.

4.2.8 Physician Group shall provide, upon CalOptima's request: (i) summaries of QI Committee meetings; (ii) findings following review of specific cases and other reviews; (iii) Medical Records; (iv) written responses to quality-of-care issues or Enrollee complaints; and/or (v) other information as required by CalOptima.

4.2.9 Physician Group shall comply with all measurement and improvement projects in the manner required by CMS, including the reporting of HEDIS, Health Outcomes Survey and Consumer Assessment of Healthcare Providers and Services measurement results consistent with Medicare requirements. Physician Group shall contribute to all applicable CMS data quality assurance processes.

4.3 **Quality Improvement and Credentialing Program**. CalOptima delegates credentialing requirements to Physician Group as provided in the Delegation Agreement. Physician Group agrees to comply with CalOptima Policies regarding credentialing standards. In order to ascertain Physician Group's continuous compliance with CalOptima standards, CalOptima retains the right to oversee Physician Group's credentialing processes and to mandate changes thereto.

4.3.1 At least annually, Physician Group shall provide CalOptima with a written credentialing program for the purpose of review and approval by CalOptima. Physician Group shall also allow CalOptima, after reasonable prior notice, to conduct an on-site audit and review a sample of physician credentialing files to determine that delegation of the credentialing process is appropriate.

4.3.2 Physician Group's credentialing program shall comply with the requirements specified in 42 CFR Sections 422.504, 423.505 and 438.214, as applicable, which include requirements addressing selection and retention of providers, credentialing and re-credentialing requirements, and nondiscrimination. Physician Group's credentialing program shall include procedures used for credentialing and re-credentialing Participating Provider's according to current NCQA standards, in addition to procedures used for reducing, suspending or terminating Participating Provider's participation in the organization for reasons relating to quality of care, competence, professional conduct, or service-related issues; procedures for reporting to appropriate authorities serious quality deficiencies that could result in suspension or termination of a Participating Provider's participation; and procedures for provider appeal, as afforded by Physician Group's fair hearing plan and corrective actions.

4.3.3 Physician Group shall make best efforts to notify CalOptima within thirty (30) days of any changes involving the rules, regulations, authorities, and responsibilities of the credentialing program. In accordance with CMS requirements, CalOptima also retains the right, based on quality-of-care and service issues, to approve, suspend, or terminate arrangements with practitioners, providers, and sites. In the event that this occurs, CalOptima will notify the Physician Group of the quality-of-care and/or service issue, and Physician Group shall take appropriate action, report to appropriate authorities any serious quality deficiencies in accordance with Laws, and provide all due process as afforded by the Physician Group's fair hearing plan and Laws.

4.3.4 If CalOptima exercises its right to terminate a Provider's participation in the CalOptima MA program, CalOptima shall give the Provider a written statement of the reason or reasons for termination with cause and comply with the procedures required by Laws, if any.

4.4 **Release of Performance Information and Data**. Physician Group acknowledges that the CalOptima MA Program focuses on improving the coordination and quality of medical, Behavioral Health, LTSS, and other services for Enrollees, and, in that regard, CalOptima's Regulators will implement capitation withholds to ensure performance consistent with established quality thresholds. Physician Group acknowledges and agrees that CalOptima may release information and data related to the performance of Physician Group under this Contract to CalOptima Regulators, Providers, Enrollees, and others without further notice to Physician Group. The performance data will be used for purposes, including quality improvement activities, and public reporting to consumers, as identified in CalOptima Policies.

V. UTILIZATION MANAGEMENT PROGRAM

5.1 **CalOptima's Utilization Management Program**. CalOptima has implemented, and continuously updates, a UM program to ensure appropriate processes are used to review and approve the provision of Medically Necessary Covered Services to Enrollees in the timeframes required by CalOptima's Regulators. Physician Group and its Downstream Entities shall comply with and cooperate in CalOptima's UM program, as established in CalOptima Policies and the CalOptima UM plan, regardless of CalOptima's delegation to Physician Group under Section 5.2.

5.2 **UM Program Responsibility—Delegation to Physician Group**. CalOptima is hereby delegating to Physician Group the process of monitoring and evaluating on a prospective, concurrent, and retrospective basis, the utilization and Medical Necessity of Covered Services provided to Physician Group's Enrollees.

5.2.1 Physician Group's UM process shall include performing case management activities, referral management and discharge planning, and managing the denial sanction process, as well as conducting peer review for Medical Necessity and appropriateness. Physician Group (and its Downstream Entities) shall ensure that its UM program complies with all criteria as set forth in CalOptima Policies and required by CalOptima's Regulators.

5.2.2 In accordance with 42 CFR §§ 438.6(h) and 422.208, compensation to individuals or entities that conduct UM activities must not be structured so as to provide incentives for Physician Group (including Group Physicians) or Downstream Entities to deny, limit, or discontinue Medically Necessary Covered Services to any Enrollee.

5.2.3 In the event Physician Group (or its Downstream Entities) fails to comply with CalOptima standards and Laws and fails to correct deficiencies within the stated time required by those provisions, CalOptima retains the right to revoke delegation of UM activities.

5.3 **Utilization Management Plan**. Physician Group will provide to CalOptima initially upon execution of this Contract, and annually thereafter, a written UM plan for review and approval by CalOptima.

5.3.1 Physician Group shall notify CalOptima within thirty (30) days of any changes involving the rules, regulations, authorities, and responsibilities for the UM plan, which shall be subject to reasonable approval by CalOptima. CalOptima approval will be assumed unless

Physician Group is notified otherwise by CalOptima. Physician Group shall comply with and accept as final, the decisions of CalOptima's UM program and, pending resolution of any dispute through the dispute resolution process, comply with the decisions of CalOptima's UM program.

5.3.2 The UM plan shall include procedures approved by CalOptima to identify, assess, establish, and implement a treatment plan for Enrollees with complex or serious medical conditions. The UM plan shall also contain procedures for direct access of Enrollees to services as mandated by CMS regulations and instructions. All Physician Group denial letters shall provide Enrollees with timely notice and shall contain appropriate Enrollee appeals rights as approved by CMS and CalOptima. Physician Group agrees to cooperate with CalOptima in furnishing the required reports identified in CalOptima' Policies

5.4 **Utilization Management Committee**. Physician Group shall establish a UM committee that shall review and document the quality, appropriateness, level of care, and utilization of health care services provided to Enrollees. CalOptima's Medical Director and/or CalOptima staff may attend Physician Group UM committee meetings.

5.5 **Process and Timeframes for Authorization**. Physician Group (and its Downstream Entities) shall ensure that its process for initial and continuing Authorizations complies with CalOptima Policies, the UM plan and requirements established by CalOptima's Regulators, including timeframes for, and manner of, Authorization.

5.6 **No Prior Authorization**. Physician Group (and its Downstream Entities) shall not require prior Authorization for the following services: (i) any services for Emergency Medical Conditions (which include emergency Behavioral Health care); (ii) Urgent Care sought outside the Service Area: (iii) Urgent Care under unusual or extraordinary circumstances provided in the Service Area when the Participating Provider is unavailable or inaccessible; (iv) preventative services; (v) family planning services; (vi) Out-of-Area renal dialysis services; (vii) basic prenatal care; (viii) sexually transmitted disease services; and (ix) HIV testing.

5.7 **Second Opinions**. Physician Group (and Downstream Entities) shall ensure that Enrollees have the right to second opinions from qualified health professionals at no cost to the Enrollee.

5.8 **Physician Direct Referral**. Physician Group agrees that an Enrollee shall, without obtaining the prior Authorization of the PCP or Physician Group, refer him or herself directly to a specialist within said Physician Group per policy including any of the following conditions: an annual well woman exam by a Gynecologist, prenatal care and delivery by an Obstetrician, annual eye exam by an Optometrist, professional services related to audiology, and family planning services, including but not limited to vasectomy.

5.8.1 CalOptima will identify Physician Group as a provider that offers Physician Group Direct Referrals to Enrollees in CalOptima's provider directory and other marketing literature, if any. In the event CalOptima determines that Physician Group is non-compliant with the requirements of the Physician Direct Referral process, CalOptima reserves the right, at its sole discretion, to cease marketing Physician Group as a Physician Direct Referral provider to Enrollees.

5.8.2 Physician Group agrees to cooperate with CalOptima and, upon reasonable prior notice, provide CalOptima with all necessary Medical Records, policies and procedures, including utilization review, reports, and other pertinent information that may be necessary or

required to enable CalOptima to ensure and verify that Physician Group has a Physician Direct Referral process acceptable to and in accordance with the requirements of CalOptima.

5.9 **Hospital Referrals**. Physician Group agrees to require Group Physicians to admit Enrollees only to a Participating Provider Hospital with the concurrence of CalOptima, except for Emergency Services, Urgent Care, or when Authorization has been received in accordance with the UM Plan.

5.10 **Personal Care Coordinator Component to the Model of Care.**

5.10.1 "**PCC Profile**" is a monthly report generated by CalOptima that provides the compliance parameters required to receive PCC supplemental capitation.

5.10.2 Physician Group shall employ PCCs and participate in all PCC component requirements, as defined in the Model of Care Profile. PCCs shall assist Enrollees in the development of an ICP, ensure communication of the Enrollee's care plan with the Enrollee, physicians, Physician Group and health care team, and provide other related services as described in the job description, CalOptima Policy, and Model of Care Profile. Physician Group shall submit monthly reports and ICPs to demonstrate adherence to Model of Care requirements, including staffing of PCCs.

5.10.3 CalOptima may amend the Model of Care Profile at any time and, in such event, CalOptima shall provide Physician Group with thirty (30) days' written notice before the effective date of any such revisions. If Physician Group is unable to agree to the revisions and no resolution is reached in the thirty (30)-day period, Physician Group may proceed with the termination of the Contract under Article 11. In the event Physician Group terminates the Contract, it shall comply with all of its obligations required by this Contract and Laws including obligations related to transfer and coordination of Enrollee care following termination.

VI. COMPENSATION

6.1 **Physician Group Compensation**. CalOptima shall compensate Physician Group for Covered Services and Administrative Services delegated to Physician Group, as set forth in Attachment C. Such Capitation Payments shall be payment in full for Covered Services and Administrative Services, except for amounts recovered through collection of Enrollee's Share of Cost, COBs, and Stop Loss Program, if applicable. Capitation Payment shall be sent on a monthly basis by the twentieth (20th) calendar day of the month, or if such day falls on a weekend or national holiday, on the first business day thereafter, for all Enrollees eligible from the first (1st) of the month, and on whose behalf payment has been received by CalOptima from CMS by the nineteenth (19th) calendar day of the month. In the event CalOptima receives payment from CMS after the nineteenth (19th) calendar day of the month, capitation payment to Physician Group will be made within five (5) working days of receipt of the monthly payment by CalOptima.

6.2 **Disputes Regarding Payments or Enrollment**. Any and all disputes related to Capitation Payments and/or enrollments shall be reported to CalOptima within ninety (90) calendar days of payment, and each dispute shall be clearly defined and include supporting documentation. Failure to dispute within the established time frame indicates acceptance of the Capitation Payment by Physician Group.

6.3 **Capitation Rate Adjustments**. The Capitation Rates may be adjusted by CalOptima during the Contract period to reflect implementation of State or federal laws or regulations, changes in the CMS Contract or CMS policy, and/or changes in Covered Services. If CalOptima receives advance notice of adjustment from CalOptima's Regulators, CalOptima shall provide notice thereof to Physician Group as soon as practicable. Capitation Rates may also be adjusted in the event of de-delegation of any function delegated under this Contract.

6.4 **Enrollee Non-Liability and Hold Harmless Requirements.** Physician Group and its Downstream Entities shall accept CalOptima's payment as described in this Contract as payment in full. Physician Group and its Downstream Entities for all Covered Services and Administrative Services under this Contract and shall not hold Enrollees liable to the Physician Group or Providers for any sums owed to Physician Group by CalOptima or owed to Providers by Physician Group.

6.4.1 Physician Group and its Downstream Entities shall hold harmless CMS, CalOptima, and Enrollees in the event Physician Group and/or Downstream Entities cannot or will not pay for services performed by Physician Group or Downstream Entities pursuant to this Contract or subcontract, as applicable.

6.4.2 Physician Group and its Downstream Entities shall ensure that Enrollees will not be held liable for Medicare Part A and B cost sharing when the State is responsible for paying such amounts and that the Physician Group will (i) accept Capitation Payment as payment in full under the Contract, or (ii) bill the appropriate State source, as required at 42 CFR §422.504(g)(1)(iii). Such services must be provided at zero cost-sharing to Enrollees.

6.4.3 Physician Group shall not hold an Enrollee liable for the following: (i) debts of Physician Group, in the event of 'Physician Group's insolvency; (ii) Covered Services provided to the Enrollee in the event that CalOptima or Physician Group fails to receive payment from CMS for such services; or (iii) payments to a clinical FDR or Downstream Entity in excess of the amount that would be owed by the Enrollee if Physician Group had directly provided the services.

6.4.4 Physician Group and its Downstream Entities shall not charge Enrollees coinsurance, co-payments, deductibles, financial penalties, or any other amount in full or part, for any service provided under this Contract, except as otherwise permitted under this Contract.

6.4.5 Physician Group and its Downstream Entities shall not deny any service provided under this Contract to an Enrollee for Enrollee's (or any entity responsible for making payment on Enrollee's behalf) failure or inability to pay any applicable charge or shall not deny any service provided under this Contract to an Enrollee who, prior to becoming eligible, incurred a bill that has not been paid.

6.5 **Overpayments Discovered by Physician Group**. Physician Group shall disclose and return all overpayments to CalOptima within sixty (60) days of when Physician Group identified the overpayment or should have identified the overpayment through the exercise of reasonable diligence.

6.6 **Recoupment for Ineligibility; Conlan Reimbursements**. CalOptima shall recoup payments made to Physician Group when CMS has determined that an individual was not eligible for the MA Program and retroactively terminates the individual, including recouping any payments made for a deceased Enrollee. CalOptima may also recoup overpayments to Physician Group owed by Physician Group to Enrollees, including offsetting any such amounts owed against Physician

Group's Capitation Payments or other amounts due from CalOptima to Physician Group under this Contract or any other agreement between the parties, if any. This Section 6.6 shall not be construed to limit CalOptima's right to recoup payment made to Physician Group on any other basis for which recoupment is appropriate.

6.7 **CalOptima Right to Recover**.

6.7.1 Overpayments. Physician Group acknowledges and agrees that, in the event that CalOptima determines that an amount has been overpaid or paid in duplicate, or that funds were paid which were not due under this Contract to Physician Group, CalOptima shall have the right to recover such amounts from Physician Group by recoupment or offset from current or future amounts due from CalOptima to Physician Group under this Contract or any other agreement between the parties, after giving Physician Group notice and an opportunity to return/pay such amounts.

6.7.2 Health Network Termination. In the event of termination of the Health Network or the transition of the Health Network to a different delegation model, CalOptima shall have the right to offset any unpaid claims that are the financial responsibility of Physician Group paid by CalOptima against any funds owed to Physician Group by CalOptima, including capitation payments, financial security withholds, pay-for-performance amounts, quality incentives, and shared risk pool surpluses.

6.7.3 Shared Risk Pool Payments Upon Termination. If this Contract terminates or expires for any reason and Physician Group is responsible for a deficit under any shared risk program under this Contract based on the final shared risk pool report results ("**Deficit**"), such Deficit shall be due to CalOptima as follows, as allowed by Laws: CalOptima may elect to recoup such Deficit by either (1) offsetting such Deficit amounts, upon notice to Physician Group, from any current or future amounts owed by CalOptima to Physician Group under the Contract or any other agreement between the Parties, including capitation payments, financial security withholds, pay-for-performance amounts, quality incentives, and shared risk pool surpluses; or (2) sending an invoice to Physician Group that payment for such Deficits are due to CalOptima within thirty (30) days of Physician Group's receipt of the CalOptima invoice.

6.7.4 Regulator Recoupment Upon Termination. If following the termination or expiration of this Contract, CalOptima's Regulators find that Physician Group (or its Downstream Entities) has failed to comply with the requirements governing physician incentive plans and CalOptima's Regulators offset, recoup and/or otherwise seek recovery of FFP, as described in Section 1.33, CalOptima may elect to recoup such FFP amounts, as allowed by Laws, by either: (1) offsetting such FFP amounts, upon notice to Physician Group, from any current or future amounts owed by CalOptima to Physician Group under the Contract or any other agreement between the Parties, including capitation payments, financial security withholds, pay-for-performance amounts, quality incentives, or shared risk pool surpluses; or (2) sending an invoice to Physician Group that payment for such FFP amounts are due to CalOptima within thirty (30) days of Physician Group's receipt of the CalOptima invoice.

6.7.5 Dispute Resolution. Physician Group may use CalOptima's provider dispute resolution procedure, as described under CalOptima's Policies, and/or the dispute resolution procedures under this Contract to resolve any disputes related to the calculation or payment of such Deficits or FFP amounts.

6.7.6 Survival. This Section 6.7 shall survive the termination or expiration of the Contract.

6.8 **Retroactive Cancellation**. CalOptima will discourage retroactive cancellation of any Enrollee. However, CalOptima may make exceptions as required by CMS or due to legitimate administrative processing requirements of CMS. CalOptima may make retroactive additions or cancellations of Enrollees, as necessary for administrative or business reasons, and such retroactive additions or cancellations of Enrollees shall not exceed ninety (90) days.

VII. REPORTING REQUIREMENTS

7.1 **Data Reporting Requirements**. Physician Group shall comply with the data reporting requirements set forth in this Contract, including the requirements specified in Standard Reporting Requirements set forth in CalOptima Policies and guidelines (referred to as the Timely and Appropriate Submission requirements). Physician Group shall provide such additional data and modify the form, content, instructions, and timetables for the collection and reporting of data, as may be required by CalOptima Policies.

7.2 **Eligibility Reports**. CalOptima will maintain, update, and distribute monthly Enrollee eligibility reports for each month in which the persons included on such list are eligible for CalOptima MA Program. This report will identify the Physician Group, PCP selected by the Enrollee, and the Enrollee's coverage. The report will be sent to Physician Group and PCPs by the tenth (10th) of each month, identifying eligible Enrollees from the first (1st) of the month.

7.3 **Utilization Data**. Physician Group shall, upon request, provide CalOptima with information on the utilization and cost of Covered Services provided to Enrollees in such detail as to allow CalOptima to conduct analysis of costs as required by CMS, as dictated by sound business practices and for the conduct of quality management and UM activities by CalOptima. Such information to be provided by Physician Group will not include information beyond that customarily provided on a claim form (such as Form CMS-1500) and shall be provided in the form of a paper report, computer disc, computer tape, or electronic file, as agreed by the parties. Required data will be delivered by Physician Group to CalOptima not later than forty-five (45) days following written request by CalOptima.

7.4 **Submission of Electronic Encounter Data**. Physician Group must meet any claims, diagnosis, and Encounter Data reporting requirements, as determined from time to time by CalOptima and CalOptima's Regulators.

7.4.1 Physician Group agrees to furnish CalOptima with complete, timely, reasonable, and accurate Encounter Data for Covered Services rendered to Enrollees. The Encounter Data will be furnished to CalOptima through Electronic Data Interchange (EDI) or a mutually acceptable format and shall be received by CalOptima per the Policy and Encounter Requirements Manual. Physician Group also agrees to furnish Medical Records that may be required to obtain any additional information or corroborate the Encounter Data. Physician Group further agrees to have its Chief Executive Officer (CEO) attest and certify the completeness and truthfulness of the Encounter Data submitted.

7.4.2 Physician Group shall be subject to financial penalties and/or sanctions if CalOptima determines that Physician is reporting to CalOptima less than all professional encounters in the CalOptima required format and timelines. Financial penalties or sanctions shall be assessed upon Physician Group should CalOptima determine that Physician Group is not meeting the standards defined in CalOptima Policies. This Section 7.4.2 shall survive the expiration or termination of this Contract, whether with or without cause, by rescission or otherwise, as to all Covered Services provided under this Contract prior to termination.

Based on CalOptima's quarterly determinations and following thirty (30) days' prior notice to Physician Group, CalOptima may withhold three (3%) percent of Capitation Payment if CalOptima determines that the monthly Encounter Data that Physician Group must provide has not been received by CalOptima within the prior quarter. If at the quarterly determination following such withhold, CalOptima determines that Physician Group has satisfactorily delivered to CalOptima the previously non-delivered Encounter Data; such withheld Capitation Payment shall be paid to Physician Group, without interest. In the event that Physician Group does not deliver such Encounter Data to CalOptima prior to such quarterly determination, CalOptima shall be entitled to retain such withheld Capitation Payment and may withhold three (3%) percent from each quarter's Capitation Payment until CalOptima receives the Encounter Data.

7.5 **Disclosure of Provider Profiling**. Physician Group shall, upon request from CalOptima, provide. CalOptima with information regarding any "economic profiling" of Group Physicians by Physician Group in order to permit CalOptima to comply with the provisions of Section 1367.02 of the Knox-Keene Act. Further, to the extent that Physician Group utilizes "economic profiling" as defined in Section 1367.02, Physician Group shall provide copies of economic profiling information to Providers in accordance with the requirements of Section 1367.02.

7.6 **Financial Reporting**. Physician Group shall prepare financial information requested in accordance with Generally Accepted Accounting Principles ("**GAAP**"). Where financial statements and projections are requested by CalOptima and/or CalOptima's Regulators, these statements and projections should be prepared in accordance with the 1989 HMO Financial Report of Affairs and Conditions Format. Where appropriate, reference has been made to the Knox-Keene Act rules found under Title 28 CCR Section 1300.51 *et. seq*. Information submitted shall be based on Physician Group's current operations. Physician Group shall submit financial information consistent with filing requirements of the DMHC, unless otherwise specified by CMS.

7.7 **Financial Statements**. CalOptima, as a Knox-Keene Act health care service plan, is required by CalOptima's Regulators to monitor the financial viability of its contracted provider network on an on-going basis. Physician Group agrees to provide CalOptima annually with a copy of Physician Group's audited financial statements, including letters to management for the most recent fiscal year end along with an opinion letter on these statements from the accounting firm that completed an audit on these financial statements. Financial statements shall be presented in a form specified by CalOptima that clearly shows the financial position of Physician Group as related to Enrollees. Physician Group shall allow representatives of CalOptima, upon written request, to verify the financial reports. In the event audited statements are unavailable, Physician Group agrees to provide CalOptima with the unaudited financial statements at Physician Group's fiscal year end. The unaudited financial statements will include: balance sheets, income statement and statement of cash flows, notes to the financial statement, name of the person preparing these statements, and representation letters from the senior financial executives of the Physician Group, attesting that these financial statements were prepared in accordance with GAAP and fairly present the financial condition of the Physician Group.

7.8 **Reports Regarding Disclosure of Confidential Enrollee Information**. If Physician Group, or any of its officers, employees, agents, or Downstream Entities, becomes aware of the unauthorized disclosure of confidential Enrollee information or of "personal information", within the meaning of California Civil Code Section 1798.3, Physician Group shall report said unauthorized disclosure to CalOptima's Privacy Officer immediately upon discovery of said disclosure, providing information on the information disclosed and how the disclosure occurred. For purposes of this section, "unauthorized disclosure" includes any unauthorized access, whether such access was

through inadvertence, mistake, theft, or other means, and whether or not Physician Group had reasonable control to avoid the disclosure. Nothing herein is intended to limit or replace Physician Group's separate obligations under the Business Associate Agreement and Laws.

7.9 **Additional Information Required by CalOptima's Regulators**. Physician Group and Downstream Entities shall, at the request of CalOptima or CalOptima's Regulators, provide the following: (i) all information related to the performance of CalOptima's responsibilities, including non-medical information for the purposes of research and evaluation, to CalOptima's Regulators; (ii) any information required to comply with all Laws; and (iii) any information required for external rapid cycle evaluation, including program expenditures, service utilization rates, rebalancing from institutional to community settings, Enrollee satisfaction, Enrollee complaints and Appeals, and enrollment/disenrollment rates.

VIII. RECORD RETENTION, ACCESS AND CONFIDENTIALITY

8.1 **Disclosure of Records**. Physician Group and its Downstream Entities agree to maintain and make available contracts, books, documents, records, and electronic systems, including, Medical Records, (collectively, the "**Records**") to CalOptima, HHS, CMS, the Comptroller General, the U.S. Government Accountability Office, any Quality Improvement Organization, or accrediting organizations, including NCQA, their designees, and other representatives of regulatory or accrediting organizations, for inspection, evaluation, and auditing. For purposes of utilization management, quality improvement, and other CalOptima administrative purposes, CalOptima and CalOptima's Regulators shall have access to, and copies of, at reasonable time upon request, the Medical Records, books, charts, and papers relating to the provision of health care services to Enrollees, the cost of such services, and payments received by Physician Group or any of Group Physicians from Enrollees (or from others on their behalf). Copies of the Medical Record shall be provided at no charge to CalOptima. Unless a longer time is required under applicable law, the records described herein shall be maintained for at least ten (10) years from the final date of the Contract or from the completion of any audit, whichever is later.

8.2 **Medical Records**. Physician Group will require that all Group Physicians and Downstream Entities establish and maintain in an accurate and timely manner, for each Enrollee who has obtained Covered Services from a Group Provider or Downstream Entity, a legible Medical Record which shall be kept in detail consistent with good medical and professional practice in accordance with Laws and CalOptima Policies. Such Medical Records shall include a historical record of diagnostic and therapeutic services recommended or provided by, or under the direction of, the Provider. Such Medical Records shall be in such a form as to allow trained health professionals, other than the Provider, to readily determine the nature and extent of the Enrollee's medical problem and the services provided and permit peer review of the care provided. Physician Group shall ensure that medical information is released in accordance with applicable Laws, or pursuant to valid court orders or subpoenas, subject to compliance with applicable privacy laws. Physician Group shall ensure than an individual is delegated the responsibility of securing and maintaining Medical Records at each Physician Group or Downstream Entity site.

8.3 **Right to Inspection**. Medical Records referred to in Section 8.2 above will be and remain the property of Physician Group or Group Physicians and will not be removed or transferred from their offices except in accordance with Laws. CalOptima or its designated representatives will have the right, in accordance with this Article 8, to inspect, review, and make copies of such records at Physician Group's expense upon request to facilitate CalOptima's obligation to conduct quality management, utilization monitoring, and peer review activities.

8.4 **Records Related to Recovery for Litigation**. Upon request by CalOptima, Physician Group and its Downstream Entities shall timely gather, preserve, and provide to CalOptima, in the form and manner specified by CalOptima, any information specified by CalOptima, subject to any lawful privileges, in Physician Group's or its Downstream Entities' possession, relating to threatened or pending litigation by or against CalOptima, HHS, and CMS. If Physician Group asserts that any requested documents are covered by a privilege, Physician Group shall: (1) identify such privileged documents with sufficient particularity to reasonably identify the document while retaining the privilege; and (2) state the privilege being claimed that supports withholding production of the document. Such request shall include a response to a request for documents submitted by any party in any litigation by or against CalOptima. Physician Group acknowledges that time may be of the essence in responding to such request. Physician Group shall use all reasonable efforts to immediately notify CalOptima of any subpoenas, document production requests, or requests for records received by Physician Group or its Downstream Entities related to this Contract or subcontracts entered into under this Contract.

8.5 **State and Federal Site Visits**. Physician Group agrees to permit CalOptima, the DMHC, HHS, and/or CMS to conduct a site evaluation of Physician Group and its facilities in accordance with Laws and to comply with the agencies' recommendations, if any.

8.6 **Enrollee Access to Records**. Physician Group (including Physician Group Providers) and its Downstream Entities shall ensure that Enrollees have access to their Medical Records in accordance with the requirements of Laws. An Enrollee shall be provided a copy of his or her Medical Records, upon request, and shall have the right to request corrections or amendments to their Medical Records as specified in 45 CFR Part 164. Physician Group and Downstream Entities shall furnish a copy of the Enrollee's Medical Records to another treating or consulting Provider regardless of whether the requesting Provider is a Participating Provider, at no cost to CalOptima or the Enrollee when (i) such a transfer of Medical Records facilitates the continuity of that Enrollee's care; (ii) the Enrollee is transferring from one Provider to another for treatment; and (iii) an Enrollee seeks to obtain a second opinion on the diagnosis or treatment of a medical condition.

IX. INSURANCE AND LIABILITY

9.1 **Indemnification**. Each Party agrees to defend, indemnify, and the other Party and the State and CMS harmless, with respect to any and all claims, costs, damages, and expenses, including reasonable attorney's fees, that are related to or arise out of the negligent or willful performance or non-performance by the indemnifying Party, or any functions, duties, or obligations of such Party. Neither termination of the Contract nor completion of the acts to be performed under this Contract shall release either Party from its obligation to indemnify as to any claims or cause of action asserted so long as the event(s) upon which such claims or cause of action is predicated shall have occurred prior to the effective date of termination or completion. CalOptima and Physician Group agree to promptly notify the other Party of any claims or demands that arise and for which indemnification hereunder is sought.

9.2 **Insurance Requirements**.

9.2.1 **Professional/Medical Malpractice**. Each Group Physician and Participating Provider providing Covered Services to Enrollees shall maintain a professional liability (medical malpractice) insurance policy for the specialty or type of service that the Group Physician provides with minimum limits of one million dollars ($1,000,000) per incident and three million dollars ($3,000,000) in the aggregate.

9.2.2 **Commercial General Liability**. Physician Group and each Participating Provider who has entered into a contract with Physician Group to provide Covered Services under this Contract shall maintain a Commercial General Liability insurance policy with minimum limits of one million dollars ($1,000,000) per occurrence and three million dollars ($3,000,000) in the aggregate. CalOptima must be named as an additional insured on Comprehensive General Liability insurance policy with respect to performance under this Contract.

9.2.3 **Workers' Compensation**. Group Physician and each Participating Provider who has entered into a contract with Physician Group to provide Covered Services under this Contract shall maintain a Workers' Compensation Insurance policy with minimum limits as follows:

- Employers' Liability Insurance:
  - One million dollars ($1,000,000) Bodily Injury by Accident - each accident.
  - One million dollars ($1,000,000) Bodily Injury by Disease - policy limit
  - One million dollars ($1,000,000) Bodily Injury by Disease - each employee

9.2.4 **Managed Care Errors and Omissions**. Physician shall maintain a Managed Care Errors and Omissions Insurance policy with minimum limits as follows:

- Managed Care Errors and Omissions: Ten million dollars ($10,000,000) each claim/ten million dollars ($10,000,000) aggregate

9.2.5 **Electronic and Computer Crimes Insurance**. HMO and its Downstream Entities shall maintain electronic and computer crimes insurance and employee fidelity insurance with limits of at least one million dollars ($1,000,000) if HMO and/or its Downstream Entities will be paying claims or receiving funds on behalf of CalOptima, or will be storing, transmitting, and/or receiving personally identifiable and/or protected health information on a regular basis in carrying out its obligations under this Contract.

9.2.6 **Insurer Ratings**. Insurance required under this Article IX shall be provided by an insurer:

(a) Rated by A.M. Best with a rating of A V or better; and

(b) "Admitted" to do business in California or an insurer approved to do business in California by the California Department of Insurance and listed on the Surplus Lines Association of California List of Eligible Surplus Lines Insurers (LESLI); or

(c) An Unincorporated Interindemnity Trust Arrangement as authorized by the California Insurance Code 12180.7

9.2.7 **Captive Risk Retention Group/Self Insured**. Where any of the insurance(s) mentioned in this Article IX is provided by a captive risk retention group or self-insured, insurer ratings requirements above may be waived at the sole discretion of CalOptima, but only after review of the captive risk retention group's or self-insured's audited financial statements.

9.2.8 **Cancellation or Material Change**. Physician Group shall not of its own initiative cause such insurance as addressed in this Article IX to be cancelled or materially changed during the Term.

9.2.9 **Proof of Insurance**. Certificates of Insurance of the insurance policies and/or evidence of self-insurance required under this Article IX shall be provided to CalOptima prior to Effective Date, annually thereafter, and upon request.

X. COOPERATION

10.1 **Non-Interference**. Physician Group and Downstream Entities may not prohibit of otherwise restrict a health care professional, acting within the lawful scope of practice, from freely communicating with Enrollees about their treatment and the following, regardless of benefit coverage limitations:

10.1.1 The Enrollee's health status, medical care, or treatment options (including any alternative treatments that may be self-administered), including the provision of sufficient information to provide an opportunity for the Enrollee to decide among all relevant treatment options;

10.1.2 The risks, benefits, and consequences of treatment or non-treatment; or

10.1.3 The opportunity for the Enrollee to refuse treatment and to express preferences about future treatment decisions.

10.2 **No Counseling to Dis-enroll**. Physician Group and Group Physicians agree that they will not, during the Term, provide advice to or counsel any Enrollee to dis-enroll from CalOptima, and Physician Group and Group Physicians will not solicit such Enrollee to become enrolled with any other health maintenance organization, preferred provider organization, or any other similar hospitalization, medical payment plan or insurance program.

10.3 **Cooperation**. CalOptima and Physician Group agree that, to the extent compatible with the separate and independent management of each, they will at all times maintain an effective liaison and close cooperation with each other to provide maximum benefits to Enrollees at the most reasonable cost, consistent with quality standards of hospital and physician care.

10.4 **Signs**. Physician Group agrees that CalOptima may post notices, mutually acceptable as to size, content and form in a prominent place instructing Enrollees as to proper procedures and limitations on coverage.

10.5 **Free Exchange of Information**. No provision of this Contract shall be construed to prohibit, nor shall any provision in any contract between Physician Group and its employees or Downstream Entities, prohibit, the free, open, and unrestricted exchange of any and all information of any kind between Providers and Enrollees regarding the nature of the Enrollee's medical condition, the health care treatment options and alternatives available and their relative risks and benefits, whether or not covered or excluded under the Enrollee's Evidence of Coverage, and the Enrollee's right to appeal any adverse decision made by Physician Group or CalOptima regarding coverage of treatment which has been recommended or rendered. Physician Group and CalOptima agree not to penalize nor sanction any Provider in any way for engaging in such free, open, and unrestricted communication with an Enrollee nor for advocating for a particular service on an Enrollee's behalf.

XI. TERM AND TERMINATION

11.1 **Term of Contract**. The term of this Contract shall become effective on the Effective Date and continue in effect for five (5) years through _____ ("Initial Term") and five (5) additional one-year automatic extensions except as directed otherwise by the Board.

11.2 **Sanctions and Terminations for Cause**. If Physician Group fails to fulfill any of its duties and obligations under this Contract, including: (i) committing acts to discriminate against Enrollees; (ii) engaging in any practice that would reasonably be expected to have the effect of denying or discouraging enrollment with the Physician Group by Enrollees whose medical condition or history indicated a need for substantial future medical services; (iii) not providing Covered Services in the scope or manner required under this Contract; (iv) engaging in prohibited marketing activities; (v) failing to comply with CalOptima's compliance and fraud, waste and abuse programs; (vi) failing to meet financial requirements in Article II; (vii) committing fraud, waste or abuse relating to Covered Services or any and all obligations, duties, and responsibilities under this Contract; (viii) failure to enforce claims payment prohibitions on Group Physicians who are denied the right to submit claims and/or receive reimbursement for services furnished to Enrollees; (ix) failure of Group Physicians to comply with pharmacy requirements as determined by CalOptima; (x) failure to submit Encounter Data or comply with other reporting requirements pursuant to this Contract and CalOptima Policies; and/or (xi) failure to take corrective action related to any such obligation or duty in the time or manner required by CalOptima, CalOptima may take any one or more of the actions described in this Article XI.

11.3 **Corrective Action Plans**. CalOptima may require a Corrective Action Plan ("**CAP**") in the event that any report, audit, survey, site review or investigation indicates that the Physician Group or any Downstream Entity is not in compliance with any provision of this Contract.

11.3.1 A CAP shall be required if CalOptima receives a substantiated complaint or grievance related to the standard of care provided by the Physician Group or any Downstream Entities. CalOptima shall issue a written notice of deficiency and shall require that a CAP to be submitted within thirty (30) calendar days following the date of notice unless otherwise stated. The CAP shall include the time and manner in which the deficiency shall be corrected. CAPs are subject to approval by CalOptima, which may be approved as submitted, accepted with specific modifications, or rejected. CalOptima may extend or reduce the time allowed for completion of the CAP depending upon the nature of the deficiency.

11.3.2 Notwithstanding any request for a CAP, CalOptima may impose monetary penalties, suspend enrollment, reduce maximum enrollment, or impose other sanctions when the Physician Group is not in compliance with the provisions of this Contract, CalOptima Policies, and minimum performance requirements as established by CalOptima. All monetary fines are payable to CalOptima within thirty (30) calendar days of receipt of written notice, unless otherwise stated in the notice. Failure to submit payment to CalOptima for any monetary fines within the thirty (30) calendar day period shall result in CalOptima deducting the penalty plus administrative fees from the Physician Group's Capitation Payment.

11.4 **CalOptima Termination for Cause**. Notwithstanding and in addition to any other provisions of this Contract, CalOptima may terminate this Contract for cause effective upon thirty (30) calendar days' written notice; cause shall include, but shall not be limited to, the actions set forth in Section 11.2. CalOptima's rights and remedies provided in this provision shall not be exclusive and are in addition to any other rights and remedies provided by law or this Contract.

11.5 **Physician Group Termination for Cause**. Physician Group may terminate this Contract for cause only upon thirty (30) calendar days' written notice and only in the event that CalOptima fails to make payments due under this Contract within fifteen (15) calendar days of when such amounts are due and payable.

11.6 **Immediate Terminations**. In addition to all other sanction and termination rights, CalOptima may terminate Contract immediately upon delivery of written notice to Physician Group if:

11.6.1 Physician Group (including Group Physicians) and/or its Downstream Entities are unable to secure the necessary governmental licenses, approvals, and/or certificates required for the performance of their duties;

11.6.2 CalOptima determines that the health, safety, or welfare of Enrollees is jeopardized by continuation of this Contract;

11.6.3 Physician Group commits fraud, waste, or abuse; or

11.6.4 CMS fails to authorize or reauthorize CalOptima to operate a MA Program for a period that overlaps the Term.

11.7 **Without Cause Termination**. Following the Initial Term, either Party may terminate this Contract for convenience, without cause, by giving written notice to the other Party of at least one hundred and eighty (180) calendar days' prior to the effective date of such termination.

11.8 **Bankruptcy**. If during the Term there is filed by or against Physician Group in any court pursuant to any statute of the United States or any state, a petition in bankruptcy or insolvency or for reorganization or for the appointment of a receiver or trustee or conservator of all or a portion of Physician Group's assets, or if Physician Group makes an assignment for the benefit of creditors, or if Physician Group becomes unable, admits in writing its inability, or fails generally to pay its debts as they become due, this Contract may, at the option of CalOptima, be canceled and terminated. In the event of the filing of a petition for bankruptcy by or against Physician Group, Physician Group shall assure that all of Physician Group's functions and duties related to the Contract are performed in accordance with the terms of the Contract. CalOptima shall have the right to withhold any and all amounts otherwise due to Physician Group until Physician Group fully discharges its obligations under the Contract. CalOptima shall also have the immediate right of offset by permanently retaining any and all withheld amounts as necessary to ensure that all Physician Group obligations have been met.

11.9 **Termination of CMS Contract.** In the event the CMS Contract with CalOptima is terminated or not renewed, the provisions of this Contract shall automatically terminate unless otherwise specified by CalOptima and subject to any provisions that survive termination. Any term provided in the Contract is subject to CMS's continuing approval of CalOptima's MA Program. Physician Group agrees to assist CalOptima with such transfer of care requirements mandated by CMS in the event of termination of the CMS Contract.

11.10 **Continuation of Benefits**. Physician Group and its Participating Providers agree that, in the event of CalOptima's insolvency or cessation of operations, benefits to Enrollees will continue through the period for which capitation has been paid or until the discharge of Enrollee from an inpatient facility, whichever time is greater. Covered Services to an Enrollee confined in an inpatient facility on the date of insolvency or other cessation of operations will continue until their appropriate discharge.

11.11 **Physician Group Obligations Following Termination**. In the event of termination of this Contract, at CalOptima's sole option, Physician Group will continue to provide Covered Services, and CalOptima shall reimburse for such services per the Medicare fee schedule, to Enrollees until CalOptima has made arrangements with alternative Providers to render care to Enrollees. Physician Group shall cooperate and assist CalOptima in the transfer of Enrollee care in the event this Contract or any relevant Downstream Entity subcontract is terminated for any reason. Physician Group shall provide a plan for the orderly termination of services under this Contract, in form and substance acceptable to CalOptima.

11.12 **Prohibition on Use of Certain Group Physicians**. Physician Group agrees that CalOptima reserves the right to require Physician Group, upon notification from CalOptima, to prohibit any Group Physician or Downstream Entity from providing services, whether Covered Services or otherwise, to Enrollees when CalOptima deems such prohibition to be in the best interests of the Enrollees, provided that imposition of the foregoing prohibition shall not terminate this Contract.

XII. GENERAL PROVISIONS

12.1 **Dispute Resolution**.

12.1.1 **Provider Appeals Process**. CalOptima maintains a Provider dispute resolution process. Physician Group may appeal any aspect of the CalOptima MA Program, including a decision to impose a sanction, terminate this Contract, or take other actions against Physician Group, by filing a complaint pursuant to CalOptima Policies. Physician Group shall exhaust all administrative remedies and any government claims requirements, as applicable, before commencing arbitration.

12.1.2 **Meet and Confer**. For any dispute not subject to or resolved by the provider appeals process, or if either Party has a dispute it seeks to address informally, the Parties shall use reasonable efforts to informally meet and confer to try and resolve the dispute. The Parties shall meet and confer within thirty (30) days of a written request submitted by either Party in an effort to settle any dispute. At each meet-and-confer meeting, each Party shall be represented by persons with final authority to settle the dispute. If either Party fails to meet within the thirty (30)-day period, that Party shall be deemed to have waived the meet-and-confer requirement, and at the other Party's option, the dispute may proceed immediately to arbitration under Section 12.1.3.

12.1.3 **Arbitration**. If the Parties are unable to resolve any dispute arising out of or relating to this Contract under Sections 12.1.1 and 12.1.2, either Party may submit the dispute for resolution exclusively through confidential, binding arbitration, instead of through trial by court or jury, in Orange County, California. The Parties may agree in writing prior to commencing the arbitration on the dispute resolution rules and arbitration service that will be used to resolve the dispute. If the Parties cannot reach such an agreement, the arbitration will be conducted by Judicial Arbitration and Mediation Services ("**JAMS**") in accordance with the commercial dispute rules then in effect for JAMS; provided, however, that this Contract shall control in instances where it conflicts with JAMS's (or the applicable arbitration service's) rules. The arbitration shall be conducted on an expedited basis by a single arbitrator. The Parties prefer that the arbitrator be a retired judge of the California Superior, Appellate, or Supreme Court or of a United States court sitting in California. If no such retired judge is available, the arbitrator may be an attorney with at least fifteen (15) years of experience, including at least five (5) years in managed health care. If the Parties are unable to agree on the arbitrator within thirty (30) days of the date that the arbitration

service accepts the arbitration, the arbitrator shall be selected by the arbitration service from a list of four potential arbitrators (all of whom shall be on arbitration services' panel of arbitrators) submitted by the Parties, two from each side; provided, however, that nothing stated in this section shall prevent a Party from disqualifying an arbitrator based on a conflict of interest. In making decisions about discovery and case management, it is the Parties' express agreement and intent that the arbitrator at all times promote efficiency without denying either Party the ability to present relevant evidence. In reaching and issuing decisions, the arbitrator shall have no jurisdiction to make errors of law and/or legal reasoning. The Parties shall share the costs of arbitration equally, and each Party shall bear its own attorneys' fees and costs.

12.1.4 **Exclusive Remedy**. With the exception of any dispute that under Laws may not be settled through arbitration, arbitration under Section 12.1.3 is the exclusive method to resolve a dispute between the Parties arising out of or relating to this Contract that is not resolved through the provider appeals or meet-and-confer processes.

12.1.5 **Waiver**. By agreeing to binding arbitration as set forth in Section 12.1.3, the Parties acknowledge that they are waiving certain substantial rights and protections which otherwise may be available if a dispute between them was determined by litigation in a court, including the right to a jury trial, attorneys' fees, and certain rights of appeal.

12.2 **Interpretation of Contract Language**. CalOptima has the right to final interpretation of the Contract language when disputes arise. Physician Group has the right to appeal disputes concerning Contract language to CalOptima.

12.3 **Waiver**. The waiver by either Party of a breach or violation of any provision of this Contract will not operate as or be construed to be a waiver of any subsequent breach thereof. To be effective, a waiver must in writing signed by the Parties.

12.4 **Assignment**. This Contract and the rights, interests, duties, and obligations hereunder shall not be assigned, transferred, pledged, or hypothecated in any way by Physician Group nor shall the duties and obligations imposed herein be subcontracted or delegated without the prior written consent of CalOptima, which consent may be withheld in CalOptima's sole and absolute discretion for any reason or no reason. Physician Group acknowledges and agrees that CalOptima's consent, if any, to assignment and/or delegation is subject to the approval of CMS. Therefore, any assignment and/or delegation of this Contract, including the rights, interests, duties, and obligations hereunder, shall be void unless prior written consent is obtained from CalOptima and CMS. Physician Group further acknowledges and agrees that CalOptima may require Physician Group and the proposed assignee/sub-delegate to cooperate in due diligence and sub-delegation assessment activities as part of its review of any request for consent to assignment of this Contract and the rights, interests, duties, and obligations hereunder. Physician Group agrees to cooperate and provide such information as requested by CalOptima. Physician Group acknowledges and agrees that (i) CalOptima's due diligence and/or assessment activities related to any proposed assignment may take one hundred eighty (180) days or more; (ii) in no event shall CalOptima's due diligence and/or delegation assessment activities be construed as CalOptima's consent to assignment; and (iii) any consent to assignment by CalOptima must be reflected in a separate writing executed by CalOptima and other relevant parties. CalOptima may, from time to time, establish policies and procedures regarding its processes for initiating review and approval of any proposed assignment of this Contract. For purposes hereof, the term "**assignment**" shall include any of the following: (i) the change of more than twenty-five percent (25%) of the ownership or equity interest in Physician Group (whether in a single transaction or in a series of transactions); (ii) the change of more than

twenty-five percent (25%) of the directors or trustees of Physician Group; (iii) the merger, reorganization, or consolidation of Physician Group with another entity with respect to which Physician is not the surviving entity; and/or (iv) a change in the management of Physician Group from management by persons appointed, elected, or otherwise selected by the governing body of Physician Group (e.g., the Board of Directors) to a third-party management person, company, group, team or other entity.

12.5 **Independent Parties**. None of the provisions of this Contract are intended to create nor will be deemed or construed to create any relationship between the Parties other than that of independent contractors, solely for the purposes of effecting the provisions of the Contract. Neither of the Parties nor any of their respective officers, directors, or employees shall act as nor be construed to be the agent, the employee, or the representative of the other Party.

12.6 **Integration of Entire Contract**. This Contract contains all of the terms and conditions agreed upon by the Parties regarding the subject matter of this Contract. Any prior agreements, promises, negotiations or representations of or between the Parties, either oral or written, relating to the subject matter of this Contract that are not expressly set forth in this Contract are null and void and of no further force or effect.

12.7 **Invalidity or Unenforceability**. The invalidity or unenforceability of any terms or provisions hereof will in no way affect the validity or enforceability of any other term or provision.

12.8 **Amendment**. CalOptima may amend this Contract immediately upon written notice to Physician Group in the event such amendment is required in order to maintain compliance with Laws. CalOptima may deem all other amendments to the Contract effective after at least forty-five (45) business days' notice or earlier if agreed to by Physician Group. All amendments of this Contract are subject to CMS approval.

12.9 **No Waiver of Immunity or Privilege**. Any information delivered, exchanged, or otherwise provided hereunder shall be delivered, exchanged, or otherwise provided in a manner, which does not constitute a waiver of immunity or privilege under applicable law.

12.10 **Choice of Law; Jurisdiction and Venue**. This Contract shall be governed by and construed in accordance with all State and federal laws and regulations governing the CMS Contract. The Parties consent to the jurisdiction of the California Courts with venue in Orange County California.

12.11 **Force Majeure**. Either Party, upon prompt written notice to the other Party, shall be excused from performance hereunder for any period that it is prevented from meeting the terms of this Contract as a result of a catastrophic occurrence or natural disaster, including, but not limited to, an act of war and excluding labor disputes ("**Force Majeure Event**");

12.12 **No Liability of County of Orange**. As required under Ordinance No. 3896, as amended, of the County of Orange, State of California, CalOptima and the Physician Group hereby acknowledge and agree that the obligations of CalOptima under this Contract are solely the obligations of CalOptima, and the County of Orange, State of California, shall have no obligation or liability therefor.

12.13 **Confidential and Proprietary Information**. Physician Group agrees to maintain confidential the following information (the "**Confidential Information**"): (a) eligibility lists and any other information containing the names, addresses and telephone numbers of CalOptima Enrollees; (b) CalOptima's administrative service manuals and all forms related thereto; (c) the financial

arrangements between CalOptima and any Participating Provider; and (d) any other information compiled or created by CalOptima that is proprietary to CalOptima and that CalOptima identifies as proprietary to Physician Group in writing. Physician Group shall not disclose or use the Confidential Information for its own benefit or gain either during the Term or after the date of termination of this Contract. Physician Group may use the Confidential Information to the extent necessary to perform its duties under this Contract or upon express prior written permission of CalOptima. Upon the effective date of termination of this Contract, Physician Group shall promptly return to CalOptima the Confidential Information in its possession, upon CalOptima's notice.

12.14 **Third Party Beneficiaries**. Nothing in this Contract, express or implied, is intended to or shall confer upon any other person or entity, any right, benefit or remedy of any nature whatsoever.

12.15 **Survival**. The terms set forth in the following sections shall survive the expiration or termination of this Contract, whether with or without cause, by rescission or otherwise, as to all Covered Services provided under this Contract prior to termination: Sections 6.2, 6.5, 7.8, Article 8, 9.1, 11.10, 11.11, 12.1, 12.2, 12.3, 12.5, 12.6, 12.7, 12.9, 12.10, 12.12, 12.13, 12.14, and any other sections that, by their terms, are intended to survive termination of the Contract.

12.16 **Recitals and Exhibits**. The recitals and exhibits set forth in this Contract are made a part of the Contract by this reference.

12.17 **Without Limitation**. Any reference in the Contract to "include(s)" or "including" means inclusion without limitation, unless otherwise distinguished within the text.

12.18 **Notices**. All notices shall be in writing and shall be deemed to have been duly given on the date of service if personally served on the Party to whom notice is given, or seventy-two (72) hours after mailing by electronic mail transmission, United States priority mail, United States mail first class (Certified Mail or Registered Mail), addressed to the Party to whom notice is to be given and such party's address as set forth below or such other address provided by notice.

To: CalOptima

Attention: Chief Operating Officer
505 City Parkway West
Orange, California 92868

To: Physician Group

_____

_____

_____

XIII. CONDITIONS PRECEDENT TO CONTRACT COMMENCEMENT

13.1 **Contract Effectiveness**. The Contract is subject to CalOptima's determination, in its sole discretion, that the following conditions have been met prior to the Effective Date: (i) Physician Group has successfully met all criteria in CalOptima's readiness assessment, including financial viability and delegated function criteria; Physician Group has signed CalOptima's Business Associate Agreement; and (iii) Physician Group has furnished all required documentation and data requested by CalOptima (e.g., insurance documents, licenses).

13.2 **Additional CalOptima Regulator Requirements**. CalOptima, in its sole discretion, may condition this Contract upon Physician Group's ability to meet other criteria imposed by CalOptima Regulators.

XIV. SIGNATURES

SUBJECT TO (I) THE UNITED STATES GOVERNMENT PROVIDING FUNDS FOR THE TERM OF THIS CONTRACT AND FOR THE PURPOSES WITH RESPECT TO WHICH IT IS ENTERED INTO; AND (II) THE APPROVAL OF THIS CONTRACT BY DMHC AND CMS, THIS CONTRACT SHALL BECOME EFFECTIVE ON THE EFFECTIVE DATE AND SHALL TERMINATE ON AS PROVIDED IN THIS CONTRACT.

IN WITNESS WHEREOF, CalOptima and Physician Group have executed this Contract as indicated below.

FOR Physician Group:	FOR CALOPTIMA:
_____	_____
SIGNATURE	SIGNATURE
_____	Yunkyung Kim
PRINT NAME	PRINT NAME
_____	Chief Operations Officer
TITLE	TITLE
_____	_____
DATE	DATE

ATTACHMENT A
DEFINITIONS

1. "**Administrative Services**" means those non-clinical, administrative functions that are the responsibility of the Physician Group as set forth under the Contract and in CalOptima Policies.

2. "**Advance Directive**" means an individual's written directive or instruction, such as a power of attorney for health care or a living will, recognized under state law (whether statutory or as recognized by the courts of the state) for the provision of that individual's health care if the individual is unable to make his or her health care wishes known.

3. "**Appeals**" means an Enrollee's actions, both internal and external to CalOptima, requesting review of the denial, reduction, or termination of benefits or services from CalOptima.

4. "**Authorization/Authorized**" means the approval of CalOptima, or its delegate (which may include Physician Group), for the provision or referral of Covered Services, obtained in accordance with, and as further described in, the Provider Manual and this Contract.

5. "**Behavioral Health**" means the mental health services and substance use disorder services arranged for or provided to Enrollees by a separate Mental Health Plan, CalOptima, or their subcontractors.

6. "**CalOptima Formulary**" means the CalOptima Approved Drug List, the Disposable Medical Equipment/Supplies List, the CalOptima OneCare Formulary, and any additional formularies as may be designated by CalOptima and provided to CalOptima's designated pharmacy benefits manager "**PBM**". There is no applicable CalOptima Formulary for the PACE program.

7. "**CalOptima Policies**" means CalOptima policies and procedures, including CalOptima's Provider Manual, that are amended from time to time at the sole discretion of CalOptima and incorporated into this Agreement by this reference.

8. "**CalOptima's Regulators**" means those government agencies that regulate and oversee CalOptima's and its FDRs' activities and obligations under this Contract including the Department of Health and Human Services, CMS, and the DMHC and other government agencies that have authority to set standards and oversee the performance of the parties to this Contract, as well as their respective agents and contractors quality improvement organizations.

9. "**Capitation Payment**" means the monthly payment paid to Physician Group by CalOptima for delivery for Covered Services to Enrollees, which is determined by multiplying the applicable Capitation Rate by Physician Group's monthly enrollment.

10. "**Capitation Rate**" means the rate set by CalOptima for the delivery of Covered Services to an Enrollee.

11. "**Care Coordinator**" means a clinician or other trained individual employed by or contracted with Physician Group who is accountable for providing care coordination services for Enrollees, as required by CalOptima Policies and who services on one or more ICTs.

12. "**C.C.R.**" means the California Code of Regulations.

13. "**C.F.R.**" means the Code of Federal Regulations.

14. "**CMS**" means the Center for Medicare & Medicaid Services.

15. "**CMS Contract**" means the agreement between CMS and CalOptima under which CalOptima can establish its MA Program for Enrollees.

16. "**COB**" refers to the coordination of benefits and determination of order of financial responsibility that applies when two or more health benefit plans provide coverage of items and services for an individual.

17. "**Compliance Program**" means the program (including the compliance manual, code of conduct and CalOptima Policies) developed and adopted by CalOptima to promote, monitor, and ensure that CalOptima's operations and practices and the practices of its Board members, employees, contractors, and Providers comply with applicable law and ethical standards. The Compliance Program includes CalOptima's Fraud, Waste and Abuse ("**FWA**") plan.

18. "**Covered Services**" means those health care items, drugs, and services that an Enrollee is entitled to receive pursuant to a Program applicable to that Enrollee. Covered Services must generally be referred and Authorized in confirming with CalOptima's Policies, including its utilization management program."

19. "**Delegation**" means the process by which CalOptima expressly grants, by formal written agreement to another entity, the authority to carry out a function that would otherwise be required to be performed by CalOptima in order to meet its obligations under the CMS Contract.

20. "**Delegation Agreement**" means the formal written agreement by which CalOptima grants to another entity the authority to carry out a function that would otherwise be required to be performed by CalOptima to meet its obligations under the CMS Contract.

21. "**Delegation Criteria**" means those criteria adopted by CalOptima, for the delegation of activities in the areas of UM, medical records audits, the Office Site Review, 'Enrollee's rights and responsibilities, and credentialing, as set forth in CalOptima Policies.

22. "**DMHC**" means the California Department of Managed Health Care.

23. "**Downstream Entity**" means all Providers and other persons or entities with which Physician Group has entered into a written subcontract (acceptable to CMS) to perform administrative functions and/or health care services to satisfy Physician Group's obligations to CalOptima under this Contract, continuing down to the ultimate provider of services. The term "Physician Group" as used in the terms of this Contract shall also include its subcontractors when such subcontractors are Downstream Entities, even if not expressly referenced in the particular provision.

24. "**Emergency Medical Condition**" means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, with an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in: (i) placing the health of the individual (or with respect to a pregnant woman, the health of the woman and her unborn child) in serious jeopardy; or (ii) serious impairment to bodily functions; or (iii) serious dysfunction of any bodily organ or part.

25. "**Emergency Services**" means those covered inpatient and outpatient services that are (i) furnished by a Provider qualified to furnish Emergency Services; and (ii) needed to evaluate and/or stabilize an Enrollee's Emergency Medical Condition.

26. "**Encounter Data**" means the record of an Enrollee receiving any item(s) or service(s) provided through Medicaid or Medicare under a prepaid, capitated, or any other risk basis payment methodology submitted to CMS. The encounter data record shall incorporate HIPAA security, privacy, and transaction standards and be submitted in ASCX12N 837 or any successor format required by CalOptima's Regulators.

27. "**Enrollee**" means an eligible individual who is enrolled in the CalOptima MA Program.

28. "**Evidence of Coverage**" means the document approved by CalOptima's Regulators and issued by CalOptima to Enrollees that describes Enrollee's benefits under the CalOptima MA Program.

29. "**FDR**" means a party that enters into a written agreement (acceptable to CMS) to provide administrative or health care services to CalOptima and/or its Enrollees that are governed by the CMS Contract.

30. "**FQHC**" means an entity that meets all of the requirements for designation as a federally qualified health center under § 1861(aa)(3) of the Social Security Act and is approved for participation in the MA program.

31. "**Grievance**" means an oral or written expression of dissatisfaction, including any compliant, dispute, request for reconsideration, or appeal, made by an Enrollee.

32. "**Group Physician**" means a Physician who is employed by or under contract with Physician Group to provide physician services.

33. "**Health Network**" means Physician Group, a physician-hospital consortium, or health care service plan (such as an HMO) that is contracted with CalOptima to provide items and services to Enrollees on a capitated basis.

34. "**HEDIS**" means the set of standardized performance measures sponsored and maintained by the NCQA.

35. "**HRA**" means the health risk assessment tool that identifies an Enrollee's primary, acute, LTSS, Behavioral Health, and functional needs.

36. "**HIPAA**" means the Health Insurance Portability and Accountability Act of 1996, Public Law 104-191, the Health Information Technology for Economic and Clinical Health Act, Public Law 111-005, and regulations promulgated thereunder by the U.S. Department of Health and Human Services, including Title 45 of the C.F.R, Parts 160 and 164.

37. "**Hospital(s)**" means licensed acute care hospital(s) that have entered into an agreement with CalOptima or Physician Group to provide services to Enrollees in the CalOptima program and where Physician Group customarily admits patients.

38. "**ICP**" means the plan of care developed by an Enrollee and/or his/her ICT or CalOptima.

39. "**Indian Enrollee**" means an Enrollee who is an Indian (as defined in the Indian Health Care Improvement Act of 1976 [25 U.S.C. §§ 1603(13), 1603 (13 and 23), or 1679(a)] or who has been determined as an Indian under 42 C.F.R. § 136.12.

40. "**Indian Health Care Provider**" means a health care program operated by the Indian Health Services or by an Indian Tribe, Tribal Organization, or Urban Indian Organization, as those terms are defined in Section 4 of the Indian Health Care Improvement Act (25 U.S.C. § 1603).

41. "**ICT**" means an interdisciplinary care team comprised of the primary care provider and Care Coordinator and other Providers at the discretion of the Enrollee that work with the Enrollee to develop, implement, and maintain the ICP.

42. "**Laws**" means any local, State, or federal statute, regulation, rule, or executive or agency order applicable to this Contract.

43. "**LTSS**" means the range of long-term services and supports that help Enrollees meet their daily needs for assistance and improve the quality of their lives and which include: (i) In-Home Supportive Services ("**IHSS**"); (ii) Community-Based Adult Services ("**CBAS**"); (iii) Multi-purpose Senior Services Program ("**MSSP**") services; and (iv) skilled nursing facility services and sub-acute care services.

44. "**Medically Necessary**" or "**Medical Necessity**" means when addressing Covered Services: (i) under Medicare, reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member, or otherwise medically necessary under 42 U.S.C. Section 1395y.

45. "**Medical Record**" means any record kept or required to be kept by any Provider that documents medical services received by the Enrollee, including inpatient, outpatient, emergency care, referral requests, and Authorizations in accordance with applicable laws including Title 28 C.C.R. § 1300.80(b), Title 42 U.S.C. § 1396a(w), 42 C.F.R. § 456.111 and 42 C.F.R. § 456.211 and CalOptima Policies.

46. "**Mental Health Plan**" means the entity that has contracted with DHCS to provide Specialty Mental Health Services to individuals, including Enrollees.

47. "**Model of Care**" means the component of CalOptima's quality improvement framework that is evidence-based, includes certain clinical and non-clinical elements, and is in addition to the comprehensive care coordination requirements specified in CalOptima Policies.

48. "**Non-Covered Services**" means those services that are not benefits under the CalOptima MA Program in accordance with CalOptima's Evidence of Coverage and applicable state and federal laws and regulations.

49. "**Non-Participating Provider**" means an institution, professional, or other Provider of health care services who has not entered into an agreement, either with CalOptima or Physician Group, to provide medical and other services to Enrollees.

50. "**Out-of-Area**" means that area that is outside the Service Area.

51. "**Outpatient Mental Health Services**" means outpatient services that are provided to Enrollees with mild to moderate mental health conditions including: (i) individual/group mental health evaluation and treatment (psychotherapy); (ii) psychological testing when clinically indicated to evaluate a mental health condition; (iii) outpatient services for the purpose of monitoring drug therapy; (iv) psychiatric consultation for mediation management; and (v) outpatient laboratory supplies and supplements.

52. "**Participating Provider**" means an institution, professional, or other provider of health care services who has entered into an agreement, either with CalOptima or Physician Group, to provide health care services to Enrollees.

53. "**PCC**" means the personal care coordinator(s) employed by Physician Group to comply with the CalOptima MOC Program.

54. "**PCC Component to the Model of Care Profile**" means the PCC Components identified in the Model of Care Profile.

55. **"Physician"** means a person with an unrestricted license to practice medicine or osteopathy in the state in which they practice.

56. "**Physician Direct Referral**" means the process whereby a PCP has the authority the decide whether a referral is deemed necessary for an Enrollee and if deemed necessary the PCP will directly refer that Enrollee within said Physician Group to any of the specialties or services specified in CalOptima Policies without requiring the prior Authorization of Physician Group.

57. "**Post-Stabilization Care Services**" means services related to an Emergency Medical Condition that are provided after an Enrollee is Stabilized in order to maintain the Stabilized condition, or under some circumstances, to improve or resolve the condition.

58. "**Preclusion List**" means the CMS-compiled list of providers and prescribers who are precluded from receiving payment for MA items and services or Part D drugs furnished or prescribed to Medicare beneficiaries.

59. "**PCP**" means a primary care physician responsible for supervising, coordinating, and providing initial and primary care to Enrollees; for serving as the medical home; for processing initial referrals for Specialist Physician care; and for maintaining the continuity of patient care.

60. "**Program**" is health care benefit program offered by CalOptima to Enrollees. Programs and their designs are subject to change periodically.

61. "**Provider**" means a physician, nurse, nurse mid-wife, nurse practitioner, medical technician, physician assistant, hospital, laboratory, health maintenance organization ("**HMO**"), or other person or institution who furnishes health care items or services.

62. "**Provider Manual**" means that comprehensive online document, as amended from time to time, and describes CalOptima's Policies and procedures affecting Physician Group Physicians' services under this Contract.

63. "**Referral**" means the process by which the Participating Provider Physician directs an Enrollee to seek and obtain Covered Services from a health professional or for care at a facility.

64. "**Rural Health Clinic (RHC)**" means an entity that meets all of the requirements for designation as a rural health clinic under § 1861(aa)(1) of the Social Security Act and is approved for participation in the MA program.

65. "**Service Area**" means the geographic area within Orange County, California.

66. "**Shared Risk Services**" will mean those Covered Services that are the financial responsibility under the Hospital Budget, as set forth in Attachment B.

67. "**Specialist Physician**" means any physician who is not a PCP, has the requisite training and education, and meets all other requirements set by CalOptima Policies for specialists.

68. "**Stabilize**" or "**Stabilized**" means, with respect to an Emergency Medical Condition, to provide such medical treatment of the condition to assure within reasonable medical probability that no material deterioration of the condition is likely to result or occur during the transfer of the individual from a facility, or in the case of a pregnant woman, that the woman has delivered the child and placenta.

69. "**Threshold Language"** means those languages as determined by CalOptima's Regulators from time to time and identified in guidance on translation requirements provided to CalOptima.

70. "**Urgent Care**" means services required to prevent serious deterioration of health following the onset of an unforeseen condition or injury and are medical services required promptly to prevent impairment of health due to symptoms that do not constitute an Emergency Medical Condition but that are the result of an unforeseen illness, injury or condition for which medical services are immediately required.

ATTACHMENT B
CALOPTIMA SENIOR PLAN
MATRIX OF FINANCIAL RESPONSIBILITY
January 1, 2023

	PHYSICIAN GROUP	RESPONSIBLE PARTY	
SERVICES	**GROUP**	**SHARED RISK SERVICES BUDGET (Between Group and Plan)**	**PLAN**
Medicare Part A Services – Not Otherwise Assigned Herein or in Any Agreement Incorporating This Exhibit:			
Inpatient		**X**	
Outpatient		**X**	
Medicare Part B Services Not Otherwise Assigned Herein or in Any Agreement Incorporating This Exhibit	**X**		
Some of the main services and those related to the Risk Sharing Program are listed below:			
Acupuncture (Medicare covered)	**X**		
Allergy			
Testing and Treatment	**X**		
Serum	**X**		
Ambulance – Air and Ground			
Emergency		**X**	
Inter-facility Transfers (all vehicle types)		**X**	
Amniocentesis			
Facility Component			
Outpatient (if not provided in physician office setting)		**X**	
Professional Component	**X**		
Audiologic			
Diagnostic	**X**		
Biofeedback	**X**		
Blood & Blood Products/Blood Transfusions (including professional component)			
Autologous Blood Donation		**X**	
From Blood Bank		**X**	
Cataract Surgery			

SERVICES	GROUP	SHARED RISK SERVICES BUDGET (Between Group and Plan)	PLAN
Professional Component	X		
Facility Component (Hospital Based Outpatient – Including Implanted Lenses)		X	
Facility Component (Ambulatory Surgery Center – Including Implanted Lenses)		X	
Chemical Dependency Rehabilitation and Detox (Medicare Covered)			
Professional Component	X		
Facility Component		X	
Methadone outpatient clinics			X
Chemotherapy			
Drugs – Outpatient (Part B)		X	
Drugs – Outpatient (Part D)			Rx
Professional Component	X		
Facility Component		X	
Chiropractic (Medicare covered)	X		
Dental Services (Medical)			
Professional Component	X		
Facility Component		X	
Facility Component (Non-Hospital) Based	X		
Diabetic Supplies			
Insulin and syringes (Rx Benefit)-see Medication-Outpatient Prescription Drug Benefit			Rx
Home Glucose Monitoring Equipment and Supplies)	X		
Diagnostic Testing			
Technical Component (Outpatient)	X		
Professional Component	X		
Durable Medical Equipment (DME)			
Outpatient	X		
Emergency Room			
Facility Component		X	
Professional Component (including interpretive reports)	X		

SERVICES	GROUP	SHARED RISK SERVICES BUDGET (Between Group and Plan)	PLAN
Endoscopy			
Facility Component		X	
Professional Component	X		
Family Planning			
Therapeutic Abortion Services, Tubal Ligation, Vasectomy, etc.			
Facility Component		X	
Professional Component	X		
Fetal Monitoring			
Facility Component		X	
Professional Component	X		
Genetic Testing/Counseling	X		
Health Education	X		
Hemodialysis/Dialysis			
Outpatient (Includes drugs per Medicare guidelines)		X	
Professional Component	X		
Home Health Care			
Medicare covered home health services (Including home IV therapy, excluding Part D drugs)		X	
Home Health Supplies (see medical supplies)		X	
Hospice	**Medicare FFS has primary responsibility**		
Hospitalization			
Facility Component (Including pre-admission diagnostic services)		X	
Interpretive Reports	X		
Professional Component (Including hospital-based physicians)	X		
Immunization and Inoculations (Part B)	X		
Immunization and Inoculations (Part D)			**Rx**
Infusion Therapy			
Professional Component	X		
Facility Component		X	

SERVICES	GROUP	SHARED RISK SERVICES BUDGET (Between Group and Plan)	PLAN
Part B drugs		X	
Part D drugs			Rx
Injectables -- (Outpatient) (see also Chemotherapy)			
Part B drugs		X	
Part D drugs			Rx
Lithotripsy			
Professional Component	X		
Facility Component		X	
Mammography	X		
Maternity/Obstetrics			
Facility Component		X	
Professional Component	X		
Medical supplies (includes catheters)			
Outpatient	X		
Medication			
Outpatient – Prescription Drug Benefit (Part D)			Rx
Outpatient medications (Part B)		X	
Mental Health			
Facility Component (includes Partial Hospitalization)		X	
Professional Component			X
Nuclear Medicine			
Inpatient, Facility Component (therapeutic)		X	
Outpatient, Facility Component	X		
Professional Component	X		
Nutrition			
Nutritional/Dietetic Counseling (Medicare Covered)	X		
Parenteral Nutrients, Supplies, Kits and Pumps			
Part B		X	
Part D			X
Enteral Nutrients, Supplies, Kits and Pumps			

SERVICES	GROUP	SHARED RISK SERVICES BUDGET (Between Group and Plan)	PLAN
Outpatient			**X**
Organ Transplants			
Pre Evaluation (All Inclusive)	**X**		
Organ Acquisition		**X**	**Medicare FFS for Kidney only**
Transplant Professional Component	**X**		
Transplant Facility Component (includes organ acquisition)		**X**	
Post Transplant (up to one year for transplant related services)			
Professional Component	**X**		
Post Transplant Facility Component (Inpatient)		**X**	
Post Transplant Facility Component (Outpatient – if provided in physician office setting)	**X**		
Orthotics and Prosthetics (Medicare Covered)			
Outpatient (Medicare defined coverage applies)		**X**	
Ostomy Supplies			
Outpatient	**X**		
Out of Area (Emergent and Urgently Needed Services)			
Facility Component		**X**	
Professional Component	**X**		
Outpatient Diagnostic Tests and Services (All Inclusive)	**X**		
Outpatient Surgery			
Facility Component (Hospital Based)		**X**	
Facility Component (Freestanding Ambulatory Surgery Center)		**X**	
Professional Component	**X**		
Cardiac catheterization and Angiograms (Professional)	**X**		
Cardiac catheterization and Angiograms (Facility)		**X**	
Physical Therapy (See Rehabilitation)			
Pain Management			

SERVICES	GROUP	SHARED RISK SERVICES BUDGET (Between Group and Plan)	PLAN
Professional	X		
Facility (if provided in other than physician office setting)		X	
Physician Visits/Consultations (inclusive of all settings)	X		
Podiatry Services (Medicare covered)	X		
Radiation Therapy			
Professional	X		
Facility, outpatient facility		X	
Radiology Services			
Outpatient, Preoperative, and Inpatient Professional Component	X		
Inpatient (facility component)		X	
Rehabilitation (Short Term e.g.: PT, OT, Speech, Cardiac)			
Outpatient Facility Component	X		
Professional Component	X		
Skilled Nursing Facility (SNF)			
Facility Component (All Inclusive)		X	
Professional Component	X		
Social Services – Medical	X		
Surgically Implanted Devices – All Categories		X	
Vision Care			
Annual routine exam			X
Glasses			X
Lenses and Frames incidental to cataract surgery (Medicare covered)	X		
Screening, Physician Office	X		
Notes:			
1. Financial responsibility is based on Medicare benefit interpretations and limitations.			
2. The symbol "Rx" denotes outpatient prescription drug services.			
Assignment of financial responsibility as outlined in this document is independent of the questions of medical necessity, coverage or benefits.			

ATTACHMENT C
CAPITATION RATES AND RISK SHARING

1. **Capitation Allocation**

1.1 **Allocation of Non-Part D CMS Revenue**. Each month, CalOptima shall allocate both the non-Part D related capitation that CalOptima receives from CMS for Enrollees affiliated with Physician Group and any applicable premiums that CalOptima charges Enrollees affiliated with Physician Group (collectively, the "**Total Revenues**") as follows:

- Facility and Other Services ("**Hospital Budget**") xx.x%
- Physician Group Capitation Payment xx.xx%

1.2 **MLR**. In accordance with Section 2.3, "Medical Loss Ratio", of the Contract, Physician Group shall maintain a minimum acceptable loss ratio of eighty-five percent (85%). Should Physician Group not meet the minimum eighty-five percent (85%) MLR, CalOptima reserves the right to require Physician Group to return to CalOptima the difference between eighty-five percent (85%) of Capitation Payments and the allowed medical expenses.

1.3 **Personal Care Coordinator**.

1.3.1 In addition to the amounts described above, and contingent on CalOptima Board of Directors' approval, CalOptima will pay Physician Group, ____dollars and ____cents ($xx.xx), a per Enrollee, per month amount for PCCs. The commencement date, amount, and duration of such PCC capitation payments, if any, will be established by the action of the CalOptima Board of Directors, and will be deemed incorporated herein by reference. Such payments, if any, may be adjusted in accordance with the PCC Reference Manual and are subject to recovery, termination, or offset as provided in this Contract and in the PCC Reference Manual.

1.3.2 Physician Group acknowledges and agrees that CalOptima may adjust and/or terminate the PCC Capitation Payments in the event Physician Group fails to comply with the requirements outlined in the PCC component of the model of care (MOC) profile. Physician Group acknowledges and agrees that CalOptima, in its sole and absolute discretion, may also offset Physician Group's future PCC Capitation Payments in the event CalOptima determines that Physician Group has not complied with the requirements set forth in the PCC component of the MOC Profile.

1.4 **Sequestration**. If CMS reduces payment to CalOptima under the CMS Contract by more than two percent (2%) at any time during the Term, CalOptima may, upon written notice to Physician Group, reduce payment to Physician Group under this Attachment C by the same percentage that CMS reduced payment to CalOptima. This provision applies each time CMS reduces payment to CalOptima by more than two percent (2%) during the Term.

1.5 **Pay-for-Performance Program**. CalOptima will develop a pay-for performance program to provide incentive payments to Physician Group. Payments will be calculated and paid

quarterly and annually based on a per Enrollee, per month rate and reflect achievement of specified program goals, which are determined by CalOptima in its sole discretion.

1.6 **Hospital Shared Risk Program Between CalOptima and Physician Group**. As an incentive to control hospital service utilization, a Hospital Shared Risk Program covering Medicare shall be established and administered by CalOptima whereby both CalOptima and Physician Group shall be at risk for the utilization of Shared Risk Services.

1.7 **Shared Risk Services—Definition**. Shared Risk Services are defined as all Covered Services that are the financial responsibility under the Hospital Budget as set forth in Attachment B.

1.8 **Shared Risk Budget and Costs**. A Shared Risk budget shall be established. The Shared Risk budget shall be the Medicare Hospital Budget percentage. Shared Risk costs shall be the actual amounts paid for Shared Risk Services less any recoveries, including overpayments and reinsurance.

1.9 **Copayments and Coordination of Benefits**. Any applicable copayments payable for Shared Risk Services shall be deducted from Shared Risk Costs. Amounts payable for COB or worker's compensation shall be deducted from Shared Risk costs for the particular service. Amounts actually received by facility and other services providers under the Hospital Budget through third-party liability recoveries for Shared Risk Services shall be deducted from Shared Risk costs in the period in which such payment is actually received, up to the amount of Shared Risk costs for the particular service.

1.10 **Shared Risk Program Settlement**. The program for Shared Risk Services shall be administered on a calendar year basis ("**Shared Risk Period**"). It shall be based on compensation earned and services rendered during the calendar year on an accrual basis, regardless of when paid, including adequate incurred but not reported ("**IBNR**") expenses, provided that only those expense items received up to and within ninety (90) days after the end of the current calendar year shall be included in the computation of the IBNR expense of the Shared Risk Services. Within one hundred twenty (120) days following the end of each calendar year of this Contract, CalOptima shall prepare a final report of the status of the Shared Risk Program. Over and under accrual of the IBNR in the current Shared Risk Period shall be adjusted in the subsequent Shared Risk Period.

1.10.1 **Deficit**. If Shared Risk Costs exceed the Shared Risk budget, fifty percent (50%) of such deficit, up to an amount not to exceed $5.00 per Enrollee, per month calculated on a calendar year basis shall be considered the responsibility of the Physician Group. Any and all deficits for which the Physician Group is responsible shall be carried forward and applied to any future Shared Risk program settlements. In the event of termination of this Contract, all deficits shall be forgiven.

1.10.2 **Surplus**. If Shared Risk costs are less than the Shared Risk budget, fifty percent (50%) of such surplus shall be paid to Physician Group by CalOptima. Any and all surplus payments shall be offset by any deficits in any other risk-sharing arrangements.

2. **Risk Pool Reports and Timely Settlement**.

2.1 **CalOptima Shared Risk Pool for Reports and Maintenance of Records related to the Risk Pool**. CalOptima shall be responsible for maintenance of records and development of reports required for administration of the Hospital Shared Risk programs. To ensure timely settlements on risk-sharing programs, CalOptima shall prepare final reports within one hundred and twenty (120) days following the end of each calendar year.

2.2 **Objections to Final Report**. Physician Group shall have thirty (30) days following receipt to review such reports produced by CalOptima. Absent objections in such thirty (30)-day period, the reports shall be considered acceptable, and all payments due pursuant to such reports shall be made.

2.3 **Settlement in the Event of Termination**. Notwithstanding anything else in the Agreement, in the event of termination of the Contract in accordance with the provisions of Article XI, the Hospital Shared Risk programs shall also terminate, once CMS has provided the annualized capitation adjustment (also known as HCC sweeps) for the period up to the termination date of this Contract.

ATTACHMENT D
CLAIMS PROCESSING AND COMPLIANCE OBLIGATIONS

I. DEFINITIONS

1.1 "**Clean Claim**" means one that can be processed without obtaining additional information from the provider of the service or from a third party. Clean claim shall have the same meaning as "complete claim" as that term is defined in Title 28, CCR Section 1300.71(a)(2). Clean Claim does not include a claim from a Provider who is under investigation for fraud or abuse, or a claim under review for Medical Necessity.

1.2 "**Unclean Claim**" means any claim other than as defined in Section 1.1 of this attachment.

1.3 "**Denied Claim**" means a claim where (a) one or more services will not be paid by Physician Group and (b) payment is the responsibility of the Enrollee. Examples of claims that are not denials and should not be reported, submitted, or presented to CalOptima as Denied Claims include claims:

1.3.1 For patients who remain enrolled with CalOptima but have transferred to another Physician Group and Physician Group is forwarding the claim,

1.3.2 For which payment responsibility belongs to another contracting entity, and Physician Group is forwarding the claim,

1.3.3 That are duplicates,

1.3.4 That are encounter only/capitated claims and no patient liability is involved, and

1.3.5 That involve reduced payment amounts due to contract terms or allowed Medicare fee schedules.

II. GENERAL TERMS

2.1 **Physician Group Claims Processing**. Physician Group shall process claims for Provider services according to all CMS requirements and, as applicable, in accordance with the requirements of the Knox-Keene Act. This Attachment D is intended to comply with all DMHC and CMS standards and requirements. Should this Attachment D be out of compliance with any existing or newly enacted DMHC or CMS standard or requirement, the DMHC and/or CMS standard or requirement will supersede this Attachment D. CalOptima will communicate any changes in requirements to Physician Group in writing.

2.2 If Physician Group enters into a contract with a Downstream Entity whereby the responsibility for claims processing is delegated to that Downstream Entity, Attachment D provisions shall apply. Physician Group will have contractual provisions to ensure such Downstream Entity conforms to all DMHC and CMS requirements and oversight provisions as outlined herein and in CalOptima Policies.

2.3 Physician Group and any applicable Downstream Entity shall be required to have an oversight program for claims processing that includes written policies and procedures, a process for reporting fraudulent or unethical conduct, and an executive accountable for review of claims data and attesting to its accuracy. The oversight program shall include internal auditing of claims functions, and self-reporting as outlined in CalOptima Policies.

III. CLAIMS PROCESSING

3.1 **Timely Provider Payments**.

3.1.1 Physician Group and Downstream Entities, if, and as applicable, must make timely payments to Participating Providers consistent with 42 CFR § 447.45.

3.1.2 Physician Group shall reimburse Clean Claims, or any portion of any Clean Claim, for Covered Services, as soon as practical, but no later than thirty (30) calendar days after receipt of the claim by Physician Group, unless the claim or portion thereof is reasonably contested, in which case the claimant shall be notified in writing that the claim is contested or denied within forty-five (45) business days after receipt of the claim by Physician Group in accordance with CalOptima Policies.

3.1.3 Physician Group must ensure that ninety percent (90%) of claims from Providers who are in individual or group practice, which can be processed without obtaining additional information from the Provider or from a third party, will be paid within thirty (30) days of the date of receipt of the claim.

3.1.4 Physician Group must ensure that ninety-nine percent (99%) of all Clean Claims from Providers for Covered Services will be paid within ninety (90) days of the date of receipt of the claim.

3.1.5 Generally, the date of receipt is the date the Physician Group receives the claim, as indicated by its date stamp on the claim. The date of payment is the date of the check or other form of payment.

3.1.6 **"30-Day" Claim Timeliness**. Physician Group shall adjudicate nine-five percent (95%) of all Clean Claims from Non-Participating Providers or suppliers within thirty (30) calendar days of receiving the claim. Adjudicate a claim shall be deemed to mean to have processed the claim (paid or denied) and mailed the remittance advice by the thirtieth (30^{th}) calendar day since the earliest receipt by Physician Group or CalOptima's contracting Providers or Hospitals.

3.1.7 **"60-Day" Claim Timeliness**. Physician Group shall pay or deny Unclean Claims from Non-Participating Providers or suppliers, claims from Participating Providers or suppliers, and claims from Medicare fiscal intermediaries and carriers within sixty (60) calendar days of receipt of such claims. Processing shall be deemed to mean either to have paid or denied and mailed the remittance advice by the sixtieth (60^{th}) calendar day since the earliest receipt by Physician Group or CalOptima's contracting Providers or Hospitals, or to have denied the claim, and have mailed the denial letter to the Enrollee by the sixtieth (60^{th}) day. In accordance with federal law and CMS regulations, failure to process such claims within sixty (60) calendar days of receipt automatically constitutes an "adverse" initial determination, which the Enrollee may appeal; thus, a denial notice must be mailed to the Enrollee.

3.1.8 **Payment Accuracy**. When paying Non-Participating Providers, Physician Group shall employ only those Medicare fee schedules that MA plans are allowed to use by law and shall comply with 42 CFR § 422.214.

3.1.9 **Denied Claims**. Decisions to deny claims that result in liability for the Enrollee must be

made in accordance with CMS guidelines. Whenever such decisions are made, the currently CMS approved Notice of Denial of Payment or Integrated Denial Notice must be used, including approved denial reasons. Under no circumstances shall Physician Group deny a claim for the second time as a consequence of responding to a request for reconsideration from an Enrollee; instead, Physician Group must direct the Enrollee to submit the request directly to CalOptima as appropriate.

3.2 **Claims for Emergency and Post-Stabilization Services.**

3.2.1 Physician Group shall not retroactively deny a claim for Emergency Services because the condition, which appeared to be an Emergency Medical Condition, turned out to be non-emergency in nature. Physician Group shall ensure that its claims processing actions do not conflict with Hospital actions required to comply with the Emergency Medical Treatment and Active Labor Act ("**EMTALA**").

3.2.2 If there is a disagreement between Physician Group or any Participating Provider and any Non-Participating Provider regarding Medically Necessity of Covered Services in an emergency, the judgment of the attending physician(s) actually caring for the Enrollee at the treating facility shall prevail. Physician Group may establish relationships with treating facility whereby the Physician Group may send a Participating Provider with privileges to assume the attending physician's responsibilities to establish treatment or may arrange to have a Participating Provider under contract with Physician Group agree to accept the transfer of the Enrollee after the Enrollee has been Stabilized.

3.2.3 Physician Group shall ensure that an enrollee with an Emergency Medical Condition will be seen on an emergency basis and that Emergency Services will be available and accessible within the Service Area twenty-four (24) hours a day. Physician Group shall cover Emergency Services without prior Authorization pursuant to Title 28 CCR Section 1300.67(g), Title 22 CCR Section 53216, and Section 1932(b)(2) of the Social Security Act. Physician Group shall coordinate access to Emergency Services in accordance with 42 CFR § 438.114 and the Physician Group's emergency department protocol.

3.2.4 Physician Group may not refuse to cover Emergency Services based on the emergency room Provider, Hospital, or fiscal agent not notifying the Enrollee's PCP managed care organization, prepaid ambulatory health plan, prepaid inpatient health plan or applicable State entity of the Enrollee's screening and treatment within ten (10) calendar days of presentation for Emergency Services. An Enrollee who has an Emergency Medical Condition may not be held liable for payment of subsequent screening and treatment needed to diagnose the specific condition or Stabilize the Enrollee.

3.2.5 Physician Group may not deny payment for treatment obtained under either of the following circumstances: an Enrollee had an Emergency Medical Condition, including cases in which the absence of immediate medical attention would not have had the outcomes specified in the definition of an Emergency Medical Condition; or the Physician Group representative instructs the Enrollee to seek Emergency Services. The attending emergency Physician, or the Provider actually treating the Enrollee, is responsible for determining when the Enrollee is sufficiently Stabilized for transfer or discharge, and that determination is binding on the entities as responsible for coverage and payment.

3.2.6 Physician Group must cover and pay for Post-Stabilization Care Services. Physician Group is financially responsible for Post-Stabilization Care Services obtained within or outside

the organization that are pre-approved by a Physician Group Provider or other Physician Group representative. Physician Group is financially responsible for Post-Stabilization Care Services obtained within or outside the Physician Group organization that are not pre-approved by a Participating Provider or other Physician Group representative, but are administered to maintain the Enrollee's Stabilized condition within one (1) hour of a request to the Physician Group for pre-approval of further Post-Stabilization Care Services. Physician Group is financially responsible for Post-Stabilization Care Services obtained from within or outside the Physician Group that are not pre-approved by a Participating Provider or other Physician Group representative, but administered to maintain, improve, or resolve the Enrollee's Stabilized condition if the Physician Group: does not respond to a request for pre-approval within one (1) hour; cannot be contacted; or the Physician Group representative and the treating physician cannot reach an agreement concerning the Enrollee's care and a Participating Provider is not available for consultation. In this situation, the Physician Group must give the treating Physician the opportunity to consult with a Participating Provider and the treating Physician may continue with care of the Enrollee until a Participating Provider is reached or one criteria in 42 C.F.R. § 113(c)(3) is met. Physician Group must limit charges to Enrollees for Post-Stabilization Care Services to an amount no greater than what the Physician Group would charge the Enrollee if he or she had obtained the services through Physician Group. Physician Group financial responsibility for Post-Stabilization Care Services it has not pre-approved ends when: a Participating Provider with privileges at the treating Hospital assumes responsibility for the Enrollee's care; a Participating Provider assumes responsibility for the Enrollee's care through transfer; Physician Group representative and the treating Physician reach an agreement concerning the Enrollee's care; or; the Enrollee is discharged.

3.2.7 Physician Group shall reimburse those Physicians providing Emergency Services and Urgent Care services with whom Physician Group has a contract according to the terms of that contract.

3.2.8 Physician Group must reimburse a Non-Participating Provider for Emergency Services or Urgent Care services at the prevailing Medicare fee-for-service ("**FFS**") rate as applicable for that service. Where the Covered Service would traditionally be covered under Medicare FFS, the Medicare FFS rate applies. Physician Group shall ensure that Enrollees maintain balance billing protections as provided in Section 6.4 of this Contract.

3.2.9 In accordance with CalOptima Policies, Physician Group shall implement the CMS Quality Payment Program known as the Merit-based Incentive Payment System ("**MIPS**"). MIPS adjustments for Part B covered professional services furnished by MIPS-eligible Providers that are not contracted with Physician Group shall be administered in the same manner as any other changes in the applicable Medicare payment schedules. Physician Group shall make positive and negative payment adjustments as identified by CMS based on the CMS MIPS adjustment data files.

3.2.9.1 CalOptima or Physician Group may apply MIPS payment adjustments either at the time the payment is made during the applicable MIPS payment year or as a retrospective adjustment to paid claims.

3.2.9.2 CalOptima or Physician Group are required to demonstrate payment through reporting or attestation by the end of March on an annual basis.

3.3 **Physician Group Financial Responsibility**. If CalOptima receives a claim for Covered Services that are the financial responsibility of Physician Group, CalOptima shall forward such claim to Physician Group for payment, in accordance with the procedures set forth in Title 28 CCR Section 1300.71, "Claims Settlement Practices." CalOptima shall not pay for services that are Physician Group's financial responsibility unless Physician Group fails to make payment within the time allowed by State and federal laws and regulations, and CalOptima is required by law to make such payment. In such cases, CalOptima, after written notice to Physician Group and reasonable opportunity to cure, will make payment, and Physician Group shall reimburse CalOptima for such payments. If Physician Group fails to reimburse CalOptima, CalOptima may offset an uncontested payment(s) against Capitation Payments or other amounts due from CalOptima to Physician Group, if any.

3.4 **Collection of Share of Cost**. Physician Group shall collect Medicare share of cost unless prohibited under this Contract.

3.5 **Capitation Payments**. Physician Group and/or Downstream Entities shall distribute monthly Capitation Payments to capitated Participating Providers within fifteen (15) calendar days following the date on which Physician receives payment from CalOptima.

3.6 **Claims Adjudication**. Except as provided in Section 3.1.1, Physician Group shall accept and adjudicate claims for Covered Services provided to Enrollees in accordance with the provisions of Sections 1371, 1371.1, 1371.2, 1371.22, 1371.35, 1371.36, 1371.37, 1371.38, 1371.4 and 1371.8 of the California Health & Safety Code, and Sections 1300.71, 1300.71.38, 1300.71.4, and 1300.77.4 of Title 28 of the CCR and CalOptima Policies. Waiver of any right or obligation specific to the Health and Safety Code and Title 28 related to claims processing and payment shall be prohibited.

3.7 **Dispute Resolution.** Physician Group shall establish and maintain a fair, fast and cost-effective dispute resolution mechanism to process and resolve provider disputes in accordance with the provisions of Sections 1371, 1371.1, 1371.2, 1371.22, 1371.35, 1371.36, 1371.37, 1371.38, 1371.4 and 1371.8 of the California Health & Safety Code, and Sections 1300.71, 1300.71.38, 1300.71.4, and 1300.77.4 of Title 28 of the CCR and CalOptima Policies.

3.8 **Right of Appeal**. Physician Group shall afford Providers an unconditional right of appeal and de novo review for claims disputes involving issues of Medical Necessity. Any Provider that submits a claim dispute to Physician Group's dispute resolution mechanism involving an issue of Medical Necessity or utilization review shall have an unconditional right of appeal for that claim dispute to CalOptima's dispute resolution process for a de novo review and resolution for a period of sixty (60) working days from Physician's Date of Determination.

3.9 **CalOptima Payment On Behalf Of Physician**. If CalOptima receives a copy of an unpaid Clean Claim as part of a Provider grievance that is thirty (30) working days old or more, CalOptima will follow all notification and acknowledgement procedures pursuant to CalOptima Policies. If Physician Group does not either notify CalOptima that the claim is reasonably contested, as set forth in CalOptima Policies, or pay the Clean Claim within the thirty (30) working day period, CalOptima shall pay the Claim on behalf of Physician, plus interest, as required by the Knox-Keene Act, and deduct the amounts reimbursed, plus processing costs, from the Capitation Payment, in accordance with CalOptima Policies.

3.10 **Quarterly Claims Payment Performance Report.**

3.10.1 Physician Group shall submit, in a format specified by CalOptima Policies, a quarterly claims payment performance report ("**Quarterly Claims Report**") to CalOptima within thirty (30) calendar days of the close of each calendar quarter. The Quarterly Claims Report shall, at a minimum, disclose Physician Group's compliance status with Sections 1371, 1371.1, 1371.2, 1371.22, 1371.35, 1371.36, 1371.37, 1371.4, and 1371.8 of the California Health and Safety Code and Sections 1300.71, 1300.71.38, 1300.71.4 and 1300.77.4 of Title 28 of the CCR.

3.10.2 Physician Group shall ensure that each Quarterly Claims Report is signed by, and includes the written verification of, a principal officer, as defined by Section 1300.45(o) of Title 28 of the CCR, of Physician Group, stating that the report is true and correct to the best knowledge and belief of the principal officer.

3.10.3 Physician Group's Quarterly Claims Report shall include a tabulated record of each Provider dispute it received, categorized by date of receipt, and including the identification of the Provider, type of dispute, disposition and working days to resolution, as to each Provider dispute received. Each individual dispute contained in a Provider's bundled notice of Provider dispute shall be reported as a separate dispute to CalOptima.

3.11 **Forwarding of Misdirected Claims.**

3.11.1 Physician Group shall have the ability to receive a standard ANSI 837I and ANSI 837P claim file format for retrieving misrouted claims that are the financial responsibility of the Physician Group. Physician Group will receive and forward misdirected claims per CalOptima Policy.

3.11.2 Physician Group shall have the ability to create a standard ANSI 837I and ANSI 837P claim file for forwarding claims that are the financial responsibility of CalOptima within ten (10) working days of receipt of the claim. CalOptima shall receive these files per CalOptima policy and load them into its system to ensure timely claims processing. Physician Group shall forward any claims that are not its payment responsibility to CalOptima within eight (8) calendar days of receipt, so that a total of only ten (10) working days will elapse prior to the claims being in the proper hands.

3.12 **Assumption of Delegated Functions**. In the event that Physician Group fails to timely and accurately reimburse its claims (including the payment of interest and penalties), CalOptima may, at its sole discretion, revoke the delegation and assume responsibility from Physician Group for claims payment, or terminate this Contract as provided for in Article XI. CalOptima's assumption of responsibility for the processing and timely reimbursement of Provider claims may be altered to the extent that Physician Group has established an approved CAP consistent with Section 1375.4 (b)(4) of the Health and Safety Code and Section 11.3 of the Contract.

3.13 **Recoupment for Assumption of Claims Processing Obligations**. CalOptima, in its sole and absolute discretion, may reduce Physician Group's Capitation Payments to recoup additional administrative costs for the assumption of the claims processing obligations of Physician Group, as described in this Article III of Attachment D, as well as any amounts, including interest due, on claims unpaid at the assumption of such obligations by CalOptima.

IV. CLAIMS COMPLIANCE

4.1 **Claims Compliance Monitoring**. Physician Group understands that claims compliance programs are required by CalOptima's Regulators and agrees that delegation is contingent upon Physician Group's compliance with required monitoring and oversight activities, as outlined in CalOptima Policies. Physician Group agrees that CalOptima reserves the right to monitor Physician Group's claims compliance activities, notwithstanding any other audit, compliance, or contractual issue between Physician Group and CalOptima. In the event Physician Group demonstrates an inability to meet CalOptima's claims payment standards, CalOptima reserves the right to revoke and assume the delegated responsibilities described above.

4.2 **Claims Non-Compliance**. In the event that CalOptima determines that Physician Group is not in ninety-five percent (95%) compliance with any of the requirements of Attachment D the following actions will be applied:

4.2.1 Within thirty (30) days of an audit that documents non-compliance, CalOptima will issue a written warning to Physician Group that describes the non-compliance. Physician Group will respond within fifteen (15) working days of receiving the non-compliance notification with a written CAP to comply. Such CAP will describe the actions to be taken and the schedule by which those actions will be completed. CalOptima will review the CAP and advise Physician Group whether or not actions or time schedules are acceptable within fifteen (15) days of receiving it. CalOptima will conduct a follow-up audit of Physician Group's claims operation within ninety (90) days from the date of serving the non-compliance notification to verify compliance with Attachment D. If CalOptima does not receive a CAP within fifteen (15) calendar days, the consequences outlined in Subsection 4.2.2 of this attachment for continued non-compliance will apply.

4.2.2 If, as a result of CalOptima's follow-up audit, Physician Group is found to still be non-compliant with Attachment D within fifteen (15) calendar days of making that determination, CalOptima will notify Physician Group in writing of the continued non-compliance and may elect to provide consultative or other assistance to help establish, maintain and monitor continued administrative compliance or assume "joint administration" of Physician Group's claims operations, involving itself only with Enrollees' claims and allowing the operation to remain on Physician Group's premises. The Parties agree to meet and develop a mutually agreeable work plan for added staffing and work stations, the cost of which will be Physician Group's sole responsibility. CalOptima will develop a CAP with Physician Group's participation to assure maximum compatibility with Physician Group's ongoing operations. CalOptima will cooperate with Physician Group in implementing changes across all risk claims processed at that site, should Physician Group so request. Within fifteen (15) calendar days of receiving the second notice of non-compliance, Physician Group will provide a written response stating the specific action to be taken to establish compliance with the help of CalOptima. If CalOptima does not receive a CAP within fifteen (15) calendar days, the consequences outlined in Subsection 4.2.3 for continued non-compliance will apply. Within ninety (90) days from the date of serving the second notice of non-compliance, CalOptima will re-audit Physician Group's claims process and documents to determine final compliance or non-compliance.

4.2.3 If, as a result of its second follow-up audit, CalOptima reasonably determines that Physician Group is still non-compliant, CalOptima reserves the right to terminate this

Contract for material breach upon ten (10) days' prior written notice and opportunity to cure.

4.2.4 Physician Group may resume sole administrative responsibility for claims processing if CalOptima determines that Physician Group has corrected the deficiencies that caused the non-compliance, and, as a result of resuming responsibility for claims processing, demonstrates compliance with the timely provider payments requirements set forth in Section 3.1 of this Attachment D.

4.2.5 With respect to the requirements of Attachment D, Physician Group will be subject to regular site-audits conducted by CalOptima to monitor all claims requirements.

V. CLAIMS FORWARDING

Physician Group shall forward any claims that are not its payment responsibility to CalOptima within ten (10) calendar days of receipt.

VI. SELF-MONITORING & REPORTING

Physician Group shall develop, implement and demonstrate upon request, a claims quality assurance process, including regular, scheduled, automated, or manual reports, self-testing procedures, and internal reporting to Physician Group's executive management of timeliness, payment accuracy, and denial accuracy (as required herein). Such self-monitoring and internal reporting shall involve use of industry standard tools and shall measure actual performance against the standards for DMHC and CMS compliance. CalOptima strongly recommends check issuance and mailing occur not less frequently than weekly and that Physician Group's internal reporting intervals match the intervals at which checks are issued, except that weekly reporting would be sufficient if checks are issued more often than weekly. At a point early in the beginning of operations under the Contract and in accordance with industry-wide CMS requirements, CalOptima will require that Physician Group submit monthly reports to CalOptima using the industry-standard Monthly Report of Claims Processing Timeliness and Overall Percent of Denial Accuracy format. Those reports must be received by CalOptima not later than the fifteenth (15th) calendar day of each month.

VII. AUDITS & AUDIT PREPARATION

Article IV, above, provides detailed, specific processes involving claims non-compliance. Even when Physician Group does meet compliance standards and successfully concludes any time periods where denials must be submitted to CalOptima for review, CalOptima will continue to schedule (1) periodic audits, (2) random, focused audits, and (3) focused reviews based on appeals and grievance results to monitor Physician Group's compliance with CMS regulations. Prior to the scheduled arrival of CalOptima's auditor, Physician Group shall retrieve claims and related documents in accordance with instructions provided to Physician Group by CalOptima in its letter confirming the appointment.

VIII. SPECIAL STUDIES

8.1 In the event DMHC and/or CMS requires that CalOptima conduct any special compliance study or effort, Physician Group shall support the study and will be subject to any DMHC and/or CMS specified time schedules or deadlines for corrective actions.

IX. FEDERALLY QUALIFIED HEALTH CENTERS AND RURAL HEALTH CLINICS

9.1 Physician Group shall meet federal requirements for access to FQHC services, including those in 42 U.S.C. § 1396 b(m). Physician Group shall reimburse FQHCs and RHCs in accordance with current Laws. If FQHC and RHCs services are not available in the Provider network, Physician Group shall authorize out-of-network services subject to the prevailing MA payment requirements for out-of-network services.

9.2 Physician Group shall ensure that its payments to FQHCs and RHCs for services to Enrollees are no less than the sum of the level and amount of payment that the Health Network or CalOptima would make for such services if the services had been furnished by an entity providing similar services that was not an FQHC and RHC. The intent of these provisions is to ensure that Physician Group pays FQHCs and RHCs amounts consistent with Medicare managed care policies while preserving the opportunity for FQHCs to separately claim supplemental payments under such policies.

X. INDIAN HEALTH CARE PROVIDERS

10.1 Physician Group shall pay non-network Indian Health Care Providers that are FQHCs for the provision of services to an Indian Enrollee at a rate equal to the rate that Physician Group would pay to a network FQHC that is not an Indian Health Care Provider, including any supplemental payment from the State to make up the difference between the contract amount and what the Indian Health Care Provider would have received FFS.

10.2 When the amount the Participating Provider Indian Health Care Provider receives from the Physician Group is less than the amount the Indian Health Care Providers would receive FFS, the State must make a supplemental payment to the Indian Health Care Provider that the Indian Health Care Provider would receive FFS or the applicable encounter rate.

10.3 Physician Group shall not impose enrollment fees, premiums, or similar charges on Indians served by an Indian Health Care Provider or through referral under contract health services. Physician Group must exempt from all cost-sharing any Indian who is currently receiving or has ever received an item or service furnished by an Indian Health Care Provider or through referral under contract health services.

10.4 Physician Group shall reimburse Indian Health Care Providers promptly who provide Covered Services to Indian Enrollees, who are eligible to receive Covered Services, at the most current and applicable outpatient per-visit rate published in the Federal Register by the Indian Health Service, and Physician Group shall ensure any retroactive outpatient per visit rates are appropriately reimbursed to the Indian Health Care Provider.

ATTACHMENT E
STATUTORY AND REGULATORY COMPLIANCE TERMS

1. **Compliance with State and Federal Laws**. Physician Group acknowledges that CalOptima is subject to certain State and federal laws, regulations, and instructions governing its MA Program. Physician Group shall comply with all Laws and DMHC and CMS administrative bulletins, plan letters and instructions. Physician Group understands that payments made by CalOptima are, in whole or in part, derived from federal funds, and therefore Physician Group and any Downstream Entities are subject to certain laws that are applicable to individuals and entities receiving federal funds, including the following: (i) Title VI of the Civil Rights Act of 1964; (ii) Sections 503 and 504 of the Rehabilitation Act of 1973; (iii) the Age Discrimination Act of 1975; (iv) the Americans with Disabilities Act of 1990; (v) the Vietnam Era Veteran's Readjustment Assistance Act; and (vi) Title IX of the Education Amendments of 1972. Any provision required to be in this Contract by the CMS Contract, the Knox-Keene Act, Title 28 of the California Code of Regulations, Medicare laws and regulations, DMHC or CMS instructions and reporting requirements and other applicable laws, shall bind CalOptima, Physician Group, and Downstream Entities, whether or not specifically set forth in this Contract.

2. **Compliance with CalOptima's Contractual Obligations**. All services and other activities furnished by Physician Group and Downstream Entities must be performed in accordance with CalOptima's contractual obligations to CMS.

3. **Compliance with FWA Requirements**. Physician Group, and its employees, agents and Downstream Entities performing services under this Contract, shall comply with CalOptima's Compliance Program including, its FWA plan. Prior to performing services under this Contract, Physician Group shall complete and submit to CalOptima, any CMS-required training and/or CalOptima-required attestations related to such training and other compliance obligations. Physician Group agrees to comply and will have any Downstream Entity agree to comply with CalOptima standards and policies.

4. **Fraud and Abuse Reporting**. Physician Group shall, in accordance with all Laws, report to CalOptima all cases of suspected fraud and/or abuse relating to the rendering of Covered Services within five (5) days of the date when Physician Group first becomes aware of or is on notice of such activity.

5. **CMS Participation Requirements**. Physician Group represents and warrants that: (i) neither Physician Group nor any of its Group Physician, employees or agents furnishing services under this Contract are excluded from participating in any federal or state healthcare program as defined in 42 U.S.C. Section 1320a-7b(f) ("**Federal Health Care Program(s)**"); (ii) Physician Group has not arranged or contracted (by employment or otherwise) with any employee, contractor or agent that Physician Group knows or should know are excluded or precluded from participation in Federal Health Care Programs; (iii) no action is pending against Physician Group or any of its Group Physicians, employees, or agents performing services under this Contract to suspend or exclude such persons or entities from participation in any Federal Health Care Program; and (iv) Physician Group will immediately notify CalOptima if it learns that it is or has employed or contracted with a person or entity that is excluded from participation in any Federal Health Care Program. If Physician Group fails to comply with this Section 5 of this attachment, CalOptima reserves the right to require Physician Group to pay immediately to CalOptima the amount of any sanctions or other penalties that may be imposed on CalOptima by CMS for violation of this prohibition, and Physician Group shall be responsible for any resulting overpayments. Physician Group shall not make payment for a healthcare item or service furnished by an individual or entity

that is excluded by the Office of the Inspector General or is included on the Preclusion List. Physician Group shall provide written notice to the Enrollee who received the services and the excluded Provider or Provider listed on the Preclusion List that payment will not be made, in accordance with CMS requirements. Physician Group shall ensure that all Participating Providers that provide Covered Services do not appear on the CMS Preclusion List in order to receive reimbursement for claims or otherwise participate in the Medicare program.

6. **Confidentiality of Enrollee Information**. Physician Group, its Downstream Entities, and their employees and agents shall comply with the specific confidentiality obligations set forth below.

6.1 Physician Group, Downstream Entities, and their employees and agents 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 them as a result of services performed under this Contract, except for statistical information not identifying any such person. Physician Group, Downstream Entities, and their employees and agents shall not use such identifying information for any purpose other than carrying out Physician Group's obligations under this Contract.

6.2 Physician Group, Downstream Entities, and their employees and agents shall promptly transmit to CalOptima all requests for disclosure of such identifying information not emanating from the Enrollee. Physician Group shall not disclose, except as otherwise specifically permitted by this Contract or authorized by the Enrollee, any such identifying information to anyone other than CMS, DMHC, 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.

6.3 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*., Welfare and Institutions Code Section 14100.2, and regulations adopted thereunder. For the purpose of this Contract, all information, records, data, and data elements collected and maintained for the operation of the Contract and pertaining to Enrollees shall be protected by Physician Group from unauthorized disclosure. Physician Group may release Medical Records in accordance with Laws pertaining to the release of this type of information. Physician Group is not required to report requests for Medical Records made in accordance with Laws.

6.4 With respect to any identifiable information concerning an Enrollee under this Contract that is obtained by Physician Group or its Downstream Entities from CalOptima's Regulators, Physician Group will, at the termination of this Contract, return all such information to CalOptima's Regulators if required by them, or maintain such information according to written procedures provided to Physician Group by CalOptima and/or CalOptima's Regulators for this purpose.

7. **Offshore Subcontracts**. Physician Group shall provide, and ensure that Downstream Entities provide, to CalOptima information and attestations related to the provision of any services under this Contract in a country other than the United States ("**Offshore Subcontractor**") to enable CalOptima to comply with CMS reporting obligations. Such information shall be submitted to CalOptima prior to engaging any Offshore Subcontractor for purposes of this Contract, and such Offshore Subcontractors are subject to approval by CalOptima.

8. **Required Disclosures**. In accordance with 42 CFR Section 1002.3, Physician Group shall immediately notify CalOptima in the event any sanctioned person (as defined in 42 CFR Section 1001.1001(a)(1)) owns or controls Physician Group.

9. **Equal Opportunity**. Physician Group and Downstream Entities shall comply with the following Equal Opportunity requirements set forth below.

9.1 Physician Group and its Downstream Entities 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. Physician Group and its Downstream Entities will take affirmative action to ensure that qualified applicants are employed, and that employees are treated during employment, without regard to their race, color, religion, sex, national origin, physical or mental handicap, disability, age, or status as a disabled veteran or veteran of the Vietnam era. Such action shall include the following: Employment, upgrading, demotion or transfer; recruitment or recruitment advertising; layoff or termination; rates of pay or other forms of compensation; and career development opportunities and selection for training, including apprenticeship. Physician and its Downstream Entities agree to post in conspicuous places, available to employees and applicants for employment, notices to be provided by the federal government, 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 Physician Group and its Downstream Entities' 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.

9.2 Physician Group and its Downstream Entities will, in all solicitations or advancements for employees placed by or on behalf of Physician Group and its Downstream Entities, 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.

9.3 Physician Group and its Downstream Entities will send to each labor union or representative of workers with which it has a collective bargaining agreement or other contract or understanding a notice, to be provided by the federal government or the State, advising the labor union or workers' representative of Physician Group and its Downstream Entities' commitments under the provisions herein and shall post copies of the notice in conspicuous places available to employees and applicants for employment.

9.4 Physician Group and its Downstream Entities 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.

9.5 Physician Group and its Downstream Entities 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 Physician Group 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.

9.6 In the event of Physician Group and its Downstream Entities' noncompliance with the requirements of the provisions herein or with any federal rules, regulations, or orders which are referenced in this Article IX, this Contract may be cancelled, terminated, or suspended in whole or in part, and Physician Group and its Downstream Entities may be declared ineligible for further State and Federal 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.

9.7 Physician Group and its Downstream Entities will include the provisions of Sections 10.1 through 10.7 of this attachment 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. Section 4212) of the Vietnam Era Veteran's Readjustment Assistance Act, so that such provisions will be binding upon each Downstream Entity. Physician and its Downstream Entities will take such action with respect to any subcontract or purchase order as the Director of the Office of Federal Contract Compliance Programs or CMS may direct as a means of enforcing such provisions, including sanctions for noncompliance; provided, however, that in the event Physician Group and/or its Downstream Entities become involved in, or are threatened with litigation by a other Downstream Entity or vendor as a result of such direction by CMS, Physician Group and its Downstream Entities may request in writing to CMS, 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.

10. **Non-Discrimination**. Physician Group and Downstream Entities shall comply with the non-discrimination requirements set forth below.

10.1 During the performance of this Contract, neither Physician Group nor any Downstream Entities shall unlawfully discriminate, harass, or allow harassment against any employee or applicant for employment because of sex, race, religion, color, national origin, ancestry, religious creed, physical disability, (including Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS), AIDS-Related Complex (ARC)), medical condition (including cancer), mental disability, marital status, age (over 40), or the

use of family and medical care leave and pregnancy disability leave. Physician Group and Downstream Entities shall insure that the evaluation and treatment of their employees and applicants for employment are free of such discrimination and harassment. Physician Group and Downstream Entities shall comply with the provisions of the Fair Employment and Housing Act (Government Code, Section 12900, *et seq*.) and the applicable regulations promulgated thereunder (Title 2 CCR Section 7285.0, *et seq*.). The applicable regulations of the Fair Employment and Housing Commission implementing Government Code, Section 12990, set forth in Chapter 5 of Division 4 of Title 2 of the CCR are incorporated into this Contract by reference and made a part hereof as if set forth in full. Physician Group and Downstream Entities shall give written notice of their obligations under this clause to labor organizations with which they have a collective bargaining or other agreement. Physician Group shall include the non-discrimination and compliance provisions of this Section 10.1 in all Downstream Entity subcontracts to perform work under this Contract.

10.2 Physician Group and all Downstream Entities shall abide by 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 1972 (regarding education programs and activities); Title 45 CFR Part 91 and the Age Discrimination Act of 1975 (discrimination based on age); and all other laws regarding privacy and confidentiality. Neither the Physician nor Downstream Entities shall discriminate against Enrollees because of race, color, creed, religion, ancestry, marital status, sexual orientation, national origin, age, sex, or physical or mental handicap in accordance with Title VI of the Civil Rights Act of 1964, 42 U.S.C., Section 2000d (race, color, national origin); 45 CFR Part 84 (physical or mental handicap); Government Code Section 11135 (ethnic group identification, religion, age, sex, color, physical or mental handicap); Civil Code Section 51 (all types of arbitrary discrimination); rules and regulations promulgated pursuant thereto, or as otherwise provided by Laws.

10.3 For the purpose of this Contract, if based on any of the foregoing criteria, the following constitute unlawful discriminations: (i) denying any Enrollee any Covered Services or availability of a facility; (ii) providing to an Enrollee any Covered Service that is different or is provided in a different manner or at a different time from that provided to other similarly situated Enrollees under this Contract, except where medically indicated; (iii) subjecting an Enrollee to segregation or separate treatment in any manner related to the receipt of any Covered Service; (iv) restricting an Enrollee in any way in the enjoyment of any advantage or privilege enjoyed by others receiving any Covered Service; or (v) treating an Enrollee differently from others similarly situated in determining compliance with admission, enrollment, quota, eligibility, or other requirements or conditions that individuals shall meet in order to be provided any Covered Service or assigning the times or places for the provision of Covered Services.

10.4 Physician Group shall take affirmative action to ensure that all Enrollees are provided Covered Services without unlawful discrimination, except where medically indicated. For the purposes of this Section 10.4, physical handicap includes the carrying of a gene that may, under some circumstances, be associated with disability in that person's offspring, but which causes no adverse effects on the carrier. Such genetic handicap shall include,

but not be limited to, Tay-Sachs trait, sickle cell trait, thalassemia trait, and X-linked hemophilia.

10.5 Physician shall act upon all complaints alleging discrimination against Enrollees in accordance with CalOptima's Policies and shall forward copies of all such grievances to CalOptima within five (5) days of receipt of same.

11. **Smoke Free Workplace**. Public Law 103-227, also known as the Pro Children Act of 1994 ("**Pro Children Act**"), requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health, day care, early childhood development services, education, or library services to children under the age of 18, if the services are funded by federal programs either directly or through state or local governments, by federal grant, contract, loan, or loan guarantee. The law also applies to children's services that are provided in indoor facilities that are constructed, operated, or maintained with such federal funds. The law does not apply to children's services provided in private residences; portions of facilities used for inpatient drug or alcohol treatment; service providers whose sole source of applicable federal funds is Medicare or Medicaid; or facilities where WIC coupons are redeemed. Failure to comply with the provisions of the law may result in the imposition of a civil monetary penalty of up to $1,000 for each violation and/or the imposition of an administrative compliance order on the responsible party. By signing this Contract, Physician Group certifies that it will comply with the requirements of the Pro Children Act and will not allow smoking within any portion of any indoor facility used for the provision of services for children as defined by the Pro Children Act. Physician further agrees that it will insert this certification into any subcontracts entered into that provide for children's services as described in the Pro Children Act.

12. **Air or Water Pollution Requirements**. Any federally funded agreement and/or subcontract in excess of $100,000 must comply with the following provisions unless said agreement is exempt under 40 CFR 15.5. Physician Group 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.

13. **Lobbying Restrictions and Disclosure Certification**. Any federally funded contracts in excess of $100,000 per Section 1352 of the 31, U.S.C. must comply with the following lobby restrictions and disclosures.

13.1 Each person (or recipient) who requests or receives a contract, subcontract, grant, or sub-grant, which is subject to 31 U.S.C. Section 1352 and which exceeds $100,000 at any tier, shall file a certification (in the form set forth in **Attachment E-1**, consisting of one page, entitled "Certification Regarding Lobbying") that the recipient has not made, and will not make, any payment prohibited by Subsection 13.6 of this attachment.

13.2 Each recipient shall file a disclosure (in the form set forth in **Attachment E-2**, entitled "Standard Form-LLL 'Disclosure of Lobbying Activities'") if such recipient has made or has agreed to make any payment using non-appropriated 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 Section 13.6 of this attachment if paid for with appropriated funds.

13.3 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 Section

13.2 of this attachment. An event that materially affects the accuracy of the information reported includes: (i) 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; (ii) a change in the person(s) or individuals(s) influencing or attempting to influence a covered federal action; or (iii) 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.

13.4 Each person (or recipient) who requests or receives, from a person referred to in Section 13.1 of this attachment, a contract, subcontract, grant or sub-grant 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.

13.5 All disclosure forms (but not certifications) shall be forwarded from tier to tier until received by the person referred to in Section 13.1 of this attachment.

13.6 31 U.S.C. Section 1352 provides in part that no appropriated funds may be expended by the recipient of a federal contract, grant, loan, or cooperative agreement to pay any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with any of the following covered federal actions: the awarding of any federal contract, the making of any federal grant, the making of any federal loan, entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any federal contract, grant, loan, or cooperative agreement.

14. **Debarment Certification**. Physician Group agrees to comply with applicable Federal suspension and debarment regulations including 7 CFR § 3017, 45 CFR §76, 40 CFR § 32, or 34 CFR § 85.

14.1 Physician Group certifies to the best of its knowledge and belief, that it and its principals:

(i) Are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded by any Federal department or agency;

(ii) Have not within a three (3)-year period preceding this Contract have been convicted of or had a civil judgment rendered against them for commission of fraud or a criminal offense in connection with obtaining, attempting to obtain, or performing a public (Federal, State or local) transaction or contract under a public transaction; violation of Federal or State antitrust statutes or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, or receiving stolen property;

(iii) Are not presently indicted for or otherwise criminally or civilly charged by a governmental entity (federal, State or local) with commission of any of the offenses enumerated in sub-provision (ii) herein;

(iv) Have not within a three (3)-year period preceding this Contract had one or more public transactions (Federal, State or local) terminated for cause or default;

(v) Shall not knowingly enter into any lower tier covered transaction with a person who is proposed for debarment under Federal regulations (i.e., 48 CFR 9, subpart 9.4), debarred, suspended, declared ineligible, or voluntarily excluded from participation in such transaction, unless authorized by the State; and

(vi) Will include a clause entitled, "Debarment and Suspension Certification'' that essentially sets forth the provisions herein, in all lower tier covered transactions and in all solicitations for lower tier covered transactions.

14.2 If Physician Group is unable to certify to any of the statements in this certification, the Physician shall submit an explanation to CalOptima.

14.3 The terms and definitions in this Section 14 have the meanings set out in the Definitions and Coverage sections of the rules implementing Federal Executive Order 12549.

14.4 If Physician Group knowingly violates this certification, in addition to other remedies available to the federal government, CalOptima may terminate this Contract for cause or default.

15. **Downstream Entity Contracts**. If any services under this Contract are to be provided by a Downstream Entity subcontracted by Physician Group, Physician Group shall ensure that such subcontracts comply with 42 CFR Sections 422.504, 423.505 and 438.6(l). Such subcontracts shall include all language required by CMS as provided in Attachment F**.**

16. **Other Statutory and Compliance Terms**. Physician Group shall not contract with, or otherwise pay for any items or services (other than an emergency item or service, not including items or services furnished in an emergency room of a Hospital):

16.1 Furnished by Physician Group by any individual or entity during any period when the individual or entity is excluded from participation under Titles V, XVIII, or XX, or under Title XIX pursuant to sections 1128, 1128A, 1156 or 1842(j)(2);

16.2 Furnished at the medical direction or the prescription of a physician, during the period when such physician is excluded from participation under Titles V, XVIII, or XX, or under Title XIX pursuant to sections 1128, 1128A, 1156, or 1842(j)(2) and when the person furnishing such item or service knew, or had some reason to know, of the exclusion (after a reasonable time period and after reasonable notice has been furnished to the person);

16.3 Furnished by an individual or entity to whom the State has suspended payments to during any period when there is a pending investigation of a credible allegation of fraud against the individual or entity, unless the State determines there is good cause not to suspend such payments;

16.4 Physician Group may not pay for an item or service with respect to any amount expended for which funds may not be used under the Assisted Suicide Funding Restriction Act of 1997

ATTACHMENT E-1
CERTIFICATION REGARDING LOBBYING

STATE OF CALIFORNIA
DEPARTMENT OF HEALTH CARE SERVICES
CERTIFICATIN 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 Physician Group Group	Printed Name of Person Signing for Physician
Contract / Grant Number	Signature of Person Signing for Physician Group
Date	Title

After execution by or on behalf of Physician Group, please return to:

CalOptima
Attn: Regulatory Affairs
505 City Parkway West
Orange, California 92868

ATTACHMENT E-2

CERTIFICATION REGARDING LOBBYING

Approved by OMB

Complete this form to disclose lobbying activities pursuant to 31 U.S.C. 1352
0348-0046 (See reverse for public burden disclosure)

<table>
<tr><td>1. Type of Federal Action:
contract
grant
cooperative agreement loan
loan guarantee
loan insurance</td><td colspan="2">2. Status of Federal Action:
bid/offer/application initial
award post-award</td><td>3. Report Type:
initial filing
material change

For Material Change Only:
Year _____ quarter_____
date of last report</td></tr>
<tr><td colspan="2">4. Name and Address of Reporting Entity:
Prime Subawardee Tier, if known:</td><td colspan="2" rowspan="2">5. If Reporting Entity in No. 4 is Subawardee,
Enter Name and Address of Prime:

Congressional District, If known:</td></tr>
<tr><td colspan="2">Congressional District, If known:</td></tr>
<tr><td colspan="2">6. Federal Department/Agency:</td><td colspan="2">Federal Program Name/Description:
CDFA Number, if applicable:</td></tr>
<tr><td colspan="2">8. Federal Action Number, if known:</td><td colspan="2">9. Award Amount, if known:</td></tr>
<tr><td colspan="2">10. a. Name and Address of Lobbying Entity
(If individual, last name, first name, MI):
(attach Continuation Sheets(s)</td><td colspan="2">b. Name and Address of Lobbying Entity
(If individual, last name, first name, MI):
SF-LLL-A, If necessary)</td></tr>
<tr><td colspan="2">Amount of Payment (check all that apply):
$ actual planned</td><td colspan="2" rowspan="3">13. Type of Payment (check all that apply):
a. retainer
b. one-time fee
c. commission
d. contingent fee
e. deferred
f. other, specify:</td></tr>
<tr><td colspan="2">Form of Payment (check all that apply):
a. cash
b. in-kind, specify: Nature</td></tr>
<tr><td colspan="2">Value</td></tr>
</table>

14. Brief Description of Services Performed or to be Performed and Dates(s) of Service, including Officer(s), Employee(s), or Member(s) Contracted for Payment indicated in item 11: (Attach Continuation Sheet(s) SF-LLL-A, If necessary)	
15. Continuation Sheet(s) SF-LLL-A Attached: Yes No	
16. Information requested through this form is authorized by Title 31, U.S.C., Section 1352. This disclosure of lobbying activities is a material representation of fact upon which reliance was placed by the tier above when this transaction was made or entered into. This disclosure is required pursuant to Title 31, U.S.C., Section 1352. This information will be reported to the Congress semiannually and will be available for public inspection. Any person who fails to file the required disclosure shall be subject to a civil penalty of not less than $19,000 and not more than $100,000 for each such failure.	Signature: Print Name: Title: Telephone No.: Date:
Federal Use Only	

INSTRUCTIONS FOR COMPLETION OF SF-LLL, DISCLOSURE OF LOBBYING ACTIVITIES

This disclosure form shall be completed by the reporting entity, whether subawardee or prime federal recipients at the initiation or receipt of a covered federal action, or a material change to a previous filing, pursuant to Title 31, U.S.C., Section 1352. The filing of a form is required for each payment or agreement to make payment to any lobbying entity for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with a covered federal action. Use the SF-LLL-A Continuation Sheet for additional information if the space on the form is inadequate. Complete all items that apply for both the initial filing and material change report. Refer to the implementing guidance published by the Office of Management and Budget for additional information.

Identify the type of covered federal action for which lobbying activity is and/or has been secured to influence the outcome of a covered federal action.

Identify the status of the covered federal action.

Identify the appropriate classification of this report. If this is a follow-up report caused by a material change to the information previously reported, enter the year and quarter in which the change occurred. Enter the date of the last previously submitted report by this reporting entity for this covered federal action.

Enter the full name, address, city, state, and ZIP code of the reporting entity. Include Congressional District, if known. Check the appropriate classification of the reporting entity that designates if it is, or expects to be, a prime or subaward recipient. Identify the tier of the subawardee, e.g., the first subawardee of the prime is the 1st tier. Subawards include but are not limited to subcontracts, subgrants, and contract awards under grants.

If the organization filing the report in Item 4 checks "Subawardee," then enter the full name, address, city, state, and ZIP code of the prime federal recipient. Include Congressional District, if known.

Enter the name of the federal agency making the award or loan commitment. Include at least one organizational level below agency name, if known. For example, Department of Transportation United States Coast Guard.

Enter the federal program name or description for the covered federal action (Item 1). If known, enter the full Catalog of Federal Domestic Assistance (CDFA) number for grants, cooperative agreements, loans, and loan commitments.

Enter the most appropriate federal identifying number available for the federal action identified in Item 1 (e.g., Request for Proposal (RFP) number; Invitation for Bid (IFB) number; grant announcement number; the contract grant, or loan award number; the application/proposal control number assigned by the federal agency). Include prefixes, e.g., "RFP-DE-90401."

For a covered federal action where there has been an award or loan commitment by the federal agency, enter the federal amount of the award/loan commitment for the prime entity identified in Item 4 or 5.

10. (a) Enter the full name, address, city, state, and ZIP code of the lobbying entity engaged by the reporting entity identified in Item 4 to influence the covered federal action.

10. (b) Enter the full names of the Individual(s) performing services and include full address if different from 10.(a). Enter last name, first name, and middle initial (MI).

Enter the amount of compensation paid or reasonably expected to be paid by the reporting entity (Item 4) to the lobbying entity (Item 10). Indicate whether the payment has been made (actual) or will be made (planned). Check all boxes that apply. If this is a material change report, enter the cumulative amount of payment made or planned to be made.

Check the appropriate box(es). Check all boxes that apply. If payment is made through an in-kind contribution, specify the nature and value of the in-kind payment.

Check the appropriate box(es). Check all boxes that apply. If other, specify nature.

Provide a specific and detailed description of the services that the lobbyist has performed, or will be expected to perform, and the date(s) of any services rendered. Include all preparatory and related activity, not just time spent in actual contact with federal officials, identify the federal official(s) or employee(s) contacted or the officer(s), employee(s), or Member(s) of Congress that were contacted.

Check whether or not a SF-LLL-A Continuation Sheet(s) is attached.

The certifying official shall sign and date the form, print his/her name, title, and telephone number.

Public reporting burden for this collection of information is estimated to average 30 minutes per response, including time for reviewing instruction, searching existing data sources, gathering and maintaining the data needed, and completing and renewing the collection of information. Send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to the Office of Management and Budget, Paperwork Reduction Project, (0348-0046), Washington, DC 20503.

ATTACHMENT F
SUBCONTRACT REGULATORY TERMS

A. **General Terms**: Language addressing the following matters shall be included in Downstream subcontracts:

1. The right of CalOptima's Regulators to monitor, audit, evaluate, inspect and have access to books, records and other information as provided in this Contract.
2. CalOptima's Regulators' right to inspect, evaluate, and audit any pertinent information related to the Contract for a period of ten (10) years from the final date of the contract period or from the date of completion of any audit as provided in this Contract.
3. Prohibitions against holding Enrollees liable for payment of any fees that are the obligation of CalOptima or the Physician Group, as applicable.
4. The services are in accordance with CalOptima's obligations to CMS and applicable CalOptima Policies.
5. The obligations of Downstream Entities to protect Enrollee privacy and confidentiality including health records, as provided in this Contract.
6. The obligation to comply with all federal and state laws, regulations and CMS instructions, including those laws that must be incorporated into such Downstream subcontracts as indicated in this Contract.
7. Language related to the obligations to submit timely and accurate Encounter Data and other data and reports required by CalOptima and CalOptima's Regulators as provided in this Contract and in CalOptima's Policies.
8. All requirements included in Attachment E not expressly addressed herein.

B. **Delegation Terms**. If, and to the extent that sub-delegation is permitted by CalOptima and Physician Group obtains CalOptima's approval as provided in this Contract, Downstream Entity subcontracts must include:

1. Language that specifies (i) the delegated activities and reporting requirements; (ii) that provides for revocation of the delegated activities and other remedies in the event CalOptima or CalOptima's Regulators find that the delegated party as not performed satisfactorily; (iii) that the performance of the parties is monitored by CalOptima on an ongoing basis; and (iv) that CalOptima may impose corrective action as necessary.
2. If the subcontract relates to credentialing of medical providers, language that the credentials of medical professionals affiliated with the party or parties will either be reviewed by CalOptima or the credential process will be reviewed and approved by CalOptima and that CalOptima must audit the process on an ongoing basis.
3. If the subcontract delegates selection of providers it must include language that CalOptima retains the right to approve, suspend or terminate any such arrangement and that CalOptima shall provide a written statement to a provider of the reason or reasons for the termination with cause.

C. **Medical Provider Downstream Subcontract Terms**.

All subcontracts or arrangements with medical providers shall include provisions addressing:

1. The term of the contract, including the beginning and ending dates as well as methods of extension, renegotiation and termination and full disclosure of the method and amount of compensation or other consideration.

2. The obligation to pay contracted medical providers under the terms of the contract and prompt payment provision, the terms of which are developed and agreed to by the parties.

3. The obligations to provide services in a culturally competent manner to all Enrollees, including those with limited English proficiency or reading skills, and diverse culturally and ethnic background and provide interpreter services for Enrollees at all provider sites.

4. The obligation to (i) abide by all federal and state laws and regulations regarding confidentiality and disclosure of medical records, or other health and enrollment information; (ii) to ensure that medical information is released in accordance with applicable federal or state law, or pursuant to court orders or subpoenas; (iii) to maintain Enrollee records and information in an accurate and timely manner; and (iv) to ensure timely access by Enrollees to the records and information that pertain to them.

5. The obligation to hold CalOptima, CalOptima's Regulators and Enrollees harmless in the event that Physician Group cannot or will not pay for services performed by the Downstream Entity and for Medicare Part A and B cost sharing. Specifically, Medicare Parts A and B services must be provided at zero cost-sharing to Enrollees.

6. Medical providers' EMTALA obligations and that they must not create any conflicts with hospital actions required to comply with EMTALA.

7. Language prohibiting providers, including PCPs, from closing or otherwise limiting their acceptance of Enrollees as patients unless the same limitations apply to all commercially insured Enrollees.

8. Language that prohibits the Downstream Entity from refusing to contract or pay an otherwise eligible health care Provider for the provision of Covered Services solely because such Provider has in good faith: (a) Communicated with or advocated on behalf of one or more of his or her prospective, current or former patients regarding the provisions, terms or requirements of the 'Downstream Entity's health benefit plans as they relate to the needs of such Provider's patients; or (b) communicated with one or more of his or her prospective, current or former patients with respect to the method by which such Provider is compensated by the Downstream Entity for services provided to the patient.

9. Language that states the Provider is not required to indemnify the Physician Group for any expenses and liabilities, including judgments, settlements, attorneys' fees, court costs and any associated charges, incurred in connection with any claim or action brought against the Physician Group based on its management decisions, utilization review provisions or other policies, guidelines or actions.

10. The obligation of the medical provider to assist CalOptima in the transfer of care, including in the transfer of care in the event of sub-subcontract termination for any reason.

11. Acknowledgement that assignment or delegation of the subcontract will be void unless prior written approval is obtained from CMS and CalOptima.

12. 'The Provider's right to submit a grievance and a description of the formal process to resolve the Provider's grievances.

13. The obligation to participate and cooperate in Physician Group's Quality Improvement System.

14. Language addressing requirements related to payment of Non-Participating Provider

emergency and post-stabilization services.

ATTACHMENT G
CMS SPECIFIC PROGRAM PERFORMANCE REQUIREMENTS

1. HCC Coding Requirements and Performance Improvement Activities

1.1 CMS pays CalOptima health-based capitation to compensate CalOptima for services rendered to Enrollees. CMS utilizes encounter data to assign Hierarchical Condition Categories ("**HCC**") to Enrollees. The Enrollee's HCC determines the payment amount received by CalOptima accounting for the variation in expenditures for Medicare Enrollees based on an Enrollee's health status.

1.2 Physician Group shall submit Enrollee-specific accurate encounter and service data. Encounters are to be submitted no less than monthly using the ANSI 837P and/or 837I format version 5010 as appropriate, or current format as required by CalOptima.

1.3 Physician Group shall support and aid CalOptima's review of encounters, including to production and/or access of supporting medical records.

1.4 To enhance encounter submission accuracy and completeness, CalOptima has initiated performance improvement activities ("**PIAs**"). These PIAs include Enrollee medical and behavioral health assessments provided in the home or a residential facility.

1.5 Physician Group has the option to perform these PIAs provided Physician Group can demonstrate that Physician Group's PIAs meet all CalOptima standards and guidelines. Should Physician Group not perform the PIAs or Physician Group's PIAs not meet CalOptima standards and guidelines as determined by CalOptima, CalOptima shall perform these activities on behalf of Physician Group and the cost for these PIAs shall be charged to or shared with Physician Group. CalOptima will provide sixty (60) days' notification prior to taking any such action.

2. ESRD Waiver Responsibilities

2.1 Physician Group shall demonstrate to CalOptima that Physician Group administers a CalOptima-approved complex case management program for all End Stage Renal Disease (ESRD) Enrollees, which is in accordance with CMS requirements and CalOptima Policies and standards.

2.2 CalOptima shall advise Physician Group if its ESRD complex case management program does not meet CMS requirements and CalOptima Policies and clinical standards. If Physician Group cannot meet requirements as provided by CalOptima, CalOptima shall have the option to de-delegate the Physician Group for the management of ESRD Enrollees and retain a portion of the Capitation Payment for ESRD Enrollees commensurate with the costs for providing or outsourcing such services.

2.3 CalOptima shall provide notification to Physician Group of the intent to de-delegate. Physician Group shall have the opportunity to submit a corrective action plan to CalOptima in accordance with CalOptima policy.

3. Appeals Rights

Physician Group may appeal CalOptima's decision to take the actions outlined above, by filing a complaint pursuant to CalOptima Policies. If Physician Group is dissatisfied with the result of any appeal; it shall proceed in accordance with CalOptima's legal claims and judicial review policy.

MEDICARE ADVANTAGE – PHYSICIAN GROUP SERVICES CONTRACT

BETWEEN

ORANGE COUNTY HEALTH AUTHORITY DBA CALOPTIMA

AND

_____

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MEDICARE ADVANTAGE PHYSICIAN GROUP SERVICES CONTRACT

This Medicare Advantage Physician Group Services Contract ("**Contract**") is January 1, 2023 ("**Effective Date**") by and between Orange County Health Authority, a public agency dba CalOptima ("**CalOptima**"), and _____ ("**Physician Group**"), a California professional medical corporation organized under the laws of the State of California. CalOptima and Physician Group may each be referred to herein as a "**Party**" and collectively as the "**Parties**".

RECITALS

A. CalOptima is a County Organized Health System ("**COHS**") organized under Welfare & Institutions Section 14087.54 and Orange County Ordinance No. 3896.

B. CalOptima is licensed as a health care service plan by the California Department of Managed Health Care ("**DMHC**") under the Knox-Keene Health Care Service Plan Act of 1975 and its implementing regulations (collectively the "**Knox-Keene Act**") and authorized to offer a Medicare Advantage ("**MA**") plan pursuant to Title 42 of the United States Code, Chapter 7, Subchapter XVIII, Part C and its implementing regulations for individuals covered under the federal Medicare program.

C. CalOptima, as a dual–eligible special needs plan ("**DSNP**"), may only enroll those dual eligible individuals who meet all applicable Medicare Advantage eligibility requirements, and who are eligible to be enrolled in CalOptima's Medi-Cal Managed Care plan, as described in the contract between CalOptima and the California Department of Health Care Services ("**DHCS**").

D. Physician Group is a duly licensed California professional medical corporation that employs or has entered into contracts with physicians who are licensed to practice medicine in the State of California ("**State**"), and other Providers who are appropriately licensed in the State.

E. Physician Group and the facilities set forth in Addendum 1 ("**Hospital**") have affiliated to operate as a physician-hospital consortium ("**PHC**"), which is an arrangement under which Physician Group and Hospital each participate in a risk pool for Covered Services provided to Enrollees as detailed in Section 2.7, for the purpose of providing or arranging for the provision of Covered Services to Enrollees under this Contract and Hospital's contract with CalOptima ("**Hospital Contract**"). Physician Group and Hospital may collectively be referred to herein as "**PHC Participants**".

F. Physician Group recognizes that in order to comply with the requirements of this Contract, Physician Group and Hospital must operate in a manner that is mutually beneficial to both entities affiliated to operate as a PHC. Accordingly, Physician Group agrees under this Contract and Hospital has agreed under the Hospital Contract to collectively and individually coordinate and cooperate with each other and with CalOptima in arranging for and providing Covered Services to Enrollees.

G. CalOptima and Physician Group desire to enter into the Contract whereby Physician Group will perform delegated administrative services and furnish health care items and services as described herein to certain Enrollees enrolled in CalOptima's MA plan.

H. Unless defined elsewhere in the Contract, the defined terms used in this Contract shall have the meanings set forth in Attachment A.

NOW, THEREFORE, in consideration of the promises and the mutual covenants herein stated, it is agreed by and between the Parties as follows:

I. PHYSICIAN GROUP SERVICE OBLIGATIONS

1.1 **Covered Services**. Physician Group shall provide Covered Services to Enrollees selecting, and assigned to, Physician Group in accordance with all provisions of this Contract and CalOptima Policies. The Covered Services that are to be provided by and are the financial responsibility of Physician Group are described in Attachment B. Physician Group specifically agrees to accept financial risk and responsibility for injectables pursuant to Health & Safety Code Section 1375.8.

1.1.1 Physician Group shall provide Covered Services: (i) in the same manner, in accordance with the same standards, and within the same time availability as offered to non-CalOptima patients; (ii) in accordance with professionally recognized standards of practice, (iii) in a culturally competent manner to all Enrollees, including those with limited English proficiency or reading skills and from diverse cultural and ethnic backgrounds; and (iv) not discriminate in the provision of such Covered Services because of an Enrollee's race, ethnicity, color, national origin, religion, sex, sexual orientation, age, medical or claims history, mental or physical disability, genetic information, or source of payment.

1.1.2 Physician Group is prohibited from closing or otherwise limiting its acceptance of Enrollees as patients unless the same limitations apply to all of its commercially insured patients.

1.1.3 Physician Group shall use its best efforts, where consistent with sound medical practice, to ensure that Covered Services are provided only by Group Physicians and/or other Participating Providers, except in cases of Emergency Services or Urgent Care Services, or if no such Group Physician or Participating Provider is available to perform the appropriate Covered Services.

1.1.4 Physician Group shall be liable for the provision and payment of all Covered Services notwithstanding a delay in payment of the Capitation Payment.

1.1.5 Physician Group acknowledges that the determination of whether a service or supply was/is a Covered Service delegated to Physician Group rests with CalOptima, subject to the Evidence of Coverage and Appeals procedures established by the DMHC and CMS.

1.1.6 CalOptima may incorporate any change in Covered Services mandated by Laws into the Contract effective the date the change goes into effect. Whenever possible, CalOptima shall give the Physician Group thirty (30) calendar days' prior notice of any such change to the Contract. CalOptima shall determine the effective date of the change in Covered Services. Attachment B shall not be amended during the current Term without mutual consent of the Parties, except as may be required for continued compliance with Laws.

1.1.7 Decisions concerning whether to provide or authorize Covered Services under this Contract shall be based solely on Medical Necessity. Physician Group shall not deny Authorization for a Covered Service that the Enrollee or the Provider demonstrates is Medically Necessary. The actual provision of any Covered Service is subject to the professional

judgment of the PCP or other physicians and/or Providers participating with Physician Group as to the Medical Necessity of the Covered Service, except that each Physician shall provide assessment and evaluation services ordered by a court or legal mandate. Physician Group acknowledges that disputes between the Physician Group and Enrollees about Medical Necessity can be appealed pursuant to CalOptima Policies and Laws.

1.1.8 Physician Group may not arbitrarily deny or reduce the amount, duration, or scope of a required Covered Service solely because of the diagnosis, type of illness, or condition. Physician Group may place appropriate limits on a service on the basis of criteria such as Medical Necessity or for utilization control, provided the services furnished can reasonably be expected to achieve their purpose and such a limitation complies with Laws.

1.2 **Confidentiality**. Physician Group and CalOptima agree to safeguard the confidentiality of Enrollee information and comply with all Laws (including, but limited to, the Health Insurance Portability and Accountability Act ("**HIPAA**"), 42 CFR Section 431.300 *et seq*., California Welfare and Institutions Code Section 14100.2, California Civil Code Section 56 *et seq.*, and the California Information Practices Act, Civil Code Section 1798) regarding the confidentiality and disclosure of Enrollee names, health, enrollment and personal information (including medical and Behavioral Health information contained in Medical Records). Physician Group shall provide counseling to Enrollees on their right to confidentiality and obtain Enrollee consent prior to releasing confidential information unless such consent is not required pursuant to Title 22 CCR Section 51009.

1.3 **Emergency Services and Urgent Care**. Physician Group shall insure that it provides and pays for all Emergency Services and Urgent Care, including those services provided by Non-Participating Providers, without prior Authorization, twenty-four (24) hours each day, seven (7) days a week, in accordance with Laws and CalOptima Policies. Physician Group shall coordinate access to Emergency Services in accordance with CalOptima's emergency department protocol. Physician Group shall ensure adequate follow-up care for those Enrollees who have been screened in the emergency room and require non-Emergency Services. Physician Group may not specify what constitutes an Emergency Medical Condition on the basis of lists of diagnoses or symptoms.

1.4 **Days to Appointment**. Physician Group shall ensure that appointments for non-Emergency Services and non-Urgent Care Covered Services are scheduled within ten (10) business days of the Enrollee's request for PCP and fifteen (15) business days of Enrollee's request for Specialist Physician; that health assessments and general physical examinations and all preventative Covered Services are scheduled within thirty (30) calendar days of Enrollee's request for an appointment, and that, if Physician Group supplies maternity Covered Services, Physician Group shall ensure that the most current standards and guidelines of the American College of Obstetricians and Gynecologists are utilized as the minimum measure of quality for perinatal services. Physician Group shall also have a process in place for follow-up on Enrollee missed appointments.

1.5 **Twenty-Four (24) Hour Physician Group Coverage**. Physician Group shall ensure that it has, at a minimum, two Group Physicians as follows: One (1) Group Physician who is available twenty-four (24) hours a day to authorize Medically Necessary, Post-Stabilization Care Services and coordinate transfer of stabilized Enrollees in an emergency department, if necessary, and one (1) Group Physician available twenty-four (24) hours a day, seven (7) days a week to resolve disputed requests for Authorizations.

1.6 **Clinical Laboratory Improvement Amendments**. Physician Group shall only use laboratories with a Clinical Laboratory Improvement Amendments ("**CLIA**") certificate of waiver or a certificate of registration along with a CLIA identification number.

1.7 **CalOptima Formulary Compliance**. Participating Providers shall comply with the CalOptima Formulary and its associated drug utilization and disease management guidelines and protocols. Requests for items not included in the CalOptima Formulary shall require prior Authorization by CalOptima. The prescribing Physician shall be responsible for obtaining Authorization through CalOptima and/or its designated pharmacy benefit management contractor ("**PBM**"), as appropriate. The prescribing Physician shall provide CalOptima and/or the PBM with all information necessary to process Authorization requests.

1.8 **Enrollee Access**. Physician Group and its Downstream Entities shall comply with all Laws and CalOptima Policies governing Enrollee access to Covered Services.

1.8.1 If Physician Group is unable to provide necessary Covered Services to a particular Enrollee, Physician Group must adequately and timely cover these services with Non-Participating Providers for the Enrollee, for as long as Physician Group is unable to provide them. Physician Group shall make prior arrangements with Non-Participating Providers for the provision of such services, shall be fully responsible for arranging and paying for such services, and shall comply with all applicable CalOptima Policies with regard to the payment and Authorization of Non-Participating Providers.

1.8.2 Physician Group shall ensure that PCPs as well as Specialty Physicians are located so as to assure sufficient geographic and physical access of Enrollees to such providers as required by Laws and CalOptima Policies.

1.8.3 Physician Group shall ensure that each Enrollee has a PCP who is available and physically present at the service site for sufficient time to ensure access for the assigned Enrollee when medically required. This requirement does not preclude an appropriately licensed professional from being a substitute for the PCP in the event of the PCP's vacation, illness, or other unforeseen circumstances.

1.8.4 Physician Group shall ensure female Enrollees have direct access to a women's health specialist within the network to provide women's routine and preventative health care services. Such access may be in addition to the Enrollee's PCP.

1.8.5 Physician Group shall cover family planning services for all Enrollees whether they are provided by a Participating Provider or Non-Participating Provider.

1.8.6 Physician Group shall reasonably accommodate Enrollees and ensure programs and services are as accessible (including a sufficient number of Providers and geographic access) to an Enrollee with disabilities as they are to an Enrollee without disabilities in accordance with CalOptima Policies. Physician Group's facilities shall comply with the requirements of Title III of the Americans with Disabilities Act of 1990 ("**ADA**") and shall ensure access for the disabled, including, but not limited to, ramps, elevators, restrooms, designated parking spaces, and drinking water provisions. Physician Group shall have policies to ensure that physical, communication and programmatic barriers do not inhibit Enrollees with disabilities from obtaining all Covered Services, including addressing reasonable accommodations required by the CMS Contract and CalOptima Policies. Physician Group will comply with CalOptima Policies and work plan requirements related to ADA compliance relevant to services under this Contract.

1.9 **Provider Network Maintenance**. Physician Group agrees to employ or contract with a sufficient number of Physicians and other Providers representing the range of medical specialties necessary,

in the determination of CalOptima, CMS, and the DMHC to ensure Enrollees of reasonable access to the full range of Covered Services.

1.9.1 During the Term, all Participating Providers of Covered Services must: (i) be and remain qualified in accordance with current applicable legal, professional, and technical standards; (ii) be and remain appropriately licensed, certified or registered; (iii) be and remain in good standing with Medicare and not be terminated or suspended from participation in the Medicare and/or Medi-Cal programs; and (v) have a valid NPI number, as applicable. Physician Group shall ensure that PCPs are located so as to assure sufficient geographic and physical access of Enrollees to such Physicians under Laws and CalOptima Policies.

1.9.2 Physician Group shall ensure that Participating Providers have the requisite training and experience in dealing with the medical problems frequently encountered in elderly, disabled, and special needs individuals.

1.9.3 Physician Group shall use primary source verification to confirm the board certification in each clinical specialty area for which the Physician is being credentialed if the Physician lists such board certification on credentialing applications.

1.9.4 Physician Group acknowledges that the requirements of this Section 1.9 apply to each individual Provider who is affiliated with and/or part of any medical group, independent physician associations ("**IPA**"), and/or other organization or entity that contracts with Physician Group to furnish Covered Services to Enrollees.

1.9.5 Physician Group will maintain accurate records, including records detailing the status, membership, and qualifications of the Participating Providers in the Physician Group's network.

1.9.6 If a Provider who seeks to become a Participating Provider is denied a contract with Physician Group or a Participating Provider is suspended or terminated for cause, Physician Group shall provide the Provider with written notice of the reason for the action, as required by Laws, including any standards and profiling data Physician Group used to evaluate the provider, the number and mix of similar health care Providers that Physician Group needs (if applicable), and notice of the Provider's right to appeal the action, including notice of the process and timing to request a hearing. In the event Physician Group terminates a contract with a Participating Provider for deficiencies in the quality of care provided, Physician Group shall give notice of the action to CalOptima, as provided by CalOptima Policies, and to the appropriate licensing and disciplinary bodies, as provided by law.

1.9.7 In the event that a Provider, including a PCP, is terminated or leaves the Physician Group for any reason, Physician Group shall give written notification of termination of such Provider to CalOptima within fifteen (15) days after receipt or issuance of the termination notice.

1.9.8 In the event that a Provider, including a PCP, is terminated or leaves the Physician Group for any reason, Physician Group shall ensure that there is no disruption in services provided to Enrollees who are receiving treatment for a chronic or ongoing medical condition in accordance with applicable Laws.

1.9.9 Physician Group shall notify CalOptima at least sixty (60) days before any significant change in Physician Group's provider network that renders Physician Group unable to

provide one or more Covered Services within CalOptima's access to care standards. If such notice is not possible because the providers terminate their participation with less than sixty (60) days' notice or Physician Group terminates the providers without prior notice as a result of their endangering the health and safety of Enrollees, providers committed criminal or fraudulent acts, or providers engaged in grossly unprofessional conduct, then Physician Group shall notify CalOptima immediately upon receipt of notice of the termination, or sending notice to the providers of a Physician Group-initiated termination.

1.9.10 Physician Group shall ensure that no Provider who fails to meet the requirements of this section furnishes items and/or services to Enrollees, submits claims and/or receives reimbursement for any Covered Services.

1.9.11 Physician Group agrees that each Participating Provider with whom Physician Group contracts to provide Covered Services will be required to execute a contract with Physician Group. Such an agreement will require all Participating Providers to comply with those aspects of this Contract relating to activities of Participating Providers and with Laws, including the standards of accrediting and regulatory agencies governing CalOptima's MA Program, and any and all provisions required by MA regulations. The Physician Group agreement with Participating Providers shall be made available to CalOptima and its regulatory agencies for inspection and copying upon request. Physician Group shall ensure that all contracts with Participating Providers allow for termination of the contract for failure to meet the requirements of this Section 1.9.

1.10 **Enrollment**. Physician Group shall accept as Enrollees all persons indicated as Enrollees by the CalOptima information system and transmitted to Physician Group and shall comply with requirements to provide notices to Enrollees in accordance with CalOptima Policies.

1.11 **Primary Care Physician**. Physician Group agrees that each Enrollee will select or be assigned a PCP. Enrollee must request a PCP assignment from CalOptima's Customer Service department. If the Enrollee has not selected a PCP, CalOptima shall assign the PCP per its policies. Physician Group agrees that it will ensure that the PCP shall be responsible for the provision, coordination, referral, and Authorization of Covered Services in accordance with the utilization management ("**UM**") program and prevailing standards of medical practice so that there is a Physician who has ultimate responsibility for the Enrollee's care management.

1.12 **Physician Group Medical Director**. Physician Group shall designate a Group Physician as Medical Director for purposes of this Contract. The Physician Group Medical Director will be a member of the Physician Group's quality management and UM committee(s) and will be the individual to whom CalOptima communicates regarding provision of professional medical care and quality and/or appropriate utilization of medical services. The Physician Group Medical Director will be the individual responsible for representing Physician Group in the resolution of any Grievances presented to CalOptima by Enrollees related to the provision of medical care.

1.13 **Care Coordination**. CalOptima shall retain the responsibility for the initial HRA and an HRA annually thereafter in accordance with CalOptima Policies, but any update during the course of the year due to change in Enrollee's condition/circumstance would be the responsibility of the Physician Group, per policy. Physician Group shall offer care coordination and case management services to all Enrollees, which shall: (i) include coordination of care across the full continuum of service providers as appropriate to Covered Services under this Contract; (ii) ensure that care coordination services reflect a person-centered, outcome-based approach, consistent with the Model of Care and CalOptima Policies; (iii) follow Enrollee direction about level of involvement

of his or her caregivers or medical providers; (iv) include the assignment of a qualified Care Coordinator to each Enrollee needing or requesting one; and (v) reflect access to appropriate community resources with a focus on providing services in the least restrictive setting and transitions between the facilities and the community.

1.14 **Model of Care**. Physician Group shall furnish Covered Services in compliance with CalOptima's Model of Care, including the PCC component, HRA, ICP and ICT requirements.

1.14.1 CalOptima will complete and communicate the HRA to Physician Group. Physician Group shall, upon notification by CalOptima of the need to follow-up on the results of an HRA administered by CalOptima, perform and provide any follow-up required by CalOptima.

1.14.2 Physician Group shall develop an ICP for each Enrollee and engage Enrollees and/or their representative in the design of the ICP in accordance with CalOptima Policies.

1.14.3 Physician Group shall offer an ICT for each Enrollee, as necessary, which will be developed around the Enrollee and integrate medical and LTSS and the coordination of Behavioral Health services. Enrollees shall not be required to participate in the ICT and may opt-out at any time. Enrollees may not be dis-enrolled from the ICT for lack of participation on the ICT. The ICT shall comply with CalOptima Policies.

1.14.4 PCPs and/or the Care Coordinator, in collaboration with CalOptima, will provide basic case management services to Enrollees in accordance with CalOptima's Policies. If the Enrollee has been identified as potentially benefiting from complex case management services, Physician Group shall provide such services to the Enrollee.

1.14.5 Physician Group shall ensure the provision of discharge planning when an Enrollee is admitted to a hospital or institution and continues into the post-discharge period. Discharge planning shall include ensuring that the necessary care, services, and supports are in place in the community for the Enrollee once he or she is discharged, including scheduling an outpatient appointment and/or conducting follow-up with the Enrollee or caregiver. Physician Group shall comply with CalOptima Policies addressing minimum criteria requirements for discharge planning.

1.15 **Behavioral Health Services Referrals**. Physician Group shall furnish and/or coordinate Behavioral Health services as specified in CalOptima Policies and this Contract.

1.15.1 For Specialty Mental Health Services, Physician Group shall refer Enrollees to CalOptima as the Administrative Service Organization contracted to provide assessment, referral and Authorization services.

1.15.2 For Outpatient Mental Health Services that are within a Physician Group' PCP's scope of practice, Physician Group shall manage according to current appropriate treatment guidelines. If the Outpatient Mental Health Services are outside its PCPs' scope of practice, Physician Group shall refer Enrollees to CalOptima's contracted behavioral health provider.

1.15.3 For Enrollees requiring alcohol or substance use disorder treatment, Physician Group shall manage according to the appropriate PCP treatment guidelines. If the alcohol or substance use disorder treatment are outside its PCPs' scope of practice, Physician Group shall refer

Enrollees to CalOptima's contracted behavioral health provider. Coordination of care through the ICT will occur as is specified in CalOptima Policies and this Contract.

1.16 **LTSS Referrals**. Physician Group shall refer Enrollees to CalOptima for LTSS pursuant to CalOptima Policies.

1.17 **Facility Site and Medical Record Reviews**. Physician Group shall participate in, and comply with requirements for, PCP site and medical reviews, including facility site physical accessibility reviews, in accordance with CalOptima Policies and guidance issued by CalOptima's Regulators, including requirements, if any, related to collaborative programs.

1.18 **Transfers**. Physician Group agrees to assist CalOptima in facilitating the transfer of care of Enrollees if determined medically acceptable by attending Physicians and the CalOptima Medical Director. Physician Group will be responsible for the cost of Covered Services provided if Physician Group refuses to accept such transfer.

1.19 **Delegation by CalOptima to Physician Group**. Physician Group agrees to accept delegated responsibility for those activities listed in the Delegation Agreement and to perform the delegated activities in a manner consistent with the Delegation Criteria. Physician Group warrants that it meets CalOptima's Delegation Criteria and acknowledges that delegation to another entity does not alter Physician Group's ultimate obligations and responsibilities set forth in this Contract. Physician Group agrees to notify CalOptima of any change in its ability to meet the Delegation Criteria within twenty-four (24) hours from the date it fails to meet such Delegation Criteria. At CalOptima's request, Physician Group shall identify the Compliance Officer or other appropriate health network representative to be the liaison expressly responsible for oversight of delegated obligations.

1.19.1 Physician Group acknowledges that it is CalOptima's responsibility to oversee, monitor and evaluate Physician Group's ongoing eligibility for delegation according to the Delegation Criteria and performance of the delegated activities according to the Delegation Criteria. Physician Group agrees to cooperate with CalOptima's oversight, monitoring, and evaluation of Physician Group's eligibility and performance of delegated activities, including the provision of reasonable access during regular business hours to the Enrollee inquiry files, credentialing files, clinical and Medical Records of Enrollees, and all other information requested by CalOptima. Physician Group shall comply with corrective actions imposed by CalOptima and/or CalOptima's Regulators in the time and manner required by them.

1.19.2 Physician Group acknowledges and agrees that CalOptima retains final authority and responsibility for activities delegated under this Contract. Activities not expressly delegated herein and in the Delegation Agreement by CalOptima or for which delegation is terminated are the responsibility of CalOptima.

1.19.3 Physician Group agrees to provide CalOptima with periodic reports on delegated activities performed by Physician Group as provided in the Delegation Criteria or specified in CalOptima Policies.

1.19.4 In the event CalOptima, DMHC, or CMS is dissatisfied with the performance of delegated functions and activities by Physician Group or its Downstream Entities, CalOptima may, in its sole discretion, modify Physician Group's delegated status (in respect to all or a particular delegated activity), including from fully delegated to delegated with corrective

action, or may immediately revoke all or part of the delegated activities. In the event Physician Group breaches its obligation to perform any delegated obligations, CalOptima shall have all remedies set forth in this Contract, including the right to revoke delegation of such function(s) and impose financial and other penalties. Moreover, CalOptima shall have the right to require Physician Group to terminate any Downstream Entity for good cause, including breach of its obligations to perform any delegated duties. Nothing herein is intended to limit CalOptima's remedies as provided for in this Contract or at law.

1.19.5 Physician Group acknowledges and agrees that CalOptima, in its sole and absolute discretion, may reduce Physician Group's Capitation Payments to recoup additional administrative costs where CalOptima revokes or modifies activities or functions delegated to Physician Group under this Contract.

1.20 **Delegation and Subcontracting of Administrative Services by Physician Group**. Except as otherwise limited by this Contract and/or CalOptima Policies, Physician Group may sub-delegate Administrative Services required of Physician Group to a management services organization ("**MSO**"), medical group and/or IPA. Delegation shall not absolve Physician Group of oversight responsibilities or its obligations under this Contract. All requests for delegation of Administrative Services (i) must be in writing; (ii) are subject to successful completion of CalOptima's readiness assessment requirements; and (iii) must be approved by CalOptima in advance of undertaking the Administrative Services. Physician Group shall obtain written approval of delegation from CalOptima pursuant to the process detailed in CalOptima Policies.

1.21 **Subcontracts**. Physician Group is required to inform CalOptima of the name and business addresses of all subcontracted Downstream Entities. Physician Group is required to ensure that all such subcontracts are in writing and include all provisions required by this Contract to be incorporated into subcontracts. Physician Group acknowledges that CalOptima's FDR subcontracts are subject to the review and approval of CMS.

1.22 **Payment to Providers**. CalOptima hereby delegates claims processing functions to Physician Group. Physician Group shall review, adjudicate, and pay (as appropriate) all claims in accordance with the benefits set forth in the Evidence of Coverage, the requirements established by Laws, and the terms of this Contract. In making payments to Providers, Physician Group shall comply with the provisions of Attachment D, including requirements related to payment of Non-Participating Provider Emergency Services and Urgent Care claims.

1.23 **Documentation and Data Submission Integrity**. Physician Group and its Downstream Entities shall not submit false claims or financial reports, encounter data, and other information to CalOptima, CMS or DMHC, whether by commission or omission. Physician Group and applicable Downstream Entities shall implement and maintain policies and procedures that address correct completion of claims, financial reports, encounter data, and other documentation requirements and penalties for falsifying such reports and other information that require all new and current employees and/or agents compiling or providing this information to sign a statement of attestation that will acknowledge understanding and compliance with said Physician Group policy.

1.24 **Advance Directives**. Physician Group shall maintain written policies and procedures related to Advanced Directives in compliance with Laws. Providers shall document Advance Directives in patient records in accordance with Laws. Physician Group shall not discriminate against any Enrollee on the basis of that Enrollee's Advance Directive status. Nothing in this Contract shall be interpreted to require an Enrollee to execute an Advance Directive or agree to orders regarding the provision of life-sustaining treatment as a condition of receipt of services.

1.25 **Enrollee Appeals**. Enrollees will be notified of all applicable MA and/or Medicare Appeal rights, the form and content of which is approved by CMS. . Medicare Appeal rights and protections will be maintained and enhanced for Medicare services. Physician Group agrees to cooperate with CalOptima in resolving Appeals related to Physician Group or Physician Group's Participating Providers and will comply with CalOptima Policies related to Appeals.

1.26 **Organization Determination Process**. Physician Group agrees to comply with CMS regulations and instructions and CalOptima Policies pertaining to timely organization determination by Physician Group with regard to the provision, denial, reduction, or suspension of a Covered Service to an Enrollee. "**Organization determination**" is defined as a decision to provide or deny service based on CMS and CalOptima criteria. Such determinations shall be made in accordance with procedures and instructions set forth in the CalOptima Policies and Laws. Physician Group shall immediately notify CalOptima of any request for an expedited initial organization determination and submit to CalOptima on a monthly basis a report which tracks the requests for standard and expedited organization determinations and the timeframe within which Enrollees were informed of decisions made by Physician Group.

1.27 **Expedited Review Process**. Physician Group shall comply with CMS regulations and CalOptima Policies pertaining to expedited initial organization determinations of Enrollee's medical care and reconsideration (Appeals) thereof in the time sensitive situations. Time sensitive situations are those outlined by CMS which include medical conditions that require initial determinations to be made within seventy-two (72) hours upon Physician Group receiving a request for an expedited review from a Provider, Enrollee, or CalOptima.

1.28 **Linguistic and Cultural Sensitivity**. Physician Group shall comply with all requirements related to the provision of linguistic and culturally sensitive services in accordance to this Contract, CalOptima's Cultural and Linguistic Services Program, and CalOptima Policies. Physician Group shall address the special health needs of Enrollees who are of any minority, are homeless, are disabled (both congenital and acquired disabilities), or are part of other special populations served by the CalOptima MA Program, including the capacity to communicate with Enrollees in languages other than English, when necessary, as well as those Enrollees who are deaf, hard-of-hearing, and/or visually impaired. Physician shall, in policies, administration, and services, practice the values of: (a) honoring the Enrollees' beliefs, traditions and customs; (b) recognizing individual differences within a culture; (c) creating an open, supportive, and responsive organization in which differences are valued, respected and managed; (d) through cultural diversity training, foster in staff and Participating Providers attitudes and interpersonal communication styles that respect Enrollees' cultural backgrounds and are sensitive to their special needs; and (e) referring Enrollees to linguistically and culturally sensitive programs. Pursuant to CalOptima Policies, Physician Group shall provide translation of written materials in the Threshold Languages as provided by CalOptima Policies. Written materials to be translated include, but are not limited to, signage, the Enrollee services guide, Enrollee information, Explanation of Coverage, Enrollee forms, Enrollee notices, and Enrollee welcome packages.

1.29 **Provision of Interpreters**. Oral interpreters, signers, and bilingual Provider services shall be provided in all languages spoken by all MA Enrollees. Physician Group shall provide linguistic interpreter/translator services for Enrollees as necessary at all Physician Group sites to ensure the availability of effective communication regarding treatment, diagnosis, medical history, and health education to Enrollees. Physician Group shall provide twenty-four (24)-hour access to interpreter services for all Enrollees. Upon an Enrollee or Participating Provider request for interpreter services in a specific situation where care is needed, Physician Group shall make all reasonable efforts to provide an interpreter in time to assist adequately with all necessary Covered Services,

including Urgent Care Services and Emergency Services, as required by Laws. Physician Group shall routinely document all such efforts and make this documentation available to CalOptima at its request. Interpreters shall be used where needed where technical, medical, or treatment information is to be discussed. Physician Group shall not require an Enrollee to use friends or family as interpreters. However, a family member or friend may be used when the use of the family member or friend: (i) is requested by the Enrollee; (ii) will not compromise the effectiveness of service; (iii) will not violate Enrollee's confidentiality; and (iv) the Enrollee is advised that an interpreter is available at no cost to the Enrollee. Physician Group shall maintain a contract with an interpreter service agency that is on "on call" status to provide interpreter services.

1.30 **Identification of Physician Group and Group Physicians**. Physician Group agrees that CalOptima may list the Physician Group's name, address, and telephone number and that of its Group Physicians and Downstream Entities in CalOptima's roster of Participating Providers that is given to Enrollees and prospective Enrollees, and CalOptima may use such names for advertising/marketing purposes. However, CalOptima is not obligated to list the name of any particular Group Physician in the roster of Participating Providers. The use of Physician Group's trademarks or logos by CalOptima is prohibited without Physician Group's prior written approval.

1.31 **Liaisons**. Physician Group shall designate an individual(s) who will assume the day-to-day responsibilities with regard to Physician Group's obligations under this Contract and to serve as liaison with CalOptima. Physician Group will also designate an individual(s) to be responsible for answering Enrollee inquiries and responding promptly to any Enrollee grievance in accordance with CalOptima's grievance procedures and Laws.

1.32 **Provider Private Contract**. Physician Group understands that CalOptima is prohibited by CMS from paying capitation to, or including in its provider network, any provider that has entered into a private contract with a Medicare beneficiary for the provision of Covered Services. Physician Group shall notify CalOptima immediately in the event that any Group Physician has a private contract with a Medicare beneficiary. In such an event, CalOptima reserves the right to exclude any such Group Physician from its provider network. In addition, Physician Group agrees that CalOptima shall have the right to offset the amount of any reimbursement that was paid either directly or indirectly to such Provider(s) against Capitation Payments or other amounts due from CalOptima to Physician Group, if any.

1.33 **Disclosure of Physician Group PIPs**. In the event that Physician Group implements and maintains a physician incentive plan ("**PIP**"), Physician Group and its Downstream Entities must comply with all applicable requirements governing PIPs, including such requirements appearing at 42 CFR Parts 417, 422, 434, 438.6(h), and 1003.

1.33.1 Physician Group shall ensure that no specific payment is made directly or indirectly under a PIP to a Physician or Physician Group as an inducement to reduce or limit Medically Necessary services furnished to an Enrollee.

1.33.2 On an annual basis, Physician Group and its Downstream Entities must submit to CalOptima all information required to be disclosed to CMS and the DMHC in the manner and format specified by them.

1.33.3 Physician Group must provide information on its PIP to any Enrollee upon request as provided in 42 CFR Section 422.208.

1.33.4 In the event that CalOptima's Regulators find that Physician Group (or its Downstream Entities) has failed to comply with the requirements governing physician incentive plans and CalOptima's Regulators offset, recoup and/or otherwise seek recovery of federal financial participation ("**FFP**") amounts from CalOptima, Physician Group agrees that CalOptima may recover such FFP amounts attributable to Physician Group from Physician Group, including through recoupment or offset to future Capitation Payments or other amounts due from CalOptima to Physician Group, if any.

1.34 **Provider Grievance Process**. Physician Group shall establish and maintain a Provider dispute resolution process that at all times complies with the requirements of Laws. Physician Group shall provide CalOptima with all necessary information and reports regarding the provider dispute resolution process as required by CalOptima to meet its obligations under the CMS Contract and Laws. If Physician Group fails to maintain a process that complies with the requirements stated in Laws and CalOptima Policies, then following written notice of such deficiency from CalOptima to Physician Group, CalOptima may revoke the delegation and assume responsibility for the administration of Physician Group's Provider dispute resolution process.

1.35 **Provider Education**. Physician Group acknowledges that CMS requires that CalOptima furnish to Participating Providers certain training, education, and orientation related to the MA Program in order to operate in full compliance with this Contract and Laws. Such training and education may address the MA Program, Enrollee rights, cultural competency and clinical protocols, evidence-based guidelines and cultural awareness and sensitivity instruction. Physician Group and its Participating Providers shall participate in such training, education, and orientation programs, as required by CalOptima, and shall attest to compliance with training requirements as required by CalOptima.

1.36 **State Licensure**. If Physician Group is licensed by the DMHC as a heath care service plan for purposes of the MA Program, it shall maintain such licensure in accordance with the Knox-Keene Act, as amended, and have no adverse actions with regard to enforcement or quality management.

1.37 **CalOptima's Regulator Requirements**. The MA Program is subject to oversight by CalOptima's Regulators, which mandate that CalOptima and its FDRs comply with certain terms and conditions in rendering services to Enrollees and that certain terms be incorporated in FDR subcontracts. Physician Group acknowledges that it will comply with CalOptima's Regulators' requirements set forth in Attachment E.

1.38 **COB Obligations of Physician Group**. Physician Group agrees to coordinate with CalOptima for proper determination of COB and to bill and collect from other payers and third-party liens such charges for which the other payer is responsible pursuant to CalOptima Policies. Physician Group agrees to establish procedures to effectively identify, at the time of service and as part of its claims payment procedures, individuals and services for which there may be a financially responsible party other than the CalOptima MA Program.

1.39 **CMS Lien Rights.** Physician Group shall coordinate benefits either operating a cost avoidance method of paying claims, when the existence of private health coverage is known at the time the claim is processed, or using the method of post-payment recovery of the cost of services, if the coverage is identified retroactively, as set forth in CalOptima Policies. Nothing herein shall be interpreted to, in any manner, impair any lien rights retained by the U.S. Department of Health and Human Services ("**HHS**") through CMS. Physician Group shall make no claim for the recovery of the value of Covered Services rendered to an Enrollee when such recovery would result from an action involving tort liability of a third party, recovery from the estate of deceased Enrollee,

Workers' Compensation, or casualty liability insurance awards and uninsured motorist coverage. Physician Group shall identify and notify CalOptima, within five (5) calendar days of discovery of potential third-party liability ("**TPL**") claims, and provide information relative to potential TPL claims, in accordance with CalOptima Policies.

1.40 **Provider Training.** Physician Group shall ensure that all network Providers receive training regarding the MA Program in order to operate in full compliance with all Laws, including rights and responsibilities pertaining to grievance and appeals procedures and timelines under this Contract. Physician Group shall ensure that network Provider training relates to MA services, policies, procedures and any modifications to existing services, policies or procedures. Training shall include methods for sharing information among network Providers, Enrollees, and/or other healthcare professionals. Physician Group shall conduct training for all network Providers within thirty (30) working days after the Physician Group places a newly contracted Provider on active status. Physician Group shall ensure that network Provider training includes information on all Enrollee rights, including the right to full disclosure of health care information and the right to actively participate in health care decisions. Physician Group will maintain policies and procedures on advance directives pursuant to 42 CFR §§ 422.128, 438.3(j), and 489.102, and will educate its network Providers concerning its policies and procedures on Advance Directives. Physician Group shall ensure that ongoing training is conducted when deemed necessary by either the Physician Group or CMS.

II. PHYSICIAN GROUP FINANCIAL OBLIGATIONS

2.1 **Financial Security Requirements**. Physician Group must establish and maintain during the Term financial security requirements as specified in Article 9 of Chapter 2 of Division 1 of Title 28 of the California Code of Regulations (SB 260 Regulations), and in compliance with CalOptima Policies. Physician Group must establish and maintain, throughout the Term, financial security reserves, in the form of time certificates of deposit, irrevocable standby letters of credit, surety bonds naming CalOptima as beneficiary, and/or other forms of financial instruments acceptable by CalOptima, as required in CalOptima Policies.

2.2 **Financial Viability Standards and Reporting**. Physician Group must establish and maintain a minimum reserve of twenty-five percent (25%) of one month's Capitation Payment. Physician shall have thirty (30) days upon receiving notice from CalOptima to cure any deficit. Physician Group shall maintain a cash-to-claims ratio of no less than 0.75 at all times during the Term. Physician Group shall substantiate compliance with this requirement by submitting all applicable reports to the DMHC that are required under Title 28 CCR Section 1300.75.4.2.

2.3 **Medical Loss Ratio**. Physician Group shall ensure that it, as well as the PHC, maintains a minimum acceptable loss ratio (as defined by CalOptima Policies) of eight five percent (85%). Physician Group shall comply with CalOptima requirements related to limitations on administrative costs, as set forth in CalOptima Policies.

2.4 **Termination of Physician Group Health Network**. If this Contract terminates or expires for any reason, CalOptima may require that Physician Group take certain actions and/or CalOptima may take certain actions to ensure that all items and services for which Physician Group is delegated financial risk under this Contract are reimbursed by Physician Group, including the following: (i) require Physician Group to reserve sufficient funds to pay any claims run out; (ii) offset Physician Group's future Capitation Payments or other amounts due from CalOptima to Physician Group under this Contract or any other agreement, if any, in order to pay Physician Group's claims; and/or (iii) withhold or offset Physician Group's Capitation Payments or other amounts due from

CalOptima to Physician Group, including to pay-for-performance, quality incentives, and shared risk pool surpluses, if any, in order to pay amounts owed by Physician Group to Providers.

2.5 **Conversion of Health Network Model**. If CalOptima approves a change in the delegated model of Physician Group at any time during the Term, CalOptima may require additional financial protections as a condition precedent to such approval, including: (i) require Physician Group to reserve sufficient funds to pay any claims run out related to claims which are the financial responsibility of Physician Group under the existing delegated relationship; (ii) require Physician Group to meet additional financial security requirements, including the maintenance of financial deposits; and/or (iii) withhold or offset Physician Group's Capitation Payments or other amounts due from CalOptima to Physician Group, including pay-for-performance, quality incentives and shared risk pool surpluses, if any, in order to pay amounts owed by Physician Group to Providers.

2.6 **Cooperation with DMHC**. Physician Group shall fully cooperate and comply with the DMHC's review and audit process and permit DMHC to obtain and evaluate supplemental financial information related to Physician Group, in accordance with Title 28 CCR Section 1300.75.4.7. Physician Group shall also fully cooperate and participate in DMHC's Corrective Action Plan process, in accordance with Title 28 CCR Section 1300.75.4.8.

2.7 **Risk Pools**. PHC in which Physician Group and Hospital participate shall have a risk pool arrangement between Hospital and Physician Group, as detailed in this Section 2.7 and Addendum 1 to this Agreement and the Hospital Contract. During the Term, Hospital and Physician Group shall annually negotiate and agree upon the terms and conditions of the risk pool arrangement ("**Risk Pool**") and shall submit the Risk Pool to CalOptima by November 30 for the next year. Physician Group shall submit to CalOptima an attestation signed by an authorized signatory of PHC Participants indicating that both Physician Group's and Hospital's Boards of Directors approved the Risk Pool. CalOptima shall pre-approve the Risk Pool before it may go into effect for the next year beginning January l. The Risk Pool shall include the following:

2.7.1 Covered Services for which PHC Participants will share risk.

2.7.2 If any part of the Risk Pool is based on utilization, the Risk Pool shall additionally include:

(a) The expected utilization of Covered Services for which PHC Participants will share risk. Recommended measures are bed days/per 1,000 Enrollees for inpatient services and $ [insert amount] per Enrollee per month for other Covered Services.

(b) The price or value for each Covered Service for which PHC Participants will share risk. These are the amounts that each unit of service will be valued at and charged against the portion of Hospital's capitation payment that the Hospital receives under the Hospital Contract and uses to fund to the Risk Pool. Inpatient rates should be listed as per diem rates, while other Covered Services should be priced by fee schedules or as a percentage of billed charges.

(c) A pro forma settlement calculation, which shall state the amount of surplus that is expected to result if Physician Group and/or Hospital achieve their utilization targets and the agreed-upon pricing model employed for the Risk Pool.

(d) A description of audit and/or other procedures required to ensure the accuracy of the surplus or deficit calculations related to the cost and volume of services rendered under the Risk Pool and other revenues and expenses, including interest

income, reinsurance premiums, and reinsurance recoveries associated with risk sharing.

(e) Defined responsibilities should deficits occur under the Risk Pool.

(f) Timing and documentation requirements for interim or final surplus distributions from the Risk Pool by Hospital, as agreed upon between the PHC Participants.

2.7.3 Physician Group shall submit [insert requirement for when these should be submitted] to CalOptima interim and final settlement calculations and attestations from all PHC Participants stating that (i) PHC Participants have met all the requirements of this Section 2.7, (ii) PHC Participants have performed all audit and reconciliation procedures, and (iii) the distribution amount to each PHC Participant is consistent with the terms of the Risk Pool, which (as approved by CalOptima annually during the Term) is incorporated into this Contract by this reference.

III. CALOPTIMA OBLIGATIONS

3.1 **CalOptima Services**. CalOptima agrees to provide certain Enrollee and Administrative Services, including processing Enrollee applications, maintaining eligibility records and a system of verifying eligibility, processing enrollments and dis-enrollments, responding to Enrollee complaints and grievances, informing Enrollees of CalOptima Policies, providing Enrollees with membership cards and informational material, and informing Enrollees of Health Networks.

3.2 **Enrollment**. CalOptima agrees to process all enrollment applications and ensure that each Enrollee selects or is assigned to Health Networks in accordance with CalOptima Policies. CalOptima reserves the right to assign Enrollees to a Health Networks other than that selected by Enrollee.

3.3 **Model of Care and Health Risk Assessment**. CalOptima shall maintain a Model of Care, as required by CalOptima's Regulators. CalOptima shall ensure that, upon enrollment in the CalOptima MA Program, each Enrollee receives an initial HRA and an HRA annually thereafter in accordance with CalOptima Policies and that results of the HRA are shared with Physician Group in order to coordinate Enrollee care. Physician Group is responsible for interim updates to the HRA.

3.4 **Authorization Process**. CalOptima shall provide a written Authorization process for Covered Services pursuant to CalOptima Policies.

3.5 **Enrollee Grievance Process**. CalOptima will inform Enrollees that they may file a grievance through CalOptima or the CMS Ombudsman Program for complaints related to Medicare-covered benefits and services. Enrollees may also file a grievance through 1-800 Medicare.

3.6 **Enrollee Appeals**. Enrollees will be notified of all applicable MA Medicare Appeal rights through a single notice prior approved by CMS.

3.7 **CalOptima Formulary**. CalOptima shall publish and maintain the CalOptima Formulary pursuant to CalOptima Policies.

3.8 **Training and Education**. CalOptima agrees to provide Participating Provider education, training, and orientation in accordance with CMS requirements, including training regarding the CalOptima MA Program, Enrollee rights, clinical protocols, evidence-based practice guidelines, and

CalOptima's cultural awareness and sensitivity instruction and cultural competency training, as applicable.

3.9 **Marketing**. Physician Group acknowledges that CalOptima will be responsible for marketing the CalOptima MA Program to Medicare beneficiaries. Physician Group acknowledges that it shall not conduct any marketing activities except as expressly approved in advance and in writing by CalOptima.

3.10 **Administration of Funds**. CalOptima will administer the funds and payments called for in this Contract to Physician Group in accordance with provisions outlined in Article VI.

3.11 **No Refusal to Pay or Contract Based on Physician Group Communications with Enrollees**. CalOptima will not refuse to contract or pay an otherwise eligible health care Provider for the provision of Covered Services solely because such Provider has, in good faith, communicated with or advocated on behalf of one or more of his or her prospective, current, or former patients regarding: (i) the provisions, terms or requirements of CalOptima's health care plans as they relate to the needs of such Provider's Enrollees; or (ii) the method by which such Provider is compensated by CalOptima for Covered Services rendered to the Enrollee.

3.12 **CalOptima Policies**. CalOptima will provide Physician Group with CalOptima Policies as necessary for Group to provide Covered Services to Enrollees. Those CalOptima Policies shall describe all benefit plans, including copayments, limitations, and exclusions offered by CalOptima to Enrollees. The Provider Manual will be made available to Physician Group to disseminate to Physicians.

3.13 **Listing of CalOptima**. CalOptima agrees that Physician Group may list its name, address, telephone number, and a description of the CalOptima MA Program, along with CalOptima's name, in Physician Group's promotional materials and advertisements. The use of CalOptima's trademarks and logos by Physician Group is prohibited without CalOptima's prior written approval.

3.14 **CalOptima Oversight**. CalOptima shall monitor Physician Group's performance under this Contract on an ongoing basis. CalOptima may conduct regularly scheduled audits as well as an annual evaluation of the delegated functions to determine Physician Group's continued compliance with the Delegation Criteria. CalOptima may impose corrective action plans on Physician Group and/or its Downstream Entities, as necessary.

3.15 **CalOptima Accountability**. The delegation of the functions and responsibilities stated in this Contract and the Delegation Agreement does not relieve CalOptima of any of its accountability to CMS and obligations to its Enrollees under Laws. CalOptima is authorized to perform and remains liable for the performance of such obligations, notwithstanding any delegation of some or all of those obligations to Physician Group.

3.16 **COB Obligations of CalOptima**. CalOptima will cooperate in providing COB information to Physician Group by collecting appropriate data from the Enrollee at the point of enrollment and supplying such data to Physician Group.

3.17 **Enrollee Rights**. CalOptima shall ensure that Enrollee rights are fully respected and observed in accordance with Laws and CalOptima Policies. CalOptima shall notify Enrollees of their rights and protections at least annually and in a manner that accounts for cultural considerations, functional status, and language needs.

3.18 **Enrollee Grievances**. CalOptima retains responsibility for the Enrollee grievance process. Physician Group will comply with CalOptima Policies related to Enrollee grievances, including timely reporting to CalOptima and resolution of Enrollee grievances. Enrollees may file an internal Enrollee grievance at any time with CalOptima or Physician Group, including grievances related to reasonable accommodations and access to services under the ADA.

IV. QUALITY IMPROVEMENT PROGRAM AND CREDENTIALING

4.1 **CalOptima's Quality Improvement Program**. Physician Group shall comply with, and participate in, CalOptima's Quality Improvement Program ("**QIP**"). Physician Group shall immediately notify CalOptima of those Enrollees and cases that fall within the catastrophic and targeted case management guidelines and shall cooperate with CalOptima's case management program for catastrophic and targeted cases. Physician Group and its Downstream Entities shall fully cooperate with CalOptima with regard to the HEDIS measurements and HEDIS audits, guideline development, preventive services utilization, disease/risk management, clinical service monitoring, and quality improvement studies and initiatives. Physician Group shall comply with and accept as final the decisions of the CalOptima QIP and, pending resolution of any dispute through the dispute resolution process, comply with the decisions of the CalOptima Quality Improvement Committee.

4.2 **Quality Improvement Functions – Delegation to Physician Group**. Physician Group shall establish, maintain and operate a Quality Improvement ("**QI**") program, in accordance with the delineation of responsibilities in the Delegation Agreement, which shall include preparation of an annual QI program plan, semi-annual work plan, and annual evaluation of effectiveness of the QI program, and report to CalOptima's QI department using the Health Industry Collaboration Effort Reporting Tool. All of the foregoing elements of the QI program shall be consistent with current industry standards, and meet CMS, National Committee for Quality Assurance ("**NCQA**"), The Joint Commission, and CalOptima QIP requirements.

4.2.1 Physician Group shall adopt a detailed written QI plan, which shall include: (i) well defined goals and objectives; (ii) a well-defined scope that considers all different types and levels of care and service provided to Enrollees; and (iii) clearly defined accountability and responsibility for the QI program.

4.2.2 The Board of Directors of the Physician Group or a multi-disciplinary QI committee designated by the Board of Directors of Physician Group shall oversee the QI program. This committee shall be separate from the utilization review committee (though members may be the same) and have a separate agenda. The QI committee shall meet at least on a quarterly basis. Physician Group shall maintain attendance records and meeting minutes related to the QI program. The QI committee shall have adequate representation from all categories of the Physician Group such as Physicians and non-Physician practitioners.

4.2.3 QI Program activities shall be reported in writing to Physician Group's Board of Directors at least on a quarterly basis. These reports shall be available to CalOptima upon request.

4.2.4 Physician Group's QI program shall include involvement and participation in network-wide studies/projects initiated by CalOptima. Physician Group shall facilitate quality studies and assist in collection of comparative data collected from all Participating Providers using objective parameters (e.g., the current version of HEDIS).

4.2.5 Physician Group shall develop an annual QI work plan, which includes the following: (i) goals, scope, and planned projects for the year; (ii) planned monitoring of identified issues and tracking these issues over time; (iii) planned studies/audits suggested by CalOptima or Physician Group; and (iv) an annual evaluation of the QI program/plan.

4.2.6 Physician Group shall have a written procedure for responding to the findings of QI activities, such as collecting data, analyzing results, implementing corrective action plans, and reassessing the same data for improvement.

4.2.7 Requirements for the Physician Group's QI program shall be established by the Physician Group's QI committee and requirements may change based on changes in industry standards. CalOptima's QI committee shall notify Physician Group of any additional changes in QI standards and requirements that shall be incorporated in Physician Group's QI program. Physician Group shall not be required to change QI program requirements more frequently than once per year.

4.2.8 Physician Group shall provide, upon CalOptima's request: (i) summaries of QI Committee meetings; (ii) findings following review of specific cases and other reviews; (iii) Medical Records; (iv) written responses to quality-of-care issues or Enrollee complaints; and/or (v) other information as required by CalOptima.

4.2.9 Physician Group shall comply with all measurement and improvement projects in the manner required by CMS, including the reporting of HEDIS, Health Outcomes Survey and Consumer Assessment of Healthcare Providers and Services measurement results consistent with Medicare requirements. Physician Group shall contribute to all applicable CMS data quality assurance processes.

4.3 **Quality Improvement and Credentialing Program**. CalOptima delegates credentialing requirements to Physician Group as provided in the Delegation Agreement. Physician Group agrees to comply with CalOptima Policies regarding credentialing standards. In order to ascertain Physician Group's continuous compliance with CalOptima standards, CalOptima retains the right to oversee Physician Group's credentialing processes and to mandate changes thereto.

4.3.1 At least annually, Physician Group shall provide CalOptima with a written credentialing program for the purpose of review and approval by CalOptima. Physician Group shall also allow CalOptima, after reasonable prior notice, to conduct an on-site audit and review a sample of physician credentialing files to determine that delegation of the credentialing process is appropriate.

4.3.2 Physician Group's credentialing program shall comply with the requirements specified in 42 CFR Sections 422.504, 423.505 and 438.214, as applicable, which include requirements addressing selection and retention of providers, credentialing and re-credentialing requirements, and nondiscrimination. Physician Group's credentialing program shall include procedures used for credentialing and re-credentialing Participating Provider's according to current NCQA standards, in addition to procedures used for reducing, suspending or terminating Participating Provider's participation in the organization for reasons relating to quality of care, competence, professional conduct, or service-related issues; procedures for reporting to appropriate authorities serious quality deficiencies that could result in suspension or termination of a Participating Provider's participation; and procedures for provider appeal, as afforded by Physician Group's fair hearing plan and corrective actions.

4.3.3 Physician Group shall make best efforts to notify CalOptima within thirty (30) days of any changes involving the rules, regulations, authorities, and responsibilities of the credentialing program. In accordance with CMS requirements, CalOptima also retains the right, based on quality-of-care and service issues, to approve, suspend, or terminate arrangements with practitioners, providers, and sites. In the event that this occurs, CalOptima will notify the Physician Group of the quality-of-care and/or service issue, and Physician Group shall take appropriate action, report to appropriate authorities any serious quality deficiencies in accordance with Laws, and provide all due process as afforded by the Physician Group's fair hearing plan and Laws.

4.3.4 If CalOptima exercises its right to terminate a Provider's participation in the CalOptima MA program, CalOptima shall give the Provider a written statement of the reason or reasons for termination with cause and comply with the procedures required by Laws, if any.

4.4 **Release of Performance Information and Data**. Physician Group acknowledges that the CalOptima MA Program focuses on improving the coordination and quality of medical, Behavioral Health, LTSS, and other services for Enrollees, and, in that regard, CalOptima's Regulators will implement capitation withholds to ensure performance consistent with established quality thresholds. Physician Group acknowledges and agrees that CalOptima may release information and data related to the performance of Physician Group under this Contract to CalOptima Regulators, Providers, Enrollees, and others without further notice to Physician Group. The performance data will be used for purposes, including quality improvement activities, and public reporting to consumers, as identified in CalOptima Policies.

V. UTILIZATION MANAGEMENT PROGRAM

5.1 **CalOptima's Utilization Management Program**. CalOptima has implemented, and continuously updates, a UM program to ensure appropriate processes are used to review and approve the provision of Medically Necessary Covered Services to Enrollees in the timeframes required by CalOptima's Regulators. Physician Group and its Downstream Entities shall comply with and cooperate in CalOptima's UM program, as established in CalOptima Policies and the CalOptima UM plan, regardless of CalOptima's delegation to Physician Group under Section 5.2.

5.2 **UM Program Responsibility—Delegation to Physician Group**. CalOptima is hereby delegating to Physician Group the process of monitoring and evaluating on a prospective, concurrent, and retrospective basis, the utilization and Medical Necessity of Covered Services provided to Physician Group's Enrollees.

5.2.1 Physician Group's UM process shall include performing case management activities, referral management and discharge planning, and managing the denial sanction process, as well as conducting peer review for Medical Necessity and appropriateness. Physician Group (and its Downstream Entities) shall ensure that its UM program complies with all criteria as set forth in CalOptima Policies and required by CalOptima's Regulators.

5.2.2 In accordance with 42 CFR §§ 438.6(h) and 422.208, compensation to individuals or entities that conduct UM activities must not be structured so as to provide incentives for Physician Group (including Group Physicians) or Downstream Entities to deny, limit, or discontinue Medically Necessary Covered Services to any Enrollee.

5.2.3 In the event Physician Group (or its Downstream Entities) fails to comply with CalOptima standards and Laws and fails to correct deficiencies within the stated time required by those provisions, CalOptima retains the right to revoke delegation of UM activities.

5.3 **Utilization Management Plan**. Physician Group will provide to CalOptima initially upon execution of this Contract, and annually thereafter, a written UM plan for review and approval by CalOptima.

5.3.1 Physician Group shall notify CalOptima within thirty (30) days of any changes involving the rules, regulations, authorities, and responsibilities for the UM plan, which shall be subject to reasonable approval by CalOptima. CalOptima approval will be assumed unless Physician Group is notified otherwise by CalOptima. Physician Group shall comply with and accept as final, the decisions of CalOptima's UM program and, pending resolution of any dispute through the dispute resolution process, comply with the decisions of CalOptima's UM program.

5.3.2 The UM plan shall include procedures approved by CalOptima to identify, assess, establish, and implement a treatment plan for Enrollees with complex or serious medical conditions. The UM plan shall also contain procedures for direct access of Enrollees to services as mandated by CMS regulations and instructions. All Physician Group denial letters shall provide Enrollees with timely notice and shall contain appropriate Enrollee appeals rights as approved by CMS and CalOptima. Physician Group agrees to cooperate with CalOptima in furnishing the required reports identified in CalOptima' Policies

5.4 **Utilization Management Committee**. Physician Group shall establish a UM committee that shall review and document the quality, appropriateness, level of care, and utilization of health care services provided to Enrollees. CalOptima's Medical Director and/or CalOptima staff may attend Physician Group UM committee meetings.

5.5 **Process and Timeframes for Authorization**. Physician Group (and its Downstream Entities) shall ensure that its process for initial and continuing Authorizations complies with CalOptima Policies, the UM plan and requirements established by CalOptima's Regulators, including timeframes for, and manner of, Authorization.

5.6 **No Prior Authorization**. Physician Group (and its Downstream Entities) shall not require prior Authorization for the following services: (i) any services for Emergency Medical Conditions (which include emergency Behavioral Health care); (ii) Urgent Care sought outside the Service Area: (iii) Urgent Care under unusual or extraordinary circumstances provided in the Service Area when the Participating Provider is unavailable or inaccessible; (iv) preventative services; (v) family planning services; (vi) Out-of-Area renal dialysis services; (vii) basic prenatal care; (viii) sexually transmitted disease services; and (ix) HIV testing.

5.7 **Second Opinions**. Physician Group (and Downstream Entities) shall ensure that Enrollees have the right to second opinions from qualified health professionals at no cost to the Enrollee.

5.8 **Physician Direct Referral**. Physician Group agrees that an Enrollee shall, without obtaining the prior Authorization of the PCP or Physician Group, refer him or herself directly to a specialist within said Physician Group per policy including any of the following conditions: an annual well woman exam by a Gynecologist, prenatal care and delivery by an Obstetrician, annual eye exam by an Optometrist, professional services related to audiology, and family planning services, including but not limited to vasectomy.

5.8.1 CalOptima will identify Physician Group as a provider that offers Physician Group Direct Referrals to Enrollees in CalOptima's provider directory and other marketing literature, if any. In the event CalOptima determines that Physician Group is non-compliant with the requirements of the Physician Direct Referral process, CalOptima reserves the right, at its sole discretion, to cease marketing Physician Group as a Physician Direct Referral provider to Enrollees.

5.8.2 Physician Group agrees to cooperate with CalOptima and, upon reasonable prior notice, provide CalOptima with all necessary Medical Records, policies and procedures, including utilization review, reports, and other pertinent information that may be necessary or required to enable CalOptima to ensure and verify that Physician Group has a Physician Direct Referral process acceptable to and in accordance with the requirements of CalOptima.

5.9 **Hospital Referrals**. Physician Group agrees to require Group Physicians to admit Enrollees only to Hospital with the concurrence of CalOptima, except for Emergency Services, Urgent Care, or when Authorization has been received in accordance with the UM Plan.

5.10 **Personal Care Coordinator Component to the Model of Care.**

5.10.1 "**PCC Profile**" is a monthly report generated by CalOptima that provides the compliance parameters required to receive PCC supplemental capitation.

5.10.2 Physician Group shall employ PCCs and participate in all PCC component requirements, as defined in the Model of Care Profile. PCCs shall assist Enrollees in the development of an ICP, ensure communication of the Enrollee's care plan with the Enrollee, physicians, Physician Group and health care team, and provide other related services as described in the job description, CalOptima Policy, and Model of Care Profile. Physician Group shall submit monthly reports and ICPs to demonstrate adherence to Model of Care requirements, including staffing of PCCs.

5.10.3 CalOptima may amend the Model of Care Profile at any time and, in such event, CalOptima shall provide Physician Group with thirty (30) days' written notice before the effective date of any such revisions. If Physician Group is unable to agree to the revisions and no resolution is reached in the thirty (30)-day period, Physician Group may proceed with the termination of the Contract under Article 11. In the event Physician Group terminates the Contract, it shall comply with all of its obligations required by this Contract and Laws including obligations related to transfer and coordination of Enrollee care following termination.

VI. COMPENSATION

6.1 **Physician Group Compensation**. CalOptima shall compensate Physician Group for Covered Services and Administrative Services delegated to Physician Group, as set forth in Attachment C. Such Capitation Payments shall be payment in full for Covered Services and Administrative Services, except for amounts recovered through collection of Enrollee's Share of Cost, COBs, and Stop Loss Program, if applicable. Capitation Payment shall be sent on a monthly basis by the twentieth (20th) calendar day of the month, or if such day falls on a weekend or national holiday, on the first business day thereafter, for all Enrollees eligible from the first (1st) of the month, and on whose behalf payment has been received by CalOptima from CMS by the nineteenth (19th) calendar day of the month. In the event CalOptima receives payment from CMS after the

nineteenth (19th) calendar day of the month, capitation payment to Physician Group will be made within five (5) working days of receipt of the monthly payment by CalOptima.

6.2 **Disputes Regarding Payments or Enrollment**. Any and all disputes related to Capitation Payments and/or enrollments shall be reported to CalOptima within ninety (90) calendar days of payment, and each dispute shall be clearly defined and include supporting documentation. Failure to dispute within the established time frame indicates acceptance of the Capitation Payment by Physician Group.

6.3 **Capitation Rate Adjustments**. The Capitation Rates may be adjusted by CalOptima during the Contract period to reflect implementation of State or federal laws or regulations, changes in the CMS Contract or CMS policy, and/or changes in Covered Services. If CalOptima receives advance notice of adjustment from CalOptima's Regulators, CalOptima shall provide notice thereof to Physician Group as soon as practicable. Capitation Rates may also be adjusted in the event of de-delegation of any function delegated under this Contract.

6.4 **Enrollee Non-Liability and Hold Harmless Requirements.** Physician Group and its Downstream Entities shall accept CalOptima's payment as described in this Contract as payment in full. Physician Group and its Downstream Entities for all Covered Services and Administrative Services under this Contract and shall not hold Enrollees liable to the Physician Group or Providers for any sums owed to Physician Group by CalOptima or owed to Providers by Physician Group.

6.4.1 Physician Group and its Downstream Entities shall hold harmless CMS, CalOptima, and Enrollees in the event Physician Group and/or Downstream Entities cannot or will not pay for services performed by Physician Group or Downstream Entities pursuant to this Contract or subcontract, as applicable.

6.4.2 Physician Group and its Downstream Entities shall ensure that Enrollees will not be held liable for Medicare Part A and B cost sharing when the State is responsible for paying such amounts and that the Physician Group will (i) accept Capitation Payment as payment in full under the Contract, or (ii) bill the appropriate State source, as required at 42 CFR §422.504(g)(1)(iii). Such services must be provided at zero cost-sharing to Enrollees.

6.4.3 Physician Group shall not hold an Enrollee liable for the following: (i) debts of Physician Group, in the event of 'Physician Group's insolvency; (ii) Covered Services provided to the Enrollee in the event that CalOptima or Physician Group fails to receive payment from CMS for such services; or (iii) payments to a clinical FDR or Downstream Entity in excess of the amount that would be owed by the Enrollee if Physician Group had directly provided the services.

6.4.4 Physician Group and its Downstream Entities shall not charge Enrollees coinsurance, co-payments, deductibles, financial penalties, or any other amount in full or part, for any service provided under this Contract, except as otherwise permitted under this Contract.

6.4.5 Physician Group and its Downstream Entities shall not deny any service provided under this Contract to an Enrollee for Enrollee's (or any entity responsible for making payment on Enrollee's behalf) failure or inability to pay any applicable charge or shall not deny any service provided under this Contract to an Enrollee who, prior to becoming eligible, incurred a bill that has not been paid.

6.5 **Physician Group-Discovered Overpayments**. Physician Group shall disclose and return all overpayments to CalOptima within sixty (60) days of when Physician Group identified the overpayment or should have identified the overpayment through the exercise of reasonable diligence.

6.6 **Recoupment for Ineligibility; Conlan Reimbursements**. CalOptima shall recoup payments made to Physician Group when CMS has determined that an individual was not eligible for the MA Program and retroactively terminates the individual, including recouping any payments made for a deceased Enrollee. CalOptima may also recoup overpayments to Physician Group owed by Physician Group to Enrollees, including offsetting any such amounts owed against Physician Group's Capitation Payments or other amounts due from CalOptima to Physician Group under this Contract or any other agreement between the parties, if any. This Section 6.6 shall not be construed to limit CalOptima's right to recoup payment made to Physician Group on any other basis for which recoupment is appropriate.

6.7 **CalOptima Right to Recover**.

6.7.1 Overpayments. Physician Group acknowledges and agrees that, in the event that CalOptima determines that an amount has been overpaid or paid in duplicate, or that funds were paid which were not due under this Contract to Physician Group, CalOptima shall have the right to recover such amounts from Physician Group by recoupment or offset from current or future amounts due from CalOptima to Physician Group under this Contract or any other agreement between the parties, after giving Physician Group notice and an opportunity to return/pay such amounts.

6.7.2 Health Network Termination. In the event of termination of the Health Network or the transition of the Health Network to a different delegation model, CalOptima shall have the right to offset any unpaid claims that are the financial responsibility of Physician Group paid by CalOptima against any funds owed to Physician Group by CalOptima, including capitation payments, financial security withholds, pay-for-performance amounts, quality incentives, and shared risk pool surpluses.

6.7.3 Shared Risk Pool Payments Upon Termination. If this Contract terminates or expires for any reason and Physician Group is responsible for a deficit under any shared risk program under this Contract based on the final shared risk pool report results ("**Deficit**"), such Deficit shall be due to CalOptima as follows, as allowed by Laws: CalOptima may elect to recoup such Deficit by either (1) offsetting such Deficit amounts, upon notice to Physician Group, from any current or future amounts owed by CalOptima to Physician Group under the Contract or any other agreement between the Parties, including capitation payments, financial security withholds, pay-for-performance amounts, quality incentives, and shared risk pool surpluses; or (2) sending an invoice to Physician Group that payment for such Deficits are due to CalOptima within thirty (30) days of Physician Group's receipt of the CalOptima invoice.

6.7.4 Regulator Recoupment Upon Termination. If following the termination or expiration of this Contract, CalOptima's Regulators find that Physician Group (or its Downstream Entities) has failed to comply with the requirements governing physician incentive plans and CalOptima's Regulators offset, recoup and/or otherwise seek recovery of FFP, as described in Section 1.33, CalOptima may elect to recoup such FFP amounts, as allowed by Laws, by either: (1) offsetting such FFP amounts, upon notice to Physician Group, from any current or future amounts owed by CalOptima to Physician Group under the Contract or any other agreement between the Parties, including capitation payments, financial security withholds, pay-for-performance amounts, quality incentives, or shared risk pool surpluses; or (2) sending an invoice to Physician Group that

payment for such FFP amounts are due to CalOptima within thirty (30) days of Physician Group's receipt of the CalOptima invoice.

6.7.5 Dispute Resolution. Physician Group may use CalOptima's provider dispute resolution procedure, as described under CalOptima's Policies, and/or the dispute resolution procedures under this Contract to resolve any disputes related to the calculation or payment of such Deficits or FFP amounts.

6.7.6 Survival. This Section 6.7 shall survive the termination or expiration of the Contract.

6.8 **Retroactive Cancellation**. CalOptima will discourage retroactive cancellation of any Enrollee. However, CalOptima may make exceptions as required by CMS or due to legitimate administrative processing requirements of CMS. CalOptima may make retroactive additions or cancellations of Enrollees, as necessary for administrative or business reasons, and such retroactive additions or cancellations of Enrollees shall not exceed ninety (90) days.

VII. REPORTING REQUIREMENTS

7.1 **Data Reporting Requirements**. Physician Group shall comply with the data reporting requirements set forth in this Contract, including the requirements specified in Standard Reporting Requirements set forth in CalOptima Policies and guidelines (referred to as the Timely and Appropriate Submission requirements). Physician Group shall provide such additional data and modify the form, content, instructions, and timetables for the collection and reporting of data, as may be required by CalOptima Policies.

7.2 **Eligibility Reports**. CalOptima will maintain, update, and distribute monthly Enrollee eligibility reports for each month in which the persons included on such list are eligible for CalOptima MA Program. This report will identify the Physician Group, PCP selected by the Enrollee, and the Enrollee's coverage. The report will be sent to Physician Group and PCPs by the tenth (10th) of each month, identifying eligible Enrollees from the first (1st) of the month.

7.3 **Utilization Data**. Physician Group shall, upon request, provide CalOptima with information on the utilization and cost of Covered Services provided to Enrollees in such detail as to allow CalOptima to conduct analysis of costs as required by CMS, as dictated by sound business practices and for the conduct of quality management and UM activities by CalOptima. Such information to be provided by Physician Group will not include information beyond that customarily provided on a claim form (such as Form CMS-1500) and shall be provided in the form of a paper report, computer disc, computer tape, or electronic file, as agreed by the parties. Required data will be delivered by Physician Group to CalOptima not later than forty-five (45) days following written request by CalOptima.

7.4 **Submission of Electronic Encounter Data**. Physician Group must meet any claims, diagnosis, and Encounter Data reporting requirements, as determined from time to time by CalOptima and CalOptima's Regulators.

7.4.1 Physician Group agrees to furnish CalOptima with complete, timely, reasonable, and accurate Encounter Data for Covered Services rendered to Enrollees. The Encounter Data will be furnished to CalOptima through Electronic Data Interchange (EDI) or a mutually acceptable format and shall be received by CalOptima per the Policy and Encounter Requirements Manual. Physician Group also agrees to furnish Medical Records that may

be required to obtain any additional information or corroborate the Encounter Data. Physician Group further agrees to have its Chief Executive Officer (CEO) attest and certify the completeness and truthfulness of the Encounter Data submitted.

7.4.2 Physician Group shall be subject to financial penalties and/or sanctions if CalOptima determines that Physician is reporting to CalOptima less than all professional encounters in the CalOptima required format and timelines. Financial penalties or sanctions shall be assessed upon Physician Group should CalOptima determine that Physician Group is not meeting the standards defined in CalOptima Policies. This Section 7.4.2 shall survive the expiration or termination of this Contract, whether with or without cause, by rescission or otherwise, as to all Covered Services provided under this Contract prior to termination. Based on CalOptima's quarterly determinations and following thirty (30) days' prior notice to Physician Group, CalOptima may withhold three (3%) percent of Capitation Payment if CalOptima determines that the monthly Encounter Data that Physician Group must provide has not been received by CalOptima within the prior quarter. If at the quarterly determination following such withhold, CalOptima determines that Physician Group has satisfactorily delivered to CalOptima the previously non-delivered Encounter Data; such withheld Capitation Payment shall be paid to Physician Group, without interest. In the event that Physician Group does not deliver such Encounter Data to CalOptima prior to such quarterly determination, CalOptima shall be entitled to retain such withheld Capitation Payment and may withhold three (3%) percent from each quarter's Capitation Payment until CalOptima receives the Encounter Data.

7.5 **Disclosure of Provider Profiling**. Physician Group shall, upon request from CalOptima, provide. CalOptima with information regarding any "economic profiling" of Group Physician Groups by Physician Group in order to permit CalOptima to comply with the provisions of Section 1367.02 of the Knox-Keene Act. Further, to the extent that Physician Group utilizes "economic profiling" as defined in Section 1367.02, Physician Group shall provide copies of economic profiling information to Providers in accordance with the requirements of Section 1367.02.

7.6 **Financial Reporting**. Physician Group shall prepare financial information requested in accordance with Generally Accepted Accounting Principles ("**GAAP**"). Where financial statements and projections are requested by CalOptima and/or CalOptima's Regulators, these statements and projections should be prepared in accordance with the 1989 HMO Financial Report of Affairs and Conditions Format. Where appropriate, reference has been made to the Knox-Keene Act rules found under Title 28 CCR Section 1300.51 *et. seq*. Information submitted shall be based on Physician Group's current operations. Physician Group shall submit financial information consistent with filing requirements of the DMHC, unless otherwise specified by CMS.

7.7 **Financial Statements**. CalOptima, as a Knox-Keene Act health care service plan, is required by CalOptima's Regulators to monitor the financial viability of its contracted provider network on an on-going basis. Physician Group agrees to provide CalOptima annually with a copy of Physician Group's audited financial statements, including letters to management for the most recent fiscal year end along with an opinion letter on these statements from the accounting firm that completed an audit on these financial statements. Financial statements shall be presented in a form specified by CalOptima that clearly shows the financial position of Physician Group as related to Enrollees. Physician Group shall allow representatives of CalOptima, upon written request, to verify the financial reports. In the event audited statements are unavailable, Physician Group agrees to provide CalOptima with the unaudited financial statements at Physician Group's fiscal year end. The unaudited financial statements will include: balance sheets, income statement and statement of cash flows, notes to the financial statement, name of the person preparing these statements, and

representation letters from the senior financial executives of the Physician Group, attesting that these financial statements were prepared in accordance with GAAP and fairly present the financial condition of the Physician Group.

7.8 **Reports Regarding Disclosure of Confidential Enrollee Information**. If Physician Group, or any of its officers, employees, agents, or Downstream Entities, becomes aware of the unauthorized disclosure of confidential Enrollee information or of "personal information", within the meaning of California Civil Code Section 1798.3, Physician Group shall report said unauthorized disclosure to CalOptima's Privacy Officer immediately upon discovery of said disclosure, providing information on the information disclosed and how the disclosure occurred. For purposes of this section, "unauthorized disclosure" includes any unauthorized access, whether such access was through inadvertence, mistake, theft, or other means, and whether or not Physician Group had reasonable control to avoid the disclosure. Nothing herein is intended to limit or replace Physician Group's separate obligations under the Business Associate Agreement and Laws.

7.9 **Additional Information Required by CalOptima's Regulators**. Physician Group and Downstream Entities shall, at the request of CalOptima or CalOptima's Regulators, provide the following: (i) all information related to the performance of CalOptima's responsibilities, including non-medical information for the purposes of research and evaluation, to CalOptima's Regulators; (ii) any information required to comply with all Laws; and (iii) any information required for external rapid cycle evaluation, including program expenditures, service utilization rates, rebalancing from institutional to community settings, Enrollee satisfaction, Enrollee complaints and Appeals, and enrollment/disenrollment rates.

VIII. RECORD RETENTION, ACCESS AND CONFIDENTIALITY

8.1 **Disclosure of Records**. Physician Group and its Downstream Entities agree to maintain and make available contracts, books, documents, records, and electronic systems, including, Medical Records, (collectively, the "**Records**") to CalOptima, HHS, CMS, the Comptroller General, the U.S. Government Accountability Office, any Quality Improvement Organization, or accrediting organizations, including NCQA, their designees, and other representatives of regulatory or accrediting organizations, for inspection, evaluation, and auditing. For purposes of utilization management, quality improvement, and other CalOptima administrative purposes, CalOptima and CalOptima's Regulators shall have access to, and copies of, at reasonable time upon request, the Medical Records, books, charts, and papers relating to the provision of health care services to Enrollees, the cost of such services, and payments received by Physician Group or any of Group Physicians from Enrollees (or from others on their behalf). Copies of the Medical Record shall be provided at no charge to CalOptima. Unless a longer time is required under applicable law, the records described herein shall be maintained for at least ten (10) years from the final date of the Contract or from the completion of any audit, whichever is later.

8.2 **Medical Records**. Physician Group will require that all Group Physicians and Downstream Entities establish and maintain in an accurate and timely manner, for each Enrollee who has obtained Covered Services from a Group Provider or Downstream Entity, a legible Medical Record which shall be kept in detail consistent with good medical and professional practice in accordance with Laws and CalOptima Policies. Such Medical Records shall include a historical record of diagnostic and therapeutic services recommended or provided by, or under the direction of, the Provider. Such Medical Records shall be in such a form as to allow trained health professionals, other than the Provider, to readily determine the nature and extent of the Enrollee's medical problem and the services provided and permit peer review of the care provided. Physician Group shall ensure that medical information is released in accordance with applicable Laws, or pursuant to valid court

orders or subpoenas, subject to compliance with applicable privacy laws. Physician Group shall ensure than an individual is delegated the responsibility of securing and maintaining Medical Records at each Physician Group or Downstream Entity site.

8.3 **Right to Inspection**. Medical Records referred to in Section 8.2 above will be and remain the property of Physician Group or Group Physicians and will not be removed or transferred from their offices except in accordance with Laws. CalOptima or its designated representatives will have the right, in accordance with this Article 8, to inspect, review, and make copies of such records at Physician Group's expense upon request to facilitate CalOptima's obligation to conduct quality management, utilization monitoring, and peer review activities.

8.4 **Records Related to Recovery for Litigation**. Upon request by CalOptima, Physician Group and its Downstream Entities shall timely gather, preserve, and provide to CalOptima, in the form and manner specified by CalOptima, any information specified by CalOptima, subject to any lawful privileges, in Physician Group's or its Downstream Entities' possession, relating to threatened or pending litigation by or against CalOptima, HHS, and CMS. If Physician Group asserts that any requested documents are covered by a privilege, Physician Group shall: (1) identify such privileged documents with sufficient particularity to reasonably identify the document while retaining the privilege; and (2) state the privilege being claimed that supports withholding production of the document. Such request shall include a response to a request for documents submitted by any party in any litigation by or against CalOptima. Physician Group acknowledges that time may be of the essence in responding to such request. Physician Group shall use all reasonable efforts to immediately notify CalOptima of any subpoenas, document production requests, or requests for records received by Physician Group or its Downstream Entities related to this Contract or subcontracts entered into under this Contract.

8.5 **State and Federal Site Visits**. Physician Group agrees to permit CalOptima, the DMHC, HHS, and/or CMS to conduct a site evaluation of Physician Group and its facilities in accordance with Laws and to comply with the agencies' recommendations, if any.

8.6 **Enrollee Access to Records**. Physician Group (including Physician Group Providers) and its Downstream Entities shall ensure that Enrollees have access to their Medical Records in accordance with the requirements of Laws. An Enrollee shall be provided a copy of his or her Medical Records, upon request, and shall have the right to request corrections or amendments to their Medical Records as specified in 45 CFR Part 164. Physician Group and Downstream Entities shall furnish a copy of the Enrollee's Medical Records to another treating or consulting Provider regardless of whether the requesting Provider is a Participating Provider, at no cost to CalOptima or the Enrollee when (i) such a transfer of Medical Records facilitates the continuity of that Enrollee's care; (ii) the Enrollee is transferring from one Provider to another for treatment; and (iii) an Enrollee seeks to obtain a second opinion on the diagnosis or treatment of a medical condition.

IX. INSURANCE AND LIABILITY

9.1 **Indemnification**. Each Party agrees to defend, indemnify, and the other Party and the State and CMS harmless, with respect to any and all claims, costs, damages, and expenses, including reasonable attorney's fees, that are related to or arise out of the negligent or willful performance or non-performance by the indemnifying Party, or any functions, duties, or obligations of such Party. Neither termination of the Contract nor completion of the acts to be performed under this Contract shall release either Party from its obligation to indemnify as to any claims or cause of action asserted so long as the event(s) upon which such claims or cause of action is predicated shall have occurred prior to the effective date of termination or completion. CalOptima and Physician Group

agree to promptly notify the other Party of any claims or demands that arise and for which indemnification hereunder is sought.

9.2 **Insurance Requirements**.

9.2.1 **Physician Group and Downstream Entity Insurance**. Physician Group agrees to procure and maintain, at its own expense, the insurance policies required by this Section 9.2 and Laws and shall require its Downstream Entities to maintain similar policies of insurance where Physician Group's insurance does not cover its Downstream Entities.

9.2.2 **Professional/Medical Malpractice**. Each Group Physician and Participating Provider providing Covered Services to Enrollees shall maintain a professional liability (medical malpractice) insurance policy for the specialty or type of service that the Group Physician provides with minimum limits of one million dollars ($1,000,000) per incident and three million dollars ($3,000,000) in the aggregate per year.

9.2.3 **Commercial General Liability**. Physician Group and each Participating Provider who has entered into a contract with Physician Group to provide Covered Services under this Contract shall maintain a Commercial General Liability insurance policy with minimum limits of one million dollars ($1,000,000) per occurrence and three million dollars ($3,000,000) in the aggregate. CalOptima must be named as an additional insured on Comprehensive General Liability insurance policy with respect to performance under this Contract.

9.2.4 **Workers' Compensation**. Group Physician and each Participating Provider who has entered into a contract with Physician Group to provide Covered Services under this Contract shall maintain a Workers' Compensation Insurance policy with minimum limits as follows:

- Employers' Liability Insurance:
  - One million dollars ($1,000,000) Bodily Injury by Accident - each accident.
  - One million dollars ($1,000,000) Bodily Injury by Disease - policy limit
  - One million dollars ($1,000,000) Bodily Injury by Disease - each employee

9.2.5 **Managed Care Errors and Omissions**. Physician shall maintain a Managed Care Errors and Omissions Insurance policy with minimum limits as follows:

- Managed Care Errors and Omissions: Ten million dollars ($10,000,000) each claim/ten million dollars ($10,000,000) aggregate

9.2.6 **Electronic and Computer Crimes Insurance**. Physician Group and its Downstream Entities shall maintain electronic and computer crimes insurance and employee fidelity insurance with limits of at least one million dollars ($1,000,000) if Physician Group and/or its Downstream Entities will be paying claims or receiving funds on behalf of CalOptima, or will be storing, transmitting, and/or receiving personally identifiable and/or protected health information on a regular basis in carrying out its obligations under this Contract..

9.2.7 **Insurer Ratings**. Insurance required under this Article IX shall be provided by an insurer:

(a) Rated by A.M. Best with a rating of A V or better; and

(b) "Admitted" to do business in California or an insurer approved to do business in California by the California Department of Insurance and listed on the Surplus Lines Association of California List of Eligible Surplus Lines Insurers (LESLI); or

(c) An Unincorporated Interindemnity Trust Arrangement as authorized by the California Insurance Code 12180.7

9.2.8 **Captive Risk Retention Group/Self Insured**. Where any of the insurance(s) mentioned in this Article IX is provided by a captive risk retention group or self-insured, insurer ratings requirements above may be waived at the sole discretion of CalOptima, but only after review of the captive risk retention group's or self-insured's audited financial statements.

9.2.9 **Cancellation or Material Change**. Physician Group shall not of its own initiative cause such insurance as addressed in this Article IX to be cancelled or materially changed during the Term.

9.2.10 **Proof of Insurance**. Certificates of Insurance of the insurance policies and/or evidence of self-insurance required under this Article IX shall be provided to CalOptima prior to Effective Date, annually thereafter, and upon request.

X. COOPERATION

10.1 **Non-Interference**. Physician Group and Downstream Entities may not prohibit of otherwise restrict a health care professional, acting within the lawful scope of practice, from freely communicating with Enrollees about their treatment and the following, regardless of benefit coverage limitations:

10.1.1 The Enrollee's health status, medical care, or treatment options (including any alternative treatments that may be self-administered), including the provision of sufficient information to provide an opportunity for the Enrollee to decide among all relevant treatment options;

10.1.2 The risks, benefits, and consequences of treatment or non-treatment; or

10.1.3 The opportunity for the Enrollee to refuse treatment and to express preferences about future treatment decisions.

10.2 **No Counseling to Dis-enroll**. Physician Group and Group Physicians agree that they will not, during the Term, provide advice to or counsel any Enrollee to dis-enroll from CalOptima, and Physician Group and Group Physicians will not solicit such Enrollee to become enrolled with any other health maintenance organization, preferred provider organization, or any other similar hospitalization, medical payment plan or insurance program.

10.3 **Cooperation**. CalOptima and Physician Group agree that, to the extent compatible with the separate and independent management of each, they will at all times maintain an effective liaison and close cooperation with each other to provide maximum benefits to Enrollees at the most reasonable cost, consistent with quality standards of hospital and physician care.

10.4 **Signs**. Physician Group agrees that CalOptima may post notices, mutually acceptable as to size, content and form in a prominent place instructing Enrollees as to proper procedures and limitations on coverage.

10.5 **Free Exchange of Information**. No provision of this Contract shall be construed to prohibit, nor shall any provision in any contract between Physician Group and its employees or Downstream Entities, prohibit, the free, open, and unrestricted exchange of any and all information of any kind between Providers and Enrollees regarding the nature of the Enrollee's medical condition, the health care treatment options and alternatives available and their relative risks and benefits, whether or not covered or excluded under the Enrollee's Evidence of Coverage, and the Enrollee's right to appeal any adverse decision made by Physician Group or CalOptima regarding coverage of treatment which has been recommended or rendered. Physician Group and CalOptima agree not to penalize nor sanction any Provider in any way for engaging in such free, open, and unrestricted communication with an Enrollee nor for advocating for a particular service on an Enrollee's behalf.

XI. TERM AND TERMINATION

11.1 **Term of Contract**. The term of this Contract shall become effective on the Effective Date and continue in effect for five (5) years through _____ ("Initial Term") and five (5) additional one-year automatic extensions except as directed otherwise by the Board.

11.2 **Sanctions and Terminations for Cause**. If Physician Group fails to fulfill any of its duties and obligations under this Contract, including: (i) committing acts to discriminate against Enrollees; (ii) engaging in any practice that would reasonably be expected to have the effect of denying or discouraging enrollment with the Physician Group by Enrollees whose medical condition or history indicated a need for substantial future medical services; (iii) not providing Covered Services in the scope or manner required under this Contract; (iv) engaging in prohibited marketing activities; (v) failing to comply with CalOptima's compliance and fraud, waste and abuse programs; (vi) failing to meet financial requirements in Article II; (vii) committing fraud, waste or abuse relating to Covered Services or any and all obligations, duties, and responsibilities under this Contract; (viii) failure to enforce claims payment prohibitions on Group Physicians who are denied the right to submit claims and/or receive reimbursement for services furnished to Enrollees; (ix) failure of Group Physicians to comply with pharmacy requirements as determined by CalOptima; (x) failure to submit Encounter Data or comply with other reporting requirements pursuant to this Contract and CalOptima Policies; and/or (xi) failure to take corrective action related to any such obligation or duty in the time or manner required by CalOptima, CalOptima may take any one or more of the actions described in this Article XI.

11.3 **Corrective Action Plans**. CalOptima may require a Corrective Action Plan ("**CAP**") in the event that any report, audit, survey, site review or investigation indicates that the Physician Group or any Downstream Entity is not in compliance with any provision of this Contract.

11.3.1 A CAP shall be required if CalOptima receives a substantiated complaint or grievance related to the standard of care provided by the Physician Group or any Downstream Entities. CalOptima shall issue a written notice of deficiency and shall require that a CAP to be submitted within thirty (30) calendar days following the date of notice unless otherwise stated. The CAP shall include the time and manner in which the deficiency shall be corrected. CAPs are subject to approval by CalOptima, which may be approved as submitted, accepted with specific modifications, or rejected. CalOptima may extend or reduce the time allowed for completion of the CAP depending upon the nature of the deficiency.

11.3.2 Notwithstanding any request for a CAP, CalOptima may impose monetary penalties, suspend enrollment, reduce maximum enrollment, or impose other sanctions when the Physician Group is not in compliance with the provisions of this Contract, CalOptima Policies, and minimum performance requirements as established by CalOptima. All monetary fines are payable to CalOptima within thirty (30) calendar days of receipt of written notice, unless otherwise stated in the notice. Failure to submit payment to CalOptima for any monetary fines within the thirty (30) calendar day period shall result in CalOptima deducting the penalty plus administrative fees from the Physician Group's Capitation Payment.

11.3.3 CalOptima may apply sanctions pursuant to this Contract and CalOptima Policies to all PHC Participants independent of the PHC Participant whose action(s) caused sanctions to be applied by CalOptima.

11.4 **CalOptima Termination for Cause**. Notwithstanding and in addition to any other provisions of this Contract, CalOptima may terminate this Contract for cause effective upon thirty (30) calendar days' written notice; cause shall include, but shall not be limited to, the actions set forth in Section 11.2. CalOptima's rights and remedies provided in this provision shall not be exclusive and are in addition to any other rights and remedies provided by law or this Contract.

11.5 **Physician Group Termination for Cause**. Physician Group may terminate this Contract for cause only upon thirty (30) calendar days' written notice and only in the event that CalOptima fails to make payments due under this Contract within fifteen (15) calendar days of when such amounts are due and payable.

11.6 **Immediate Terminations**. In addition to all other sanction and termination rights, CalOptima may terminate Contract immediately upon delivery of written notice to Physician Group if:

11.6.1 Physician Group (including Group Physicians) and/or its Downstream Entities are unable to secure the necessary governmental licenses, approvals, and/or certificates required for the performance of their duties;

11.6.2 CalOptima determines that the health, safety, or welfare of Enrollees is jeopardized by continuation of this Contract;

11.6.3 Physician Group commits fraud, waste, or abuse; or

11.6.4 CMS fails to authorize or reauthorize CalOptima to operate a MA Program for a period that overlaps the Term.

11.6.5 This Contract shall terminate upon the termination of the Hospital Contract. Notification of termination to any PHC Participant shall constitute notification of termination to all PHC Participants.

11.7 **Without Cause Termination**. Following the Initial Term, either Party may terminate this Contract for convenience, without cause, by giving written notice to the other Party of at least one hundred and eighty (180) calendar days' prior to the effective date of such termination.

11.8 **Bankruptcy**. If during the Term there is filed by or against Physician Group in any court pursuant to any statute of the United States or any state, a petition in bankruptcy or insolvency or for reorganization or for the appointment of a receiver or trustee or conservator of all or a portion of

Physician Group's assets, or if Physician Group makes an assignment for the benefit of creditors, or if Physician Group becomes unable, admits in writing its inability, or fails generally to pay its debts as they become due, this Contract may, at the option of CalOptima, be canceled and terminated. In the event of the filing of a petition for bankruptcy by or against Physician Group, Physician Group shall assure that all of Physician Group's functions and duties related to the Contract are performed in accordance with the terms of the Contract. CalOptima shall have the right to withhold any and all amounts otherwise due to Physician Group until Physician Group fully discharges its obligations under the Contract. CalOptima shall also have the immediate right of offset by permanently retaining any and all withheld amounts as necessary to ensure that all Physician Group obligations have been met.

11.9 **Termination of CMS Contract.** In the event the CMS Contract with CalOptima is terminated or not renewed, the provisions of this Contract shall automatically terminate unless otherwise specified by CalOptima and subject to any provisions that survive termination. Any term provided in the Contract is subject to CMS's continuing approval of CalOptima's MA Program. Physician Group agrees to assist CalOptima with such transfer of care requirements mandated by CMS in the event of termination of the CMS Contract.

11.10 **Continuation of Benefits**. Physician Group and its Participating Providers agree that, in the event of CalOptima's insolvency or cessation of operations, benefits to Enrollees will continue through the period for which capitation has been paid or until the discharge of Enrollee from an inpatient facility, whichever time is greater. Covered Services to an Enrollee confined in an inpatient facility on the date of insolvency or other cessation of operations will continue until their appropriate discharge.

11.11 **Physician Group Obligations Following Termination**. In the event of termination of this Contract, at CalOptima's sole option, Physician Group will continue to provide Covered Services, and CalOptima shall reimburse for such services per the Medicare fee schedule, to Enrollees until CalOptima has made arrangements with alternative Providers to render care to Enrollees. Physician Group shall cooperate and assist CalOptima in the transfer of Enrollee care in the event this Contract or any relevant Downstream Entity subcontract is terminated for any reason. Physician Group shall provide a plan for the orderly termination of services under this Contract, in form and substance acceptable to CalOptima.

11.12 **Prohibition on Use of Certain Group Physicians**. Physician Group agrees that CalOptima reserves the right to require Physician Group, upon notification from CalOptima, to prohibit any Group Physician or Downstream Entity from providing services, whether Covered Services or otherwise, to Enrollees when CalOptima deems such prohibition to be in the best interests of the Enrollees, provided that imposition of the foregoing prohibition shall not terminate this Contract.

11.13 **PHC Primary Hospital Usage Requirement**. In order to qualify as a PHC, PHC Participants must ensure that, during every annual contract year period during the Term, at least seventy percent (70%) of the bed days for those Enrollees assigned to the PHC who require inpatient hospitalization during the previous calendar year must have occurred at Hospital or within the same hospital system as Hospital, except as otherwise provided under CalOptima Policies. For purposes of calculating the bed day percentage, only bed days in Orange County hospitals shall count. Failure to meet this requirement shall be cause for termination by CalOptima under Section 11.4 of this Contract. In the event of termination as a result of breaching this Section 11.13, Physician Group shall be offered the opportunity to continue be a Participating Provider through a separate risk-sharing arrangement with CalOptima, subject to meeting all applicable financial, operational, and other criteria for such an arrangement. Termination of Hospital under the

equivalent of this section in the Hospital Contract shall have no effect on any fee-for-service contract between CalOptima and Hospital.

XII. GENERAL PROVISIONS

12.1 **Dispute Resolution**.

12.1.1 **Provider Appeals Process**. CalOptima maintains a Provider dispute resolution process. Physician Group may appeal any aspect of the CalOptima MA Program, including a decision to impose a sanction, terminate this Contract, or take other actions against Physician Group, by filing a complaint pursuant to CalOptima Policies. Physician Group shall exhaust all administrative remedies and any government claims requirements, as applicable, before commencing arbitration.

12.1.2 **Meet and Confer**. For any dispute not subject to or resolved by the provider appeals process, or if either Party has a dispute it seeks to address informally, the Parties shall use reasonable efforts to informally meet and confer to try and resolve the dispute. The Parties shall meet and confer within thirty (30) days of a written request submitted by either Party in an effort to settle any dispute. At each meet-and-confer meeting, each Party shall be represented by persons with final authority to settle the dispute. If either Party fails to meet within the thirty (30)-day period, that Party shall be deemed to have waived the meet-and-confer requirement, and at the other Party's option, the dispute may proceed immediately to arbitration under Section 12.1.3.

12.1.3 **Arbitration**. If the Parties are unable to resolve any dispute arising out of or relating to this Contract under Sections 12.1.1 and 12.1.2, either Party may submit the dispute for resolution exclusively through confidential, binding arbitration, instead of through trial by court or jury, in Orange County, California. The Parties may agree in writing prior to commencing the arbitration on the dispute resolution rules and arbitration service that will be used to resolve the dispute. If the Parties cannot reach such an agreement, the arbitration will be conducted by Judicial Arbitration and Mediation Services ("**JAMS**") in accordance with the commercial dispute rules then in effect for JAMS; provided, however, that this Contract shall control in instances where it conflicts with JAMS's (or the applicable arbitration service's) rules. The arbitration shall be conducted on an expedited basis by a single arbitrator. The Parties prefer that the arbitrator be a retired judge of the California Superior, Appellate, or Supreme Court or of a United States court sitting in California. If no such retired judge is available, the arbitrator may be an attorney with at least fifteen (15) years of experience, including at least five (5) years in managed health care. If the Parties are unable to agree on the arbitrator within thirty (30) days of the date that the arbitration service accepts the arbitration, the arbitrator shall be selected by the arbitration service from a list of four potential arbitrators (all of whom shall be on arbitration services' panel of arbitrators) submitted by the Parties, two from each side; provided, however, that nothing stated in this section shall prevent a Party from disqualifying an arbitrator based on a conflict of interest. In making decisions about discovery and case management, it is the Parties' express agreement and intent that the arbitrator at all times promote efficiency without denying either Party the ability to present relevant evidence. In reaching and issuing decisions, the arbitrator shall have no jurisdiction to make errors of law and/or legal reasoning. The Parties shall share the costs of arbitration equally, and each Party shall bear its own attorneys' fees and costs.

12.1.4 **Exclusive Remedy**. With the exception of any dispute that under Laws may not be settled through arbitration, arbitration under Section 12.1.3 is the exclusive method to resolve a dispute between the Parties arising out of or relating to this Contract that is not resolved through the provider appeals or meet-and-confer processes.

12.1.5 **Waiver**. By agreeing to binding arbitration as set forth in Section 12.1.3, the Parties acknowledge that they are waiving certain substantial rights and protections which otherwise may be available if a dispute between them was determined by litigation in a court, including the right to a jury trial, attorneys' fees, and certain rights of appeal.

12.2 **Interpretation of Contract Language**. CalOptima has the right to final interpretation of the Contract language when disputes arise. Physician Group has the right to appeal disputes concerning Contract language to CalOptima.

12.3 **Waiver**. The waiver by either Party of a breach or violation of any provision of this Contract will not operate as or be construed to be a waiver of any subsequent breach thereof. To be effective, a waiver must in writing signed by the Parties.

12.4 **Assignment**. This Contract and the rights, interests, duties, and obligations hereunder shall not be assigned, transferred, pledged, or hypothecated in any way by Physician Group nor shall the duties and obligations imposed herein be subcontracted or delegated without the prior written consent of CalOptima, which consent may be withheld in CalOptima's sole and absolute discretion for any reason or no reason. Physician Group acknowledges and agrees that CalOptima's consent, if any, to assignment and/or delegation is subject to the approval of CMS. Therefore, any assignment and/or delegation of this Contract, including the rights, interests, duties, and obligations hereunder, shall be void unless prior written consent is obtained from CalOptima and CMS. Physician Group further acknowledges and agrees that CalOptima may require Physician Group and the proposed assignee/sub-delegate to cooperate in due diligence and sub-delegation assessment activities as part of its review of any request for consent to assignment of this Contract and the rights, interests, duties, and obligations hereunder. Physician Group agrees to cooperate and provide such information as requested by CalOptima. Physician Group acknowledges and agrees that (i) CalOptima's due diligence and/or assessment activities related to any proposed assignment may take one hundred eighty (180) days or more; (ii) in no event shall CalOptima's due diligence and/or delegation assessment activities be construed as CalOptima's consent to assignment; and (iii) any consent to assignment by CalOptima must be reflected in a separate writing executed by CalOptima and other relevant parties. CalOptima may, from time to time, establish policies and procedures regarding its processes for initiating review and approval of any proposed assignment of this Contract. For purposes hereof, the term "assignment" shall include any of the following: (i) the change of more than twenty-five percent (25%) of the ownership or equity interest in Physician Group (whether in a single transaction or in a series of transactions); (ii) the change of more than twenty-five percent (25%) of the directors or trustees of Physician Group; (iii) the merger, reorganization, or consolidation of Physician Group with another entity with respect to which Physician is not the surviving entity; and/or (iv) a change in the management of Physician Group from management by persons appointed, elected, or otherwise selected by the governing body of Physician Group (e.g., the Board of Directors) to a third-party management person, company, group, team or other entity.

12.5 **Independent Parties**. None of the provisions of this Contract are intended to create nor will be deemed or construed to create any relationship between the Parties other than that of independent contractors, solely for the purposes of effecting the provisions of the Contract. Neither of the

Parties nor any of their respective officers, directors, or employees shall act as nor be construed to be the agent, the employee, or the representative of the other Party.

12.6 **Integration of Entire Contract**. This Contract contains all of the terms and conditions agreed upon by the Parties regarding the subject matter of this Contract. Any prior agreements, promises, negotiations or representations of or between the Parties, either oral or written, relating to the subject matter of this Contract that are not expressly set forth in this Contract are null and void and of no further force or effect.

12.7 **Invalidity or Unenforceability**. The invalidity or unenforceability of any terms or provisions hereof will in no way affect the validity or enforceability of any other term or provision.

12.8 **Amendment**. CalOptima may amend this Contract immediately upon written notice to Physician Group in the event such amendment is required in order to maintain compliance with Laws. CalOptima may deem all other amendments to the Contract effective after at least forty-five (45) business days' notice or earlier if agreed to by Physician Group. All amendments of this Contract are subject to CMS approval.

12.9 **No Waiver of Immunity or Privilege**. Any information delivered, exchanged, or otherwise provided hereunder shall be delivered, exchanged, or otherwise provided in a manner, which does not constitute a waiver of immunity or privilege under applicable law.

12.10 **Choice of Law; Jurisdiction and Venue**. This Contract shall be governed by and construed in accordance with all State and federal laws and regulations governing the CMS Contract. The Parties consent to the jurisdiction of the California Courts with venue in Orange County California.

12.11 **Force Majeure**. Either Party, upon prompt written notice to the other Party, shall be excused from performance hereunder for any period that it is prevented from meeting the terms of this Contract as a result of a catastrophic occurrence or natural disaster, including, but not limited to, an act of war and excluding labor disputes ("**Force Majeure Event**");

12.12 **No Liability of County of Orange**. As required under Ordinance No. 3896, as amended, of the County of Orange, State of California, CalOptima and the Physician Group hereby acknowledge and agree that the obligations of CalOptima under this Contract are solely the obligations of CalOptima, and the County of Orange, State of California, shall have no obligation or liability therefor.

12.13 **Confidential and Proprietary Information**. Physician Group agrees to maintain confidential the following information (the "**Confidential Information**"): (a) eligibility lists and any other information containing the names, addresses and telephone numbers of CalOptima Enrollees; (b) CalOptima's administrative service manuals and all forms related thereto; (c) the financial arrangements between CalOptima and any Participating Provider; and (d) any other information compiled or created by CalOptima that is proprietary to CalOptima and that CalOptima identifies as proprietary to Physician Group in writing. Physician Group shall not disclose or use the Confidential Information for its own benefit or gain either during the Term or after the date of termination of this Contract. Physician Group may use the Confidential Information to the extent necessary to perform its duties under this Contract or upon express prior written permission of CalOptima. Upon the effective date of termination of this Contract, Physician Group shall promptly return to CalOptima the Confidential Information in its possession, upon CalOptima's notice.

12.14 **Third Party Beneficiaries**. Nothing in this Contract, express or implied, is intended to or shall confer upon any other person or entity, any right, benefit or remedy of any nature whatsoever.

12.15 **Survival**. The terms set forth in the following sections shall survive the expiration or termination of this Contract, whether with or without cause, by rescission or otherwise, as to all Covered Services provided under this Contract prior to termination: Sections 6.2, 6.5, 7.8, Article 8, 9.1, 11.10, 11.11, 12.1, 12.2, 12.3, 12.5, 12.6, 12.7, 12.9, 12.10, 12.12, 12.13, 12.14, and any other sections that, by their terms, are intended to survive termination of the Contract.

12.16 **Recitals and Exhibits**. The recitals, exhibits, and addenda set forth in this Contract are made a part of the Contract by this reference.

12.17 **Without Limitation**. Any reference in the Contract to "include(s)" or "including" means inclusion without limitation, unless otherwise distinguished within the text.

12.18 **Notices**. All notices shall be in writing and shall be deemed to have been duly given on the date of service if personally served on the Party to whom notice is given, or seventy-two (72) hours after mailing by electronic mail transmission, United States priority mail, United States mail first class (Certified Mail or Registered Mail), addressed to the Party to whom notice is to be given and such party's address as set forth below or such other address provided by notice.

To: CalOptima

Attention: Chief Operating Officer
505 City Parkway West
Orange, California 92868

To: Physician Group

_____

_____

_____

XIII. CONDITIONS PRECEDENT TO CONTRACT COMMENCEMENT

13.1 **Contract Effectiveness**. The Contract is subject to CalOptima's determination, in its sole discretion, that the following conditions have been met prior to the Effective Date: (i) Physician Group has successfully met all criteria in CalOptima's readiness assessment, including financial viability and delegated function criteria; Physician Group has signed CalOptima's Business Associate Agreement; and (iii) Physician Group has furnished all required documentation and data requested by CalOptima (e.g., insurance documents, licenses).

13.2 **Additional CalOptima Regulator Requirements**. CalOptima, in its sole discretion, may condition this Contract upon Physician Group's ability to meet other criteria imposed by CalOptima Regulators.

XIV. SIGNATURES

SUBJECT TO (I) THE UNITED STATES GOVERNMENT PROVIDING FUNDS FOR THE TERM OF THIS CONTRACT AND FOR THE PURPOSES WITH RESPECT TO WHICH IT IS ENTERED INTO; AND (II) THE APPROVAL OF THIS CONTRACT BY DMHC AND CMS, THIS

CONTRACT SHALL BECOME EFFECTIVE ON THE EFFECTIVE DATE AND SHALL TERMINATE ON AS PROVIDED IN THIS CONTRACT.

IN WITNESS WHEREOF, CalOptima and Physician Group have executed this Contract as indicated below.

FOR Physician Group:	FOR CALOPTIMA:
_____	_____
SIGNATURE	SIGNATURE
_____	Yunkyung Kim
PRINT NAME	PRINT NAME
_____	Chief Operations Officer
TITLE	TITLE
_____	_____
DATE	DATE

ADDENDUM 1

Entities Comprising the PHC

ATTACHMENT A
DEFINITIONS

1. "**Administrative Services**" means those non-clinical, administrative functions that are the responsibility of the Physician Group as set forth under the Contract and in CalOptima Policies.

2. "**Advance Directive**" means an individual's written directive or instruction, such as a power of attorney for health care or a living will, recognized under state law (whether statutory or as recognized by the courts of the state) for the provision of that individual's health care if the individual is unable to make his or her health care wishes known.

3. "**Appeals**" means an Enrollee's actions, both internal and external to CalOptima, requesting review of the denial, reduction, or termination of benefits or services from CalOptima.

4. "**Authorization/Authorized**" means the approval of CalOptima, or its delegate (which may include Physician Group), for the provision or referral of Covered Services, obtained in accordance with, and as further described in, the Provider Manual and this Contract.

5. "**Behavioral Health**" means the mental health services and substance use disorder services arranged for or provided to Enrollees by a separate Mental Health Plan, CalOptima, or their subcontractors.

6. "**CalOptima Formulary**" means the CalOptima Approved Drug List, the Disposable Medical Equipment/Supplies List, the CalOptima OneCare Formulary, and any additional formularies as may be designated by CalOptima and provided to CalOptima's designated pharmacy benefits manager "PBM". There is no applicable CalOptima Formulary for the PACE program.

7. "**CalOptima Policies**" means CalOptima policies and procedures, including CalOptima's Provider Manual, that are amended from time to time at the sole discretion of CalOptima and incorporated into this Agreement by this reference.

8. "**CalOptima's Regulators**" means those government agencies that regulate and oversee CalOptima's and its FDRs' activities and obligations under this Contract including the Department of Health and Human Services, CMS, and the DMHC and other government agencies that have authority to set standards and oversee the performance of the parties to this Contract, as well as their respective agents and contractors quality improvement organizations.

9. "**Capitation Payment**" means the monthly payment paid to Physician Group by CalOptima for delivery for Covered Services to Enrollees, which is determined by multiplying the applicable Capitation Rate by Physician Group's monthly enrollment.

10. "**Capitation Rate**" means the rate set by CalOptima for the delivery of Covered Services to an Enrollee.

11. "**Care Coordinator**" means a clinician or other trained individual employed by or contracted with Physician Group who is accountable for providing care coordination services for Enrollees, as required by CalOptima Policies and who services on one or more ICTs.

12. "**C.C.R.**" means the California Code of Regulations.

13. "**C.F.R.**" means the Code of Federal Regulations.

14. "**CMS**" means the Center for Medicare & Medicaid Services.

15. "**CMS Contract**" means the agreement between CMS and CalOptima under which CalOptima can establish its MA Program for Enrollees.

16. "**COB**" refers to the coordination of benefits and determination of order of financial responsibility that applies when two or more health benefit plans provide coverage of items and services for an individual.

17. "**Compliance Program**" means the program (including the compliance manual, code of conduct and CalOptima Policies) developed and adopted by CalOptima to promote, monitor, and ensure that CalOptima's operations and practices and the practices of its Board members, employees, contractors, and Providers comply with applicable law and ethical standards. The Compliance Program includes CalOptima's Fraud, Waste and Abuse ("FWA") plan.

18. "**Covered Services**" means those health care items, drugs, and services that an Enrollee is entitled to receive pursuant to a Program applicable to that Enrollee. Covered Services must generally be referred and Authorized in confirming with CalOptima's Policies, including its utilization management program."

19. "**Delegation**" means the process by which CalOptima expressly grants, by formal written agreement to another entity, the authority to carry out a function that would otherwise be required to be performed by CalOptima in order to meet its obligations under the CMS Contract.

20. "**Delegation Agreement**" means the formal written agreement by which CalOptima grants to another entity the authority to carry out a function that would otherwise be required to be performed by CalOptima to meet its obligations under the CMS Contract.

21. "**Delegation Criteria**" means those criteria adopted by CalOptima, for the delegation of activities in the areas of UM, medical records audits, the Office Site Review, 'Enrollee's rights and responsibilities, and credentialing, as set forth in CalOptima Policies.

22. "**DMHC**" means the California Department of Managed Health Care.

23. "**Downstream Entity**" means all Providers and other persons or entities with which Physician Group has entered into a written subcontract (acceptable to CMS) to perform administrative functions and/or health care services to satisfy Physician Group's obligations to CalOptima under this Contract, continuing down to the ultimate provider of services. The term "Physician Group" as used in the terms of this Contract shall also include its subcontractors when such subcontractors are Downstream Entities, even if not expressly referenced in the particular provision.

24. "**Emergency Medical Condition**" means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, with an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in: (i) placing the health of the individual (or with respect to a pregnant woman, the health of the woman and her unborn child) in serious jeopardy; or (ii) serious impairment to bodily functions; or (iii) serious dysfunction of any bodily organ or part.

25. "**Emergency Services**" means those covered inpatient and outpatient services that are (i) furnished by a Provider qualified to furnish Emergency Services; and (ii) needed to evaluate and/or stabilize an Enrollee's Emergency Medical Condition.

26. "**Encounter Data**" means the record of an Enrollee receiving any item(s) or service(s) provided through Medicaid or Medicare under a prepaid, capitated, or any other risk basis payment methodology submitted to CMS. The encounter data record shall incorporate HIPAA security, privacy, and transaction standards and be submitted in ASCX12N 837 or any successor format required by CalOptima's Regulators.

27. "**Enrollee**" means an eligible individual who is enrolled in the CalOptima MA Program.

28. "**Evidence of Coverage**" means the document approved by CalOptima's Regulators and issued by CalOptima to Enrollees that describes Enrollee's benefits under the CalOptima MA Program.

29. "**FDR**" means a party that enters into a written agreement (acceptable to CMS) to provide administrative or health care services to CalOptima and/or its Enrollees that are governed by the CMS Contract.

30. "**FQHC**" means an entity that meets all of the requirements for designation as a federally qualified health center under § 1861(aa)(3) of the Social Security Act and is approved for participation in the MA program.

31. "**Grievance**" means an oral or written expression of dissatisfaction, including any compliant, dispute, request for reconsideration, or appeal, made by an Enrollee.

32. "**Group Physician**" means a Physician who is employed by or under contract with Physician Group to provide physician services.

33. "**Health Network**" means Physician Group, a PHC, or health care service plan (such as an HMO) that is contracted with CalOptima to provide items and services to Enrollees on a capitated basis.

34. "**HEDIS**" means the set of standardized performance measures sponsored and maintained by the NCQA.

35. "**HRA**" means the health risk assessment tool that identifies an Enrollee's primary, acute, LTSS, Behavioral Health, and functional needs.

36. "**HIPAA**" means the Health Insurance Portability and Accountability Act of 1996, Public Law 104-191, the Health Information Technology for Economic and Clinical Health Act, Public Law 111-005, and regulations promulgated thereunder by the U.S. Department of Health and Human Services, including Title 45 of the C.F.R, Parts 160 and 164.

37. "**ICP**" means the plan of care developed by an Enrollee and/or his/her ICT or CalOptima.

38. "**Indian Enrollee**" means an Enrollee who is an Indian (as defined in the Indian Health Care Improvement Act of 1976 [25 U.S.C. §§ 1603(13), 1603 (13 and 23), or 1679(a)] or who has been determined as an Indian under 42 C.F.R. § 136.12.

39. "**Indian Health Care Provider**" means a health care program operated by the Indian Health Services or by an Indian Tribe, Tribal Organization, or Urban Indian Organization, as those terms are defined in Section 4 of the Indian Health Care Improvement Act (25 U.S.C. § 1603).

40. "**ICT**" means an interdisciplinary care team comprised of the primary care provider and Care Coordinator and other Providers at the discretion of the Enrollee that work with the Enrollee to develop, implement, and maintain the ICP.

41. "**Laws**" means any local, State, or federal statute, regulation, rule, or executive or agency order applicable to this Contract.

42. "**LTSS**" means the range of long-term services and supports that help Enrollees meet their daily needs for assistance and improve the quality of their lives and which include: (i) In-Home Supportive Services ("IHSS"); (ii) Community-Based Adult Services ("CBAS"); (iii) Multi-purpose Senior Services Program ("MSSP") services; and (iv) skilled nursing facility services and sub-acute care services.

43. "**Medically Necessary**" or "**Medical Necessity**" means when addressing Covered Services: (i) under Medicare, reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member, or otherwise medically necessary under 42 U.S.C. Section 1395y.

44. "**Medical Record**" means any record kept or required to be kept by any Provider that documents medical services received by the Enrollee, including inpatient, outpatient, emergency care, referral requests, and Authorizations in accordance with applicable laws including Title 28 C.C.R. § 1300.80(b), Title 42 U.S.C. § 1396a(w), 42 C.F.R. § 456.111 and 42 C.F.R. § 456.211 and CalOptima Policies.

45. "**Mental Health Plan**" means the entity that has contracted with DHCS to provide Specialty Mental Health Services to individuals, including Enrollees.

46. "**Model of Care**" means the component of CalOptima's quality improvement framework that is evidence-based, includes certain clinical and non-clinical elements, and is in addition to the comprehensive care coordination requirements specified in CalOptima Policies.

47. "**Non-Covered Services**" means those services that are not benefits under the CalOptima MA Program in accordance with CalOptima's Evidence of Coverage and applicable state and federal laws and regulations.

48. "**Non-Participating Provider**" means an institution, professional, or other Provider of health care services who has not entered into an agreement, either with CalOptima or Physician Group, to provide medical and other services to Enrollees.

49. "**Out-of-Area**" means that area that is outside the Service Area.

50. "**Outpatient Mental Health Services**" means outpatient services that are provided to Enrollees with mild to moderate mental health conditions including: (i) individual/group mental health evaluation and treatment (psychotherapy); (ii) psychological testing when clinically indicated to evaluate a mental health condition; (iii) outpatient services for the purpose of monitoring drug therapy; (iv) psychiatric consultation for mediation management; and (v) outpatient laboratory supplies and supplements.

51. "**Participating Provider**" means an institution, professional, or other provider of health care services who has entered into an agreement, either with CalOptima or Physician Group, to provide health care services to Enrollees.

52. "**PCC**" means the personal care coordinator(s) employed by Physician Group to comply with the CalOptima MOC Program.

53. "**PCC Component to the Model of Care Profile**" means the PCC Components identified in the Model of Care Profile.

54. **"Physician"** means a person with an unrestricted license to practice medicine or osteopathy in the state in which they practice.

55. "**Physician Direct Referral**" means the process whereby a PCP has the authority the decide whether a referral is deemed necessary for an Enrollee and if deemed necessary the PCP will directly refer that Enrollee within said Physician Group to any of the specialties or services specified in CalOptima Policies without requiring the prior Authorization of Physician Group.

56. "**Post-Stabilization Care Services**" means services related to an Emergency Medical Condition that are provided after an Enrollee is Stabilized in order to maintain the Stabilized condition, or under some circumstances, to improve or resolve the condition.

57. "**Preclusion List**" means the CMS-compiled list of providers and prescribers who are precluded from receiving payment for MA items and services or Part D drugs furnished or prescribed to Medicare beneficiaries.

58. "**PCP**" means a primary care physician responsible for supervising, coordinating, and providing initial and primary care to Enrollees; for serving as the medical home; for processing initial referrals for Specialist Physician care; and for maintaining the continuity of patient care.

59. "**Program**" is health care benefit program offered by CalOptima to Enrollees. Programs and their designs are subject to change periodically.

60. "**Provider**" means a physician, nurse, nurse mid-wife, nurse practitioner, medical technician, physician assistant, hospital, laboratory, health maintenance organization ("HMO"), or other person or institution who furnishes health care items or services.

61. "**Provider Manual**" means that comprehensive online document, as amended from time to time, and describes CalOptima's Policies and procedures affecting Physician Group Physicians' services under this Contract.

62. "**Referral**" means the process by which the Participating Provider Physician directs an Enrollee to seek and obtain Covered Services from a health professional or for care at a facility.

63. "**Rural Health Clinic (RHC)**" means an entity that meets all of the requirements for designation as a rural health clinic under § 1861(aa)(1) of the Social Security Act and is approved for participation in the MA program.

64. "**Service Area**" means the geographic area within Orange County, California.

65. "**Specialist Physician**" means any physician who is not a PCP, has the requisite training and education, and meets all other requirements set by CalOptima Policies for specialists.

66. "**Stabilize**" or "**Stabilized**" means, with respect to an Emergency Medical Condition, to provide such medical treatment of the condition to assure within reasonable medical probability that no

material deterioration of the condition is likely to result or occur during the transfer of the individual from a facility, or in the case of a pregnant woman, that the woman has delivered the child and placenta.

67. "**Threshold Language**" means those languages as determined by CalOptima's Regulators from time to time and identified in guidance on translation requirements provided to CalOptima.

68. "**Urgent Care**" means services required to prevent serious deterioration of health following the onset of an unforeseen condition or injury and are medical services required promptly to prevent impairment of health due to symptoms that do not constitute an Emergency Medical Condition but that are the result of an unforeseen illness, injury or condition for which medical services are immediately required.

ATTACHMENT B
CALOPTIMA SENIOR PLAN
MATRIX OF FINANCIAL RESPONSIBILITY
January 1, 2023

	PHYSICIAN GROUP	RESPONSIBLE PARTY	
SERVICES	**GROUP**	**SHARED RISK SERVICES BUDGET (Between Group and Plan)**	**PLAN**
Medicare Part A Services – Not Otherwise Assigned Herein or in Any Agreement Incorporating This Exhibit:			
Inpatient		**X**	
Outpatient		**X**	
Medicare Part B Services Not Otherwise Assigned Herein or in Any Agreement Incorporating This Exhibit	**X**		
Some of the main services and those related to the Risk Sharing Program are listed below:			
Acupuncture (Medicare covered)	**X**		
Allergy			
Testing and Treatment	**X**		
Serum	**X**		
Ambulance – Air and Ground			
Emergency		**X**	
Inter-facility Transfers (all vehicle types)		**X**	
Amniocentesis			
Facility Component			
Outpatient (if not provided in physician office setting)		**X**	
Professional Component	**X**		
Audiologic			
Diagnostic	**X**		
Biofeedback	**X**		
Blood & Blood Products/Blood Transfusions (including professional component)			
Autologous Blood Donation		**X**	
From Blood Bank		**X**	
Cataract Surgery			

SERVICES	GROUP	SHARED RISK SERVICES BUDGET (Between Group and Plan)	PLAN
Professional Component	X		
Facility Component (Hospital Based Outpatient – Including Implanted Lenses)		X	
Facility Component (Ambulatory Surgery Center – Including Implanted Lenses)		X	
Chemical Dependency Rehabilitation and Detox (Medicare Covered)			
Professional Component	X		
Facility Component		X	
Methadone outpatient clinics			X
Chemotherapy			
Drugs – Outpatient (Part B)		X	
Drugs – Outpatient (Part D)			Rx
Professional Component	X		
Facility Component		X	
Chiropractic (Medicare covered)	X		
Dental Services (Medical)			
Professional Component	X		
Facility Component		X	
Facility Component (Non-Hospital) Based	X		
Diabetic Supplies			
Insulin and syringes (Rx Benefit)-see Medication-Outpatient Prescription Drug Benefit			Rx
Home Glucose Monitoring Equipment and Supplies)	X		
Diagnostic Testing			
Technical Component (Outpatient)	X		
Professional Component	X		
Durable Medical Equipment (DME)			
Outpatient	X		
Emergency Room			
Facility Component		X	
Professional Component (including interpretive reports)	X		

SERVICES	GROUP	SHARED RISK SERVICES BUDGET (Between Group and Plan)	PLAN
Endoscopy			
Facility Component		X	
Professional Component	X		
Family Planning			
Therapeutic Abortion Services, Tubal Ligation, Vasectomy, etc.			
Facility Component		X	
Professional Component	X		
Fetal Monitoring			
Facility Component		X	
Professional Component	X		
Genetic Testing/Counseling	X		
Health Education	X		
Hemodialysis/Dialysis			
Outpatient (Includes drugs per Medicare guidelines)		X	
Professional Component	X		
Home Health Care			
Medicare covered home health services (Including home IV therapy, excluding Part D drugs)		X	
Home Health Supplies (see medical supplies)		X	
Hospice	**Medicare FFS has primary responsibility**		
Hospitalization			
Facility Component (Including pre-admission diagnostic services)		X	
Interpretive Reports	X		
Professional Component (Including hospital-based physicians)	X		
Immunization and Inoculations (Part B)	X		
Immunization and Inoculations (Part D)			**Rx**
Infusion Therapy			
Professional Component	X		
Facility Component		X	

SERVICES	GROUP	SHARED RISK SERVICES BUDGET (Between Group and Plan)	PLAN
Part B drugs		X	
Part D drugs			Rx
Injectables -- (Outpatient) (see also Chemotherapy)			
Part B drugs		X	
Part D drugs			Rx
Lithotripsy			
Professional Component	X		
Facility Component		X	
Mammography	X		
Maternity/Obstetrics			
Facility Component		X	
Professional Component	X		
Medical supplies (includes catheters)			
Outpatient	X		
Medication			
Outpatient – Prescription Drug Benefit (Part D)			Rx
Outpatient medications (Part B)		X	
Mental Health			
Facility Component (includes Partial Hospitalization)		X	
Professional Component			X
Nuclear Medicine			
Inpatient, Facility Component (therapeutic)		X	
Outpatient, Facility Component	X		
Professional Component	X		
Nutrition			
Nutritional/Dietetic Counseling (Medicare Covered)	X		
Parenteral Nutrients, Supplies, Kits and Pumps			
Part B		X	
Part D			X
Enteral Nutrients, Supplies, Kits and Pumps			

SERVICES	GROUP	SHARED RISK SERVICES BUDGET (Between Group and Plan)	PLAN
Outpatient			**X**
Organ Transplants			
Pre Evaluation (All Inclusive)	**X**		
Organ Acquisition		**X**	**Medicare FFS for Kidney only**
Transplant Professional Component	**X**		
Transplant Facility Component (includes organ acquisition)		**X**	
Post Transplant (up to one year for transplant related services)			
Professional Component	**X**		
Post Transplant Facility Component (Inpatient)		**X**	
Post Transplant Facility Component (Outpatient – if provided in physician office setting)	**X**		
Orthotics and Prosthetics (Medicare Covered)			
Outpatient (Medicare defined coverage applies)		**X**	
Ostomy Supplies			
Outpatient	**X**		
Out of Area (Emergent and Urgently Needed Services)			
Facility Component		**X**	
Professional Component	**X**		
Outpatient Diagnostic Tests and Services (All Inclusive)	**X**		
Outpatient Surgery			
Facility Component (Hospital Based)		**X**	
Facility Component (Freestanding Ambulatory Surgery Center)		**X**	
Professional Component	**X**		
Cardiac catheterization and Angiograms (Professional)	**X**		
Cardiac catheterization and Angiograms (Facility)		**X**	
Physical Therapy (See Rehabilitation)			
Pain Management			

SERVICES	GROUP	SHARED RISK SERVICES BUDGET (Between Group and Plan)	PLAN
Professional	X		
Facility (if provided in other than physician office setting)		X	
Physician Visits/Consultations (inclusive of all settings)	X		
Podiatry Services (Medicare covered)	X		
Radiation Therapy			
Professional	X		
Facility, outpatient facility		X	
Radiology Services			
Outpatient, Preoperative, and Inpatient Professional Component	X		
Inpatient (facility component)		X	
Rehabilitation (Short Term e.g.: PT, OT, Speech, Cardiac)			
Outpatient Facility Component	X		
Professional Component	X		
Skilled Nursing Facility (SNF)			
Facility Component (All Inclusive)		X	
Professional Component	X		
Social Services – Medical	X		
Surgically Implanted Devices – All Categories		X	
Vision Care			
Annual routine exam			X
Glasses			X
Lenses and Frames incidental to cataract surgery (Medicare covered)	X		
Screening, Physician Office	X		

Notes:

1. **Financial responsibility is based on Medicare benefit interpretations and limitations.**
2. **The symbol "Rx" denotes outpatient prescription drug services.**

Assignment of financial responsibility as outlined in this document is independent of the questions of medical necessity, coverage or benefits.

ATTACHMENT C
CAPITATION RATES AND RISK SHARING

1. **Capitation Allocation**

1.1 **Allocation of Non-Part D CMS Revenue**. Each month, CalOptima shall allocate both the non-Part D related capitation that CalOptima receives from CMS for Enrollees affiliated with Physician Group and any applicable premiums that CalOptima charges Enrollees affiliated with Physician Group (collectively, the "**Total Revenues**") as follows:

- Facility and Other Services ("**Hospital Budget**") xx.x%
- Physician Group Capitation Payment xx.xx%

1.2 **MLR**. In accordance with Section 2.3, "Medical Loss Ratio", of the Contract, Physician Group shall maintain a minimum acceptable loss ratio of eighty-five percent (85%). Should Physician Group not meet the minimum eighty-five percent (85%) MLR, CalOptima reserves the right to require Physician Group to return to CalOptima the difference between eighty-five percent (85%) of Capitation Payments and the allowed medical expenses.

1.3 **Personal Care Coordinator**.

1.3.1 In addition to the amounts described above, and contingent on CalOptima Board of Directors' approval, CalOptima will pay Physician Group, ____dollars and ____cents ($xx.xx), a per Enrollee, per month amount for PCCs. The commencement date, amount, and duration of such PCC capitation payments, if any, will be established by the action of the CalOptima Board of Directors, and will be deemed incorporated herein by reference. Such payments, if any, may be adjusted in accordance with the PCC Reference Manual and are subject to recovery, termination, or offset as provided in this Contract and in the PCC Reference Manual.

1.3.2 Physician Group acknowledges and agrees that CalOptima may adjust and/or terminate the PCC Capitation Payments in the event Physician Group fails to comply with the requirements outlined in the PCC component of the model of care (MOC) profile. Physician Group acknowledges and agrees that CalOptima, in its sole and absolute discretion, may also offset Physician Group's future PCC Capitation Payments in the event CalOptima determines that Physician Group has not complied with the requirements set forth in the PCC component of the MOC Profile.

1.4 **Sequestration**. If CMS reduces payment to CalOptima under the CMS Contract by more than two percent (2%) at any time during the Term, CalOptima may, upon written notice to Physician Group, reduce payment to Physician Group under this Attachment C by the same percentage that CMS reduced payment to CalOptima. This provision applies each time CMS reduces payment to CalOptima by more than two percent (2%) during the Term.

1.5 **Pay-for-Performance Program**. CalOptima will develop a pay-for performance program to provide incentive payments to Physician Group. Payments will be calculated and paid

quarterly and annually based on a per Enrollee, per month rate and reflect achievement of specified program goals, which are determined by CalOptima in its sole discretion.

ATTACHMENT D
CLAIMS PROCESSING AND COMPLIANCE OBLIGATIONS

I. DEFINITIONS

1.1 "**Clean Claim**" means one that can be processed without obtaining additional information from the provider of the service or from a third party. Clean claim shall have the same meaning as "complete claim" as that term is defined in Title 28, CCR Section 1300.71(a)(2). Clean Claim does not include a claim from a Provider who is under investigation for fraud or abuse, or a claim under review for Medical Necessity.

1.2 "**Unclean Claim**" means any claim other than as defined in Section 1.1 of this attachment.

1.3 "**Denied Claim**" means a claim where (a) one or more services will not be paid by Physician Group and (b) payment is the responsibility of the Enrollee. Examples of claims that are not denials and should not be reported, submitted, or presented to CalOptima as Denied Claims include claims:

1.3.1 For patients who remain enrolled with CalOptima but have transferred to another Physician Group and Physician Group is forwarding the claim,

1.3.2 For which payment responsibility belongs to another contracting entity, and Physician Group is forwarding the claim,

1.3.3 That are duplicates,

1.3.4 That are encounter only/capitated claims and no patient liability is involved, and

1.3.5 That involve reduced payment amounts due to contract terms or allowed Medicare fee schedules.

II. GENERAL TERMS

2.1 **Physician Group Claims Processing**. Physician Group shall process claims for Provider services according to all CMS requirements and, as applicable, in accordance with the requirements of the Knox-Keene Act. This Attachment D is intended to comply with all DMHC and CMS standards and requirements. Should this Attachment D be out of compliance with any existing or newly enacted DMHC or CMS standard or requirement, the DMHC and/or CMS standard or requirement will supersede this Attachment D. CalOptima will communicate any changes in requirements to Physician Group in writing.

2.2 If Physician Group enters into a contract with a Downstream Entity whereby the responsibility for claims processing is delegated to that Downstream Entity, Attachment D provisions shall apply. Physician Group will have contractual provisions to ensure such Downstream Entity conforms to all DMHC and CMS requirements and oversight provisions as outlined herein and in CalOptima Policies.

2.3 Physician Group and any applicable Downstream Entity shall be required to have an oversight program for claims processing that includes written policies and procedures, a process for reporting fraudulent or unethical conduct, and an executive accountable for review of claims data and attesting to its accuracy. The oversight program shall include internal auditing of claims functions, and self-reporting as outlined in CalOptima Policies.

III. CLAIMS PROCESSING

3.1 **Timely Provider Payments**.

3.1.1 Physician Group and Downstream Entities, if, and as applicable, must make timely payments to Participating Providers consistent with 42 CFR § 447.45.

3.1.2 Physician Group shall reimburse Clean Claims, or any portion of any Clean Claim, for Covered Services, as soon as practical, but no later than thirty (30) calendar days after receipt of the claim by Physician Group, unless the claim or portion thereof is reasonably contested, in which case the claimant shall be notified in writing that the claim is contested or denied within forty-five (45) business days after receipt of the claim by Physician Group in accordance with CalOptima Policies.

3.1.3 Physician Group must ensure that ninety percent (90%) of claims from Providers who are in individual or group practice, which can be processed without obtaining additional information from the Provider or from a third party, will be paid within thirty (30) days of the date of receipt of the claim.

3.1.4 Physician Group must ensure that ninety-nine percent (99%) of all Clean Claims from Providers for Covered Services will be paid within ninety (90) days of the date of receipt of the claim.

3.1.5 Generally, the date of receipt is the date the Physician Group receives the claim, as indicated by its date stamp on the claim. The date of payment is the date of the check or other form of payment.

3.1.6 **"30-Day" Claim Timeliness**. Physician Group shall adjudicate nine-five percent (95%) of all Clean Claims from Non-Participating Providers or suppliers within thirty (30) calendar days of receiving the claim. Adjudicate a claim shall be deemed to mean to have processed the claim (paid or denied) and mailed the remittance advice by the thirtieth (30^{th}) calendar day since the earliest receipt by Physician Group or CalOptima's contracting Providers.

3.1.7 **"60-Day" Claim Timeliness**. Physician Group shall pay or deny Unclean Claims from Non-Participating Providers or suppliers, claims from Participating Providers or suppliers, and claims from Medicare fiscal intermediaries and carriers within sixty (60) calendar days of receipt of such claims. Processing shall be deemed to mean either to have paid or denied and mailed the remittance advice by the sixtieth (60^{th}) calendar day since the earliest receipt by Physician Group or CalOptima's contracting Providers, or to have denied the claim, and have mailed the denial letter to the Enrollee by the sixtieth (60^{th}) day. In accordance with federal law and CMS regulations, failure to process such claims within sixty (60) calendar days of receipt automatically constitutes an "adverse" initial determination, which the Enrollee may appeal; thus, a denial notice must be mailed to the Enrollee.

3.1.8 **Payment Accuracy**. When paying Non-Participating Providers, Physician Group shall employ only those Medicare fee schedules that MA plans are allowed to use by law and shall comply with 42 CFR § 422.214.

3.1.9 **Denied Claims**. Decisions to deny claims that result in liability for the Enrollee must be made in accordance with CMS guidelines. Whenever such decisions are made, the currently CMS approved Notice of Denial of Payment or Integrated Denial Notice must be

used, including approved denial reasons. Under no circumstances shall Physician Group deny a claim for the second time as a consequence of responding to a request for reconsideration from an Enrollee; instead, Physician Group must direct the Enrollee to submit the request directly to CalOptima as appropriate.

3.2 **Claims for Emergency and Post-Stabilization Services.**

3.2.1 Physician Group shall not retroactively deny a claim for Emergency Services because the condition, which appeared to be an Emergency Medical Condition, turned out to be non-emergency in nature. Physician Group shall ensure that its claims processing actions do not conflict with Hospital actions required to comply with the Emergency Medical Treatment and Active Labor Act ("**EMTALA**").

3.2.2 If there is a disagreement between Physician Group or any Participating Provider and any Non-Participating Provider regarding Medically Necessity of Covered Services in an emergency, the judgment of the attending physician(s) actually caring for the Enrollee at the treating facility shall prevail. Physician Group may establish relationships with treating facility whereby the Physician Group may send a Participating Provider with privileges to assume the attending physician's responsibilities to establish treatment or may arrange to have a Participating Provider under contract with Physician Group agree to accept the transfer of the Enrollee after the Enrollee has been Stabilized.

3.2.3 Physician Group shall ensure that an enrollee with an Emergency Medical Condition will be seen on an emergency basis and that Emergency Services will be available and accessible within the Service Area twenty-four (24) hours a day. Physician Group shall cover Emergency Services without prior Authorization pursuant to Title 28 CCR Section 1300.67(g), Title 22 CCR Section 53216, and Section 1932(b)(2) of the Social Security Act. Physician Group shall coordinate access to Emergency Services in accordance with 42 CFR § 438.114 and the Physician Group's emergency department protocol.

3.2.4 Physician Group may not refuse to cover Emergency Services based on the emergency room Provider, Hospital, or fiscal agent not notifying the Enrollee's PCP managed care organization, prepaid ambulatory health plan, prepaid inpatient health plan or applicable State entity of the Enrollee's screening and treatment within ten (10) calendar days of presentation for Emergency Services. An Enrollee who has an Emergency Medical Condition may not be held liable for payment of subsequent screening and treatment needed to diagnose the specific condition or Stabilize the Enrollee.

3.2.5 Physician Group may not deny payment for treatment obtained under either of the following circumstances: an Enrollee had an Emergency Medical Condition, including cases in which the absence of immediate medical attention would not have had the outcomes specified in the definition of an Emergency Medical Condition; or the Physician Group representative instructs the Enrollee to seek Emergency Services. The attending emergency Physician, or the Provider actually treating the Enrollee, is responsible for determining when the Enrollee is sufficiently Stabilized for transfer or discharge, and that determination is binding on the entities as responsible for coverage and payment.

3.2.6 Physician Group must cover and pay for Post-Stabilization Care Services. Physician Group is financially responsible for Post-Stabilization Care Services obtained within or outside the organization that are pre-approved by a Physician Group Provider or other Physician Group representative. Physician Group is financially responsible for Post-Stabilization

Care Services obtained within or outside the Physician Group organization that are not pre-approved by a Participating Provider or other Physician Group representative, but are administered to maintain the Enrollee's Stabilized condition within one (1) hour of a request to the Physician Group for pre-approval of further Post-Stabilization Care Services. Physician Group is financially responsible for Post-Stabilization Care Services obtained from within or outside the Physician Group that are not pre-approved by a Participating Provider or other Physician Group representative, but administered to maintain, improve, or resolve the Enrollee's Stabilized condition if the Physician Group: does not respond to a request for pre-approval within one (1) hour; cannot be contacted; or the Physician Group representative and the treating physician cannot reach an agreement concerning the Enrollee's care and a Participating Provider is not available for consultation. In this situation, the Physician Group must give the treating Physician the opportunity to consult with a Participating Provider and the treating Physician may continue with care of the Enrollee until a Participating Provider is reached or one criteria in 42 C.F.R. § 113(c)(3) is met. Physician Group must limit charges to Enrollees for Post-Stabilization Care Services to an amount no greater than what the Physician Group would charge the Enrollee if he or she had obtained the services through Physician Group. Physician Group financial responsibility for Post-Stabilization Care Services it has not pre-approved ends when: a Participating Provider with privileges at the treating hospital assumes responsibility for the Enrollee's care; a Participating Provider assumes responsibility for the Enrollee's care through transfer; Physician Group representative and the treating Physician reach an agreement concerning the Enrollee's care; or; the Enrollee is discharged.

3.2.7 Physician Group shall reimburse those Physicians providing Emergency Services and Urgent Care services with whom Physician Group has a contract according to the terms of that contract.

3.2.8 Physician Group must reimburse a Non-Participating Provider for Emergency Services or Urgent Care services at the prevailing Medicare fee-for-service ("**FFS**") rate as applicable for that service. Where the Covered Service would traditionally be covered under Medicare FFS, the Medicare FFS rate applies. Physician Group shall ensure that Enrollees maintain balance billing protections as provided in Section 6.4 of this Contract.

3.2.9 In accordance with CalOptima Policies, Physician Group shall implement the CMS Quality Payment Program known as the Merit-based Incentive Payment System ("**MIPS**"). MIPS adjustments for Part B covered professional services furnished by MIPS-eligible Providers that are not contracted with Physician Group shall be administered in the same manner as any other changes in the applicable Medicare payment schedules. Physician Group shall make positive and negative payment adjustments as identified by CMS based on the CMS MIPS adjustment data files.

3.2.9.1 CalOptima or Physician Group may apply MIPS payment adjustments either at the time the payment is made during the applicable MIPS payment year or as a retrospective adjustment to paid claims.

3.2.9.2 CalOptima or Physician Group are required to demonstrate payment through reporting or attestation by the end of March on an annual basis.

3.3 **Physician Group Financial Responsibility**. If CalOptima receives a claim for Covered Services that are the financial responsibility of Physician Group, CalOptima shall forward such claim to Physician Group for payment, in accordance with the procedures set forth in Title 28 CCR Section

1300.71, "Claims Settlement Practices." CalOptima shall not pay for services that are Physician Group's financial responsibility unless Physician Group fails to make payment within the time allowed by State and federal laws and regulations, and CalOptima is required by law to make such payment. In such cases, CalOptima, after written notice to Physician Group and reasonable opportunity to cure, will make payment, and Physician Group shall reimburse CalOptima for such payments. If Physician Group fails to reimburse CalOptima, CalOptima may offset an uncontested payment(s) against Capitation Payments or other amounts due from CalOptima to Physician Group, if any.

3.4 **Collection of Share of Cost**. Physician Group shall collect Medicare share of cost unless prohibited under this Contract.

3.5 **Capitation Payments**. Physician Group and/or Downstream Entities shall distribute monthly Capitation Payments to capitated Participating Providers within fifteen (15) calendar days following the date on which Physician receives payment from CalOptima.

3.6 **Claims Adjudication**. Except as provided in Section 3.1.1, Physician Group shall accept and adjudicate claims for Covered Services provided to Enrollees in accordance with the provisions of Sections 1371, 1371.1, 1371.2, 1371.22, 1371.35, 1371.36, 1371.37, 1371.38, 1371.4 and 1371.8 of the California Health & Safety Code, and Sections 1300.71, 1300.71.38, 1300.71.4, and 1300.77.4 of Title 28 of the CCR and CalOptima Policies. Waiver of any right or obligation specific to the Health and Safety Code and Title 28 related to claims processing and payment shall be prohibited.

3.7 **Dispute Resolution.** Physician Group shall establish and maintain a fair, fast and cost-effective dispute resolution mechanism to process and resolve provider disputes in accordance with the provisions of Sections 1371, 1371.1, 1371.2, 1371.22, 1371.35, 1371.36, 1371.37, 1371.38, 1371.4 and 1371.8 of the California Health & Safety Code, and Sections 1300.71, 1300.71.38, 1300.71.4, and 1300.77.4 of Title 28 of the CCR and CalOptima Policies.

3.8 **Right of Appeal**. Physician Group shall afford Providers an unconditional right of appeal and de novo review for claims disputes involving issues of Medical Necessity. Any Provider that submits a claim dispute to Physician Group's dispute resolution mechanism involving an issue of Medical Necessity or utilization review shall have an unconditional right of appeal for that claim dispute to CalOptima's dispute resolution process for a de novo review and resolution for a period of sixty (60) working days from Physician's Date of Determination.

3.9 **CalOptima Payment On Behalf Of Physician**. If CalOptima receives a copy of an unpaid Clean Claim as part of a Provider grievance that is thirty (30) working days old or more, CalOptima will follow all notification and acknowledgement procedures pursuant to CalOptima Policies. If Physician Group does not either notify CalOptima that the claim is reasonably contested, as set forth in CalOptima Policies, or pay the Clean Claim within the thirty (30) working day period, CalOptima shall pay the Claim on behalf of Physician, plus interest, as required by the Knox-Keene Act, and deduct the amounts reimbursed, plus processing costs, from the Capitation Payment, in accordance with CalOptima Policies.

3.10 **Quarterly Claims Payment Performance Report.**

3.10.1 Physician Group shall submit, in a format specified by CalOptima Policies, a quarterly claims payment performance report ("**Quarterly Claims Report**") to CalOptima within thirty (30) calendar days of the close of each calendar quarter. The Quarterly Claims Report

shall, at a minimum, disclose Physician Group's compliance status with Sections 1371, 1371.1, 1371.2, 1371.22, 1371.35, 1371.36, 1371.37, 1371.4, and 1371.8 of the California Health and Safety Code and Sections 1300.71, 1300.71.38, 1300.71.4 and 1300.77.4 of Title 28 of the CCR.

3.10.2 Physician Group shall ensure that each Quarterly Claims Report is signed by, and includes the written verification of, a principal officer, as defined by Section 1300.45(o) of Title 28 of the CCR, of Physician Group, stating that the report is true and correct to the best knowledge and belief of the principal officer.

3.10.3 Physician Group's Quarterly Claims Report shall include a tabulated record of each Provider dispute it received, categorized by date of receipt, and including the identification of the Provider, type of dispute, disposition and working days to resolution, as to each Provider dispute received. Each individual dispute contained in a Provider's bundled notice of Provider dispute shall be reported as a separate dispute to CalOptima.

3.11 **Forwarding of Misdirected Claims.**

3.11.1 Physician Group shall have the ability to receive a standard ANSI 837I and ANSI 837P claim file format for retrieving misrouted claims that are the financial responsibility of the Physician Group. Physician Group will receive and forward misdirected claims per CalOptima Policy.

3.11.2 Physician Group shall have the ability to create a standard ANSI 837I and ANSI 837P claim file for forwarding claims that are the financial responsibility of CalOptima within ten (10) working days of receipt of the claim. CalOptima shall receive these files per CalOptima policy and load them into its system to ensure timely claims processing. Physician Group shall forward any claims that are not its payment responsibility to CalOptima within eight (8) calendar days of receipt, so that a total of only ten (10) working days will elapse prior to the claims being in the proper hands.

3.12 **Assumption of Delegated Functions**. In the event that Physician Group fails to timely and accurately reimburse its claims (including the payment of interest and penalties), CalOptima may, at its sole discretion, revoke the delegation and assume responsibility from Physician Group for claims payment, or terminate this Contract as provided for in Article XI. CalOptima's assumption of responsibility for the processing and timely reimbursement of Provider claims may be altered to the extent that Physician Group has established an approved CAP consistent with Section 1375.4 (b)(4) of the Health and Safety Code and Section 11.3 of the Contract.

3.13 **Recoupment for Assumption of Claims Processing Obligations**. CalOptima, in its sole and absolute discretion, may reduce Physician Group's Capitation Payments to recoup additional administrative costs for the assumption of the claims processing obligations of Physician Group, as described in this Article III of Attachment D, as well as any amounts, including interest due, on claims unpaid at the assumption of such obligations by CalOptima.

IV. CLAIMS COMPLIANCE

4.1 **Claims Compliance Monitoring**. Physician Group understands that claims compliance programs are required by CalOptima's Regulators and agrees that delegation is contingent upon Physician Group's compliance with required monitoring and oversight activities, as outlined in CalOptima Policies. Physician Group agrees that CalOptima reserves the right to monitor Physician Group's

claims compliance activities, notwithstanding any other audit, compliance, or contractual issue between Physician Group and CalOptima. In the event Physician Group demonstrates an inability to meet CalOptima's claims payment standards, CalOptima reserves the right to revoke and assume the delegated responsibilities described above.

4.2 **Claims Non-Compliance**. In the event that CalOptima determines that Physician Group is not in ninety-five percent (95%) compliance with any of the requirements of Attachment D the following actions will be applied:

4.2.1 Within thirty (30) days of an audit that documents non-compliance, CalOptima will issue a written warning to Physician Group that describes the non-compliance. Physician Group will respond within fifteen (15) working days of receiving the non-compliance notification with a written CAP to comply. Such CAP will describe the actions to be taken and the schedule by which those actions will be completed. CalOptima will review the CAP and advise Physician Group whether or not actions or time schedules are acceptable within fifteen (15) days of receiving it. CalOptima will conduct a follow-up audit of Physician Group's claims operation within ninety (90) days from the date of serving the non-compliance notification to verify compliance with Attachment D. If CalOptima does not receive a CAP within fifteen (15) calendar days, the consequences outlined in Subsection 4.2.2 of this attachment for continued non-compliance will apply.

4.2.2 If, as a result of CalOptima's follow-up audit, Physician Group is found to still be non-compliant with Attachment D within fifteen (15) calendar days of making that determination, CalOptima will notify Physician Group in writing of the continued non-compliance and may elect to provide consultative or other assistance to help establish, maintain and monitor continued administrative compliance or assume "joint administration" of Physician Group's claims operations, involving itself only with Enrollees' claims and allowing the operation to remain on Physician Group's premises. The Parties agree to meet and develop a mutually agreeable work plan for added staffing and work stations, the cost of which will be Physician Group's sole responsibility. CalOptima will develop a CAP with Physician Group's participation to assure maximum compatibility with Physician Group's ongoing operations. CalOptima will cooperate with Physician Group in implementing changes across all risk claims processed at that site, should Physician Group so request. Within fifteen (15) calendar days of receiving the second notice of non-compliance, Physician Group will provide a written response stating the specific action to be taken to establish compliance with the help of CalOptima. If CalOptima does not receive a CAP within fifteen (15) calendar days, the consequences outlined in Subsection 4.2.3 for continued non-compliance will apply. Within ninety (90) days from the date of serving the second notice of non-compliance, CalOptima will re-audit Physician Group's claims process and documents to determine final compliance or non-compliance.

4.2.3 If, as a result of its second follow-up audit, CalOptima reasonably determines that Physician Group is still non-compliant, CalOptima reserves the right to terminate this Contract for material breach upon ten (10) days' prior written notice and opportunity to cure.

4.2.4 Physician Group may resume sole administrative responsibility for claims processing if CalOptima determines that Physician Group has corrected the deficiencies that caused the non-compliance, and, as a result of resuming responsibility for claims processing,

demonstrates compliance with the timely provider payments requirements set forth in Section 3.1 of this Attachment D.

4.2.5 With respect to the requirements of Attachment D, Physician Group will be subject to regular site-audits conducted by CalOptima to monitor all claims requirements.

V. CLAIMS FORWARDING

Physician Group shall forward any claims that are not its payment responsibility to CalOptima within ten (10) calendar days of receipt.

VI. SELF-MONITORING & REPORTING

Physician Group shall develop, implement and demonstrate upon request, a claims quality assurance process, including regular, scheduled, automated, or manual reports, self-testing procedures, and internal reporting to Physician Group's executive management of timeliness, payment accuracy, and denial accuracy (as required herein). Such self-monitoring and internal reporting shall involve use of industry standard tools and shall measure actual performance against the standards for DMHC and CMS compliance. CalOptima strongly recommends check issuance and mailing occur not less frequently than weekly and that Physician Group's internal reporting intervals match the intervals at which checks are issued, except that weekly reporting would be sufficient if checks are issued more often than weekly. At a point early in the beginning of operations under the Contract and in accordance with industry-wide CMS requirements, CalOptima will require that Physician Group submit monthly reports to CalOptima using the industry-standard Monthly Report of Claims Processing Timeliness and Overall Percent of Denial Accuracy format. Those reports must be received by CalOptima not later than the fifteenth (15th) calendar day of each month.

VII. AUDITS & AUDIT PREPARATION

Article IV, above, provides detailed, specific processes involving claims non-compliance. Even when Physician Group does meet compliance standards and successfully concludes any time periods where denials must be submitted to CalOptima for review, CalOptima will continue to schedule (1) periodic audits, (2) random, focused audits, and (3) focused reviews based on appeals and grievance results to monitor Physician Group's compliance with CMS regulations. Prior to the scheduled arrival of CalOptima's auditor, Physician Group shall retrieve claims and related documents in accordance with instructions provided to Physician Group by CalOptima in its letter confirming the appointment.

VIII. SPECIAL STUDIES

8.1 In the event DMHC and/or CMS requires that CalOptima conduct any special compliance study or effort, Physician Group shall support the study and will be subject to any DMHC and/or CMS specified time schedules or deadlines for corrective actions.

IX. FEDERALLY QUALIFIED HEALTH CENTERS AND RURAL HEALTH CLINICS

9.1 Physician Group shall meet federal requirements for access to FQHC services, including those in 42 U.S.C. § 1396 b(m). Physician Group shall reimburse FQHCs and RHCs in accordance with current Laws. If FQHC and RHCs services are not available in the Provider network, Physician Group shall authorize out-of-network services subject to the prevailing MA payment requirements for out-of-network services.

9.2 Physician Group shall ensure that its payments to FQHCs and RHCs for services to Enrollees are no less than the sum of the level and amount of payment that the Health Network or CalOptima would make for such services if the services had been furnished by an entity providing similar services that was not an FQHC and RHC. The intent of these provisions is to ensure that Physician Group pays FQHCs and RHCs amounts consistent with Medicare managed care policies while preserving the opportunity for FQHCs to separately claim supplemental payments under such policies.

X. INDIAN HEALTH CARE PROVIDERS

10.1 Physician Group shall pay non-network Indian Health Care Providers that are FQHCs for the provision of services to an Indian Enrollee at a rate equal to the rate that Physician Group would pay to a network FQHC that is not an Indian Health Care Provider, including any supplemental payment from the State to make up the difference between the contract amount and what the Indian Health Care Provider would have received FFS.

10.2 When the amount the Participating Provider Indian Health Care Provider receives from the Physician Group is less than the amount the Indian Health Care Providers would receive FFS, the State must make a supplemental payment to the Indian Health Care Provider that the Indian Health Care Provider would receive FFS or the applicable encounter rate.

10.3 Physician Group shall not impose enrollment fees, premiums, or similar charges on Indians served by an Indian Health Care Provider or through referral under contract health services. Physician Group must exempt from all cost-sharing any Indian who is currently receiving or has ever received an item or service furnished by an Indian Health Care Provider or through referral under contract health services.

10.4 Physician Group shall reimburse Indian Health Care Providers promptly who provide Covered Services to Indian Enrollees, who are eligible to receive Covered Services, at the most current and applicable outpatient per-visit rate published in the Federal Register by the Indian Health Service, and Physician Group shall ensure any retroactive outpatient per visit rates are appropriately reimbursed to the Indian Health Care Provider.

ATTACHMENT E
STATUTORY AND REGULATORY COMPLIANCE TERMS

1. **Compliance with State and Federal Laws**. Physician Group acknowledges that CalOptima is subject to certain State and federal laws, regulations, and instructions governing its MA Program. Physician Group shall comply with all Laws and DMHC and CMS administrative bulletins, plan letters and instructions. Physician Group understands that payments made by CalOptima are, in whole or in part, derived from federal funds, and therefore Physician Group and any Downstream Entities are subject to certain laws that are applicable to individuals and entities receiving federal funds, including the following: (i) Title VI of the Civil Rights Act of 1964; (ii) Sections 503 and 504 of the Rehabilitation Act of 1973; (iii) the Age Discrimination Act of 1975; (iv) the Americans with Disabilities Act of 1990; (v) the Vietnam Era Veteran's Readjustment Assistance Act; and (vi) Title IX of the Education Amendments of 1972. Any provision required to be in this Contract by the CMS Contract, the Knox-Keene Act, Title 28 of the California Code of Regulations, Medicare laws and regulations, DMHC or CMS instructions and reporting requirements and other applicable laws, shall bind CalOptima, Physician Group, and Downstream Entities, whether or not specifically set forth in this Contract.

2. **Compliance with CalOptima's Contractual Obligations**. All services and other activities furnished by Physician Group and Downstream Entities must be performed in accordance with CalOptima's contractual obligations to CMS.

3. **Compliance with FWA Requirements**. Physician Group, and its employees, agents and Downstream Entities performing services under this Contract, shall comply with CalOptima's Compliance Program including, its FWA plan. Prior to performing services under this Contract, Physician Group shall complete and submit to CalOptima, any CMS-required training and/or CalOptima-required attestations related to such training and other compliance obligations. Physician Group agrees to comply and will have any Downstream Entity agree to comply with CalOptima standards and policies.

4. **Fraud and Abuse Reporting**. Physician Group shall, in accordance with all Laws, report to CalOptima all cases of suspected fraud and/or abuse relating to the rendering of Covered Services within five (5) days of the date when Physician Group first becomes aware of or is on notice of such activity.

5. **CMS Participation Requirements**. Physician Group represents and warrants that: (i) neither Physician Group nor any of its Group Physician, employees or agents furnishing services under this Contract are excluded from participating in any federal or state healthcare program as defined in 42 U.S.C. Section 1320a-7b(f) ("**Federal Health Care Program(s)**"); (ii) Physician Group has not arranged or contracted (by employment or otherwise) with any employee, contractor or agent that Physician Group knows or should know are excluded or precluded from participation in Federal Health Care Programs; (iii) no action is pending against Physician Group or any of its Group Physicians, employees, or agents performing services under this Contract to suspend or exclude such persons or entities from participation in any Federal Health Care Program; and (iv) Physician Group will immediately notify CalOptima if it learns that it is or has employed or contracted with a person or entity that is excluded from participation in any Federal Health Care Program. If Physician Group fails to comply with this Section 5 of this attachment, CalOptima reserves the right to require Physician Group to pay immediately to CalOptima the amount of any sanctions or other penalties that may be imposed on CalOptima by CMS for violation of this prohibition, and Physician Group shall be responsible for any resulting overpayments. Physician Group shall not make payment for a healthcare item or service furnished by an individual or entity

that is excluded by the Office of the Inspector General or is included on the Preclusion List. Physician Group shall provide written notice to the Enrollee who received the services and the excluded Provider or Provider listed on the Preclusion List that payment will not be made, in accordance with CMS requirements. Physician Group shall ensure that all Participating Providers that provide Covered Services do not appear on the CMS Preclusion List in order to receive reimbursement for claims or otherwise participate in the Medicare program.

6. **Confidentiality of Enrollee Information**. Physician Group, its Downstream Entities, and their employees and agents shall comply with the specific confidentiality obligations set forth below.

6.1 Physician Group, Downstream Entities, and their employees and agents 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 them as a result of services performed under this Contract, except for statistical information not identifying any such person. Physician Group, Downstream Entities, and their employees and agents shall not use such identifying information for any purpose other than carrying out Physician Group's obligations under this Contract.

6.2 Physician Group, Downstream Entities, and their employees and agents shall promptly transmit to CalOptima all requests for disclosure of such identifying information not emanating from the Enrollee. Physician Group shall not disclose, except as otherwise specifically permitted by this Contract or authorized by the Enrollee, any such identifying information to anyone other than CMS, DMHC, 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.

6.3 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*., Welfare and Institutions Code Section 14100.2, and regulations adopted thereunder. For the purpose of this Contract, all information, records, data, and data elements collected and maintained for the operation of the Contract and pertaining to Enrollees shall be protected by Physician Group from unauthorized disclosure. Physician Group may release Medical Records in accordance with Laws pertaining to the release of this type of information. Physician Group is not required to report requests for Medical Records made in accordance with Laws.

6.4 With respect to any identifiable information concerning an Enrollee under this Contract that is obtained by Physician Group or its Downstream Entities from CalOptima's Regulators, Physician Group will, at the termination of this Contract, return all such information to CalOptima's Regulators if required by them, or maintain such information according to written procedures provided to Physician Group by CalOptima and/or CalOptima's Regulators for this purpose.

7. **Offshore Subcontracts**. Physician Group shall provide, and ensure that Downstream Entities provide, to CalOptima information and attestations related to the provision of any services under this Contract in a country other than the United States ("**Offshore Subcontractor**") to enable CalOptima to comply with CMS reporting obligations. Such information shall be submitted to CalOptima prior to engaging any Offshore Subcontractor for purposes of this Contract, and such Offshore Subcontractors are subject to approval by CalOptima.

8. **Required Disclosures**. In accordance with 42 CFR Section 1002.3, Physician Group shall immediately notify CalOptima in the event any sanctioned person (as defined in 42 CFR Section 1001.1001(a)(1)) owns or controls Physician Group.

9. **Equal Opportunity**. Physician Group and Downstream Entities shall comply with the following Equal Opportunity requirements set forth below.

9.1 Physician Group and its Downstream Entities 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. Physician Group and its Downstream Entities will take affirmative action to ensure that qualified applicants are employed, and that employees are treated during employment, without regard to their race, color, religion, sex, national origin, physical or mental handicap, disability, age, or status as a disabled veteran or veteran of the Vietnam era. Such action shall include the following: Employment, upgrading, demotion or transfer; recruitment or recruitment advertising; layoff or termination; rates of pay or other forms of compensation; and career development opportunities and selection for training, including apprenticeship. Physician and its Downstream Entities agree to post in conspicuous places, available to employees and applicants for employment, notices to be provided by the federal government, 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 Physician Group and its Downstream Entities' 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.

9.2 Physician Group and its Downstream Entities will, in all solicitations or advancements for employees placed by or on behalf of Physician Group and its Downstream Entities, 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.

9.3 Physician Group and its Downstream Entities will send to each labor union or representative of workers with which it has a collective bargaining agreement or other contract or understanding a notice, to be provided by the federal government or the State, advising the labor union or workers' representative of Physician Group and its Downstream Entities' commitments under the provisions herein and shall post copies of the notice in conspicuous places available to employees and applicants for employment.

9.4 Physician Group and its Downstream Entities 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.

9.5 Physician Group and its Downstream Entities 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 Physician Group 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.

9.6 In the event of Physician Group and its Downstream Entities' noncompliance with the requirements of the provisions herein or with any federal rules, regulations, or orders which are referenced in this Article IX, this Contract may be cancelled, terminated, or suspended in whole or in part, and Physician Group and its Downstream Entities may be declared ineligible for further State and Federal 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.

9.7 Physician Group and its Downstream Entities will include the provisions of Sections 10.1 through 10.7 of this attachment 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. Section 4212) of the Vietnam Era Veteran's Readjustment Assistance Act, so that such provisions will be binding upon each Downstream Entity. Physician and its Downstream Entities will take such action with respect to any subcontract or purchase order as the Director of the Office of Federal Contract Compliance Programs or CMS may direct as a means of enforcing such provisions, including sanctions for noncompliance; provided, however, that in the event Physician Group and/or its Downstream Entities become involved in, or are threatened with litigation by a other Downstream Entity or vendor as a result of such direction by CMS, Physician Group and its Downstream Entities may request in writing to CMS, 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.

10. **Non-Discrimination**. Physician Group and Downstream Entities shall comply with the non-discrimination requirements set forth below.

10.1 During the performance of this Contract, neither Physician Group nor any Downstream Entities shall unlawfully discriminate, harass, or allow harassment against any employee or applicant for employment because of sex, race, religion, color, national origin, ancestry, religious creed, physical disability, (including Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS), AIDS-Related Complex (ARC)), medical condition (including cancer), mental disability, marital status, age (over 40), or the

use of family and medical care leave and pregnancy disability leave. Physician Group and Downstream Entities shall insure that the evaluation and treatment of their employees and applicants for employment are free of such discrimination and harassment. Physician Group and Downstream Entities shall comply with the provisions of the Fair Employment and Housing Act (Government Code, Section 12900, *et seq*.) and the applicable regulations promulgated thereunder (Title 2 CCR Section 7285.0, *et seq*.). The applicable regulations of the Fair Employment and Housing Commission implementing Government Code, Section 12990, set forth in Chapter 5 of Division 4 of Title 2 of the CCR are incorporated into this Contract by reference and made a part hereof as if set forth in full. Physician Group and Downstream Entities shall give written notice of their obligations under this clause to labor organizations with which they have a collective bargaining or other agreement. Physician Group shall include the non-discrimination and compliance provisions of this Section 10.1 in all Downstream Entity subcontracts to perform work under this Contract.

10.2 Physician Group and all Downstream Entities shall abide by 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 1972 (regarding education programs and activities); Title 45 CFR Part 91 and the Age Discrimination Act of 1975 (discrimination based on age); and all other laws regarding privacy and confidentiality. Neither the Physician nor Downstream Entities shall discriminate against Enrollees because of race, color, creed, religion, ancestry, marital status, sexual orientation, national origin, age, sex, or physical or mental handicap in accordance with Title VI of the Civil Rights Act of 1964, 42 U.S.C., Section 2000d (race, color, national origin); 45 CFR Part 84 (physical or mental handicap); Government Code Section 11135 (ethnic group identification, religion, age, sex, color, physical or mental handicap); Civil Code Section 51 (all types of arbitrary discrimination); rules and regulations promulgated pursuant thereto, or as otherwise provided by Laws.

10.3 For the purpose of this Contract, if based on any of the foregoing criteria, the following constitute unlawful discriminations: (i) denying any Enrollee any Covered Services or availability of a facility; (ii) providing to an Enrollee any Covered Service that is different or is provided in a different manner or at a different time from that provided to other similarly situated Enrollees under this Contract, except where medically indicated; (iii) subjecting an Enrollee to segregation or separate treatment in any manner related to the receipt of any Covered Service; (iv) restricting an Enrollee in any way in the enjoyment of any advantage or privilege enjoyed by others receiving any Covered Service; or (v) treating an Enrollee differently from others similarly situated in determining compliance with admission, enrollment, quota, eligibility, or other requirements or conditions that individuals shall meet in order to be provided any Covered Service or assigning the times or places for the provision of Covered Services.

10.4 Physician Group shall take affirmative action to ensure that all Enrollees are provided Covered Services without unlawful discrimination, except where medically indicated. For the purposes of this Section 10.4, physical handicap includes the carrying of a gene that may, under some circumstances, be associated with disability in that person's offspring, but which causes no adverse effects on the carrier. Such genetic handicap shall include,

but not be limited to, Tay-Sachs trait, sickle cell trait, thalassemia trait, and X-linked hemophilia.

10.5 Physician shall act upon all complaints alleging discrimination against Enrollees in accordance with CalOptima's Policies and shall forward copies of all such grievances to CalOptima within five (5) days of receipt of same.

11. **Smoke Free Workplace**. Public Law 103-227, also known as the Pro Children Act of 1994 ("**Pro Children Act**"), requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health, day care, early childhood development services, education, or library services to children under the age of 18, if the services are funded by federal programs either directly or through state or local governments, by federal grant, contract, loan, or loan guarantee. The law also applies to children's services that are provided in indoor facilities that are constructed, operated, or maintained with such federal funds. The law does not apply to children's services provided in private residences; portions of facilities used for inpatient drug or alcohol treatment; service providers whose sole source of applicable federal funds is Medicare or Medicaid; or facilities where WIC coupons are redeemed. Failure to comply with the provisions of the law may result in the imposition of a civil monetary penalty of up to $1,000 for each violation and/or the imposition of an administrative compliance order on the responsible party. By signing this Contract, Physician Group certifies that it will comply with the requirements of the Pro Children Act and will not allow smoking within any portion of any indoor facility used for the provision of services for children as defined by the Pro Children Act. Physician further agrees that it will insert this certification into any subcontracts entered into that provide for children's services as described in the Pro Children Act.

12. **Air or Water Pollution Requirements**. Any federally funded agreement and/or subcontract in excess of $100,000 must comply with the following provisions unless said agreement is exempt under 40 CFR 15.5. Physician Group 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.

13. **Lobbying Restrictions and Disclosure Certification**. Any federally funded contracts in excess of $100,000 per Section 1352 of the 31, U.S.C. must comply with the following lobby restrictions and disclosures.

13.1 Each person (or recipient) who requests or receives a contract, subcontract, grant, or sub-grant, which is subject to 31 U.S.C. Section 1352 and which exceeds $100,000 at any tier, shall file a certification (in the form set forth in **Attachment E-1**, consisting of one page, entitled "Certification Regarding Lobbying") that the recipient has not made, and will not make, any payment prohibited by Subsection 13.6 of this attachment.

13.2 Each recipient shall file a disclosure (in the form set forth in **Attachment E-2**, entitled "Standard Form-LLL 'Disclosure of Lobbying Activities'") if such recipient has made or has agreed to make any payment using non-appropriated 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 Section 13.6 of this attachment if paid for with appropriated funds.

13.3 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 Section

13.2 of this attachment. An event that materially affects the accuracy of the information reported includes: (i) 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; (ii) a change in the person(s) or individuals(s) influencing or attempting to influence a covered federal action; or (iii) 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.

13.4 Each person (or recipient) who requests or receives, from a person referred to in Section 13.1 of this attachment, a contract, subcontract, grant or sub-grant 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.

13.5 All disclosure forms (but not certifications) shall be forwarded from tier to tier until received by the person referred to in Section 13.1 of this attachment.

13.6 31 U.S.C. Section 1352 provides in part that no appropriated funds may be expended by the recipient of a federal contract, grant, loan, or cooperative agreement to pay any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with any of the following covered federal actions: the awarding of any federal contract, the making of any federal grant, the making of any federal loan, entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any federal contract, grant, loan, or cooperative agreement.

14. **Debarment Certification**. Physician Group agrees to comply with applicable Federal suspension and debarment regulations including 7 CFR § 3017, 45 CFR §76, 40 CFR § 32, or 34 CFR § 85.

14.1 Physician Group certifies to the best of its knowledge and belief, that it and its principals:

(i) Are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded by any Federal department or agency;

(ii) Have not within a three (3)-year period preceding this Contract have been convicted of or had a civil judgment rendered against them for commission of fraud or a criminal offense in connection with obtaining, attempting to obtain, or performing a public (Federal, State or local) transaction or contract under a public transaction; violation of Federal or State antitrust statutes or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, or receiving stolen property;

(iii) Are not presently indicted for or otherwise criminally or civilly charged by a governmental entity (federal, State or local) with commission of any of the offenses enumerated in sub-provision (ii) herein;

(iv) Have not within a three (3)-year period preceding this Contract had one or more public transactions (Federal, State or local) terminated for cause or default;

(v) Shall not knowingly enter into any lower tier covered transaction with a person who is proposed for debarment under Federal regulations (i.e., 48 CFR 9, subpart 9.4), debarred, suspended, declared ineligible, or voluntarily excluded from participation in such transaction, unless authorized by the State; and

(vi) Will include a clause entitled, "Debarment and Suspension Certification'' that essentially sets forth the provisions herein, in all lower tier covered transactions and in all solicitations for lower tier covered transactions.

14.2 If Physician Group is unable to certify to any of the statements in this certification, the Physician shall submit an explanation to CalOptima.

14.3 The terms and definitions in this Section 14 have the meanings set out in the Definitions and Coverage sections of the rules implementing Federal Executive Order 12549.

14.4 If Physician Group knowingly violates this certification, in addition to other remedies available to the federal government, CalOptima may terminate this Contract for cause or default.

15. **Downstream Entity Contracts**. If any services under this Contract are to be provided by a Downstream Entity subcontracted by Physician Group, Physician Group shall ensure that such subcontracts comply with 42 CFR Sections 422.504, 423.505 and 438.6(l). Such subcontracts shall include all language required by CMS as provided in Attachment F**.**

16. **Other Statutory and Compliance Terms**. Physician Group shall not contract with, or otherwise pay for any items or services (other than an emergency item or service, not including items or services furnished in an emergency room of a hospital):

16.1 Furnished by Physician Group by any individual or entity during any period when the individual or entity is excluded from participation under Titles V, XVIII, or XX, or under Title XIX pursuant to sections 1128, 1128A, 1156 or 1842(j)(2);

16.2 Furnished at the medical direction or the prescription of a physician, during the period when such physician is excluded from participation under Titles V, XVIII, or XX, or under Title XIX pursuant to sections 1128, 1128A, 1156, or 1842(j)(2) and when the person furnishing such item or service knew, or had some reason to know, of the exclusion (after a reasonable time period and after reasonable notice has been furnished to the person);

16.3 Furnished by an individual or entity to whom the State has suspended payments to during any period when there is a pending investigation of a credible allegation of fraud against the individual or entity, unless the State determines there is good cause not to suspend such payments;

16.4 Physician Group may not pay for an item or service with respect to any amount expended for which funds may not be used under the Assisted Suicide Funding Restriction Act of 1997

ATTACHMENT E-1
CERTIFICATION REGARDING LOBBYING

STATE OF CALIFORNIA
DEPARTMENT OF HEALTH CARE SERVICES
CERTIFICATIN 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 Physician Group Group	Printed Name of Person Signing for Physician
Contract / Grant Number	Signature of Person Signing for Physician Group
Date	Title

After execution by or on behalf of Physician Group, please return to:

CalOptima
Attn: Regulatory Affairs
505 City Parkway West
Orange, California 92868

ATTACHMENT E-2

CERTIFICATION REGARDING LOBBYING

Approved by OMB

Complete this form to disclose lobbying activities pursuant to 31 U.S.C. 1352
0348-0046 (See reverse for public burden disclosure)

<table>
<tr><td>1. Type of Federal Action:
contract
grant
cooperative agreement loan
loan guarantee
loan insurance</td><td>2. Status of Federal Action:
bid/offer/application initial
award post-award</td><td>3. Report Type:
initial filing
material change

For Material Change Only:
Year _____ quarter_____
date of last report</td></tr>
<tr><td colspan="2">4. Name and Address of Reporting Entity:
Prime Subawardee Tier, if known:</td><td rowspan="2">5. If Reporting Entity in No. 4 is Subawardee, Enter Name and Address of Prime:

Congressional District, If known:</td></tr>
<tr><td colspan="2">Congressional District, If known:</td></tr>
<tr><td colspan="2">6. Federal Department/Agency:</td><td>Federal Program Name/Description:
CDFA Number, if applicable:</td></tr>
<tr><td colspan="2">8. Federal Action Number, if known:</td><td>9. Award Amount, if known:</td></tr>
<tr><td colspan="2">10. a. Name and Address of Lobbying Entity
(If individual, last name, first name, MI):
(attach Continuation Sheets(s)</td><td>b. Name and Address of Lobbying Entity
(If individual, last name, first name, MI):
SF-LLL-A, If necessary)</td></tr>
<tr><td colspan="2">Amount of Payment (check all that apply):
$ actual planned</td><td rowspan="3">13. Type of Payment (check all that apply):
a. retainer
b. one-time fee
c. commission
d. contingent fee
e. deferred
f. other, specify:</td></tr>
<tr><td colspan="2">Form of Payment (check all that apply):
a. cash
b. in-kind, specify: Nature</td></tr>
<tr><td colspan="2">Value</td></tr>
</table>

14. Brief Description of Services Performed or to be Performed and Dates(s) of Service, including Officer(s), Employee(s), or Member(s) Contracted for Payment indicated in item 11: (Attach Continuation Sheet(s) SF-LLL-A, If necessary)	
15. Continuation Sheet(s) SF-LLL-A Attached: Yes No	
16. Information requested through this form is authorized by Title 31, U.S.C., Section 1352. This disclosure of lobbying activities is a material representation of fact upon which reliance was placed by the tier above when this transaction was made or entered into. This disclosure is required pursuant to Title 31, U.S.C., Section 1352. This information will be reported to the Congress semiannually and will be available for public inspection. Any person who fails to file the required disclosure shall be subject to a civil penalty of not less than $19,000 and not more than $100,000 for each such failure.	Signature: Print Name: Title: Telephone No.: Date:
Federal Use Only	

INSTRUCTIONS FOR COMPLETION OF SF-LLL, DISCLOSURE OF LOBBYING ACTIVITIES

This disclosure form shall be completed by the reporting entity, whether subawardee or prime federal recipients at the initiation or receipt of a covered federal action, or a material change to a previous filing, pursuant to Title 31, U.S.C., Section 1352. The filing of a form is required for each payment or agreement to make payment to any lobbying entity for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with a covered federal action. Use the SF-LLL-A Continuation Sheet for additional information if the space on the form is inadequate. Complete all items that apply for both the initial filing and material change report. Refer to the implementing guidance published by the Office of Management and Budget for additional information.

Identify the type of covered federal action for which lobbying activity is and/or has been secured to influence the outcome of a covered federal action.

Identify the status of the covered federal action.

Identify the appropriate classification of this report. If this is a follow-up report caused by a material change to the information previously reported, enter the year and quarter in which the change occurred. Enter the date of the last previously submitted report by this reporting entity for this covered federal action.

Enter the full name, address, city, state, and ZIP code of the reporting entity. Include Congressional District, if known. Check the appropriate classification of the reporting entity that designates if it is, or expects to be, a prime or subaward recipient. Identify the tier of the subawardee, e.g., the first subawardee of the prime is the 1st tier. Subawards include but are not limited to subcontracts, subgrants, and contract awards under grants.

If the organization filing the report in Item 4 checks "Subawardee," then enter the full name, address, city, state, and ZIP code of the prime federal recipient. Include Congressional District, if known.

Enter the name of the federal agency making the award or loan commitment. Include at least one organizational level below agency name, if known. For example, Department of Transportation United States Coast Guard.

Enter the federal program name or description for the covered federal action (Item 1). If known, enter the full Catalog of Federal Domestic Assistance (CDFA) number for grants, cooperative agreements, loans, and loan commitments.

Enter the most appropriate federal identifying number available for the federal action identified in Item 1 (e.g., Request for Proposal (RFP) number; Invitation for Bid (IFB) number; grant announcement number; the contract grant, or loan award number; the application/proposal control number assigned by the federal agency). Include prefixes, e.g., "RFP-DE-90401."

For a covered federal action where there has been an award or loan commitment by the federal agency, enter the federal amount of the award/loan commitment for the prime entity identified in Item 4 or 5.

10. (a) Enter the full name, address, city, state, and ZIP code of the lobbying entity engaged by the reporting entity identified in Item 4 to influence the covered federal action.

10. (b) Enter the full names of the Individual(s) performing services and include full address if different from 10.(a). Enter last name, first name, and middle initial (MI).

Enter the amount of compensation paid or reasonably expected to be paid by the reporting entity (Item 4) to the lobbying entity (Item 10). Indicate whether the payment has been made (actual) or will be made (planned). Check all boxes that apply. If this is a material change report, enter the cumulative amount of payment made or planned to be made.

Check the appropriate box(es). Check all boxes that apply. If payment is made through an in-kind contribution, specify the nature and value of the in-kind payment.

Check the appropriate box(es). Check all boxes that apply. If other, specify nature.

Provide a specific and detailed description of the services that the lobbyist has performed, or will be expected to perform, and the date(s) of any services rendered. Include all preparatory and related activity, not just time spent in actual contact with federal officials, identify the federal official(s) or employee(s) contacted or the officer(s), employee(s), or Member(s) of Congress that were contacted.

Check whether or not a SF-LLL-A Continuation Sheet(s) is attached.

The certifying official shall sign and date the form, print his/her name, title, and telephone number.

Public reporting burden for this collection of information is estimated to average 30 minutes per response, including time for reviewing instruction, searching existing data sources, gathering and maintaining the data needed, and completing and renewing the collection of information. Send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to the Office of Management and Budget, Paperwork Reduction Project, (0348-0046), Washington, DC 20503.

ATTACHMENT F
SUBCONTRACT REGULATORY TERMS

A. **General Terms**: Language addressing the following matters shall be included in Downstream subcontracts:

1. The right of CalOptima's Regulators to monitor, audit, evaluate, inspect and have access to books, records and other information as provided in this Contract.
2. CalOptima's Regulators' right to inspect, evaluate, and audit any pertinent information related to the Contract for a period of ten (10) years from the final date of the contract period or from the date of completion of any audit as provided in this Contract.
3. Prohibitions against holding Enrollees liable for payment of any fees that are the obligation of CalOptima or the Physician Group, as applicable.
4. The services are in accordance with CalOptima's obligations to CMS and applicable CalOptima Policies.
5. The obligations of Downstream Entities to protect Enrollee privacy and confidentiality including health records, as provided in this Contract.
6. The obligation to comply with all federal and state laws, regulations and CMS instructions, including those laws that must be incorporated into such Downstream subcontracts as indicated in this Contract.
7. Language related to the obligations to submit timely and accurate Encounter Data and other data and reports required by CalOptima and CalOptima's Regulators as provided in this Contract and in CalOptima's Policies.
8. All requirements included in Attachment E not expressly addressed herein.

B. **Delegation Terms**. If, and to the extent that sub-delegation is permitted by CalOptima and Physician Group obtains CalOptima's approval as provided in this Contract, Downstream Entity subcontracts must include:

1. Language that specifies (i) the delegated activities and reporting requirements; (ii) that provides for revocation of the delegated activities and other remedies in the event CalOptima or CalOptima's Regulators find that the delegated party as not performed satisfactorily; (iii) that the performance of the parties is monitored by CalOptima on an ongoing basis; and (iv) that CalOptima may impose corrective action as necessary.
2. If the subcontract relates to credentialing of medical providers, language that the credentials of medical professionals affiliated with the party or parties will either be reviewed by CalOptima or the credential process will be reviewed and approved by CalOptima and that CalOptima must audit the process on an ongoing basis.
3. If the subcontract delegates selection of providers it must include language that CalOptima retains the right to approve, suspend or terminate any such arrangement and that CalOptima shall provide a written statement to a provider of the reason or reasons for the termination with cause.

C. **Medical Provider Downstream Subcontract Terms**.

All subcontracts or arrangements with medical providers shall include provisions addressing:

1. The term of the contract, including the beginning and ending dates as well as methods of extension, renegotiation and termination and full disclosure of the method and amount of compensation or other consideration.

2. The obligation to pay contracted medical providers under the terms of the contract and prompt payment provision, the terms of which are developed and agreed to by the parties.

3. The obligations to provide services in a culturally competent manner to all Enrollees, including those with limited English proficiency or reading skills, and diverse culturally and ethnic background and provide interpreter services for Enrollees at all provider sites.

4. The obligation to (i) abide by all federal and state laws and regulations regarding confidentiality and disclosure of medical records, or other health and enrollment information; (ii) to ensure that medical information is released in accordance with applicable federal or state law, or pursuant to court orders or subpoenas; (iii) to maintain Enrollee records and information in an accurate and timely manner; and (iv) to ensure timely access by Enrollees to the records and information that pertain to them.

5. The obligation to hold CalOptima, CalOptima's Regulators and Enrollees harmless in the event that Physician Group cannot or will not pay for services performed by the Downstream Entity and for Medicare Part A and B cost sharing. Specifically, Medicare Parts A and B services must be provided at zero cost-sharing to Enrollees.

6. Medical providers' EMTALA obligations and that they must not create any conflicts with hospital actions required to comply with EMTALA.

7. Language prohibiting providers, including PCPs, from closing or otherwise limiting their acceptance of Enrollees as patients unless the same limitations apply to all commercially insured Enrollees.

8. Language that prohibits the Downstream Entity from refusing to contract or pay an otherwise eligible health care Provider for the provision of Covered Services solely because such Provider has in good faith: (a) Communicated with or advocated on behalf of one or more of his or her prospective, current or former patients regarding the provisions, terms or requirements of the 'Downstream Entity's health benefit plans as they relate to the needs of such Provider's patients; or (b) communicated with one or more of his or her prospective, current or former patients with respect to the method by which such Provider is compensated by the Downstream Entity for services provided to the patient.

9. Language that states the Provider is not required to indemnify the Physician Group for any expenses and liabilities, including judgments, settlements, attorneys' fees, court costs and any associated charges, incurred in connection with any claim or action brought against the Physician Group based on its management decisions, utilization review provisions or other policies, guidelines or actions.

10. The obligation of the medical provider to assist CalOptima in the transfer of care, including in the transfer of care in the event of sub-subcontract termination for any reason.

11. Acknowledgement that assignment or delegation of the subcontract will be void unless prior written approval is obtained from CMS and CalOptima.

12. 'The Provider's right to submit a grievance and a description of the formal process to resolve the Provider's grievances.

13. The obligation to participate and cooperate in Physician Group's Quality Improvement System.

14. Language addressing requirements related to payment of Non-Participating Provider

emergency and post-stabilization services.

ATTACHMENT G
CMS SPECIFIC PROGRAM PERFORMANCE REQUIREMENTS

1. HCC Coding Requirements and Performance Improvement Activities

1.1 CMS pays CalOptima health-based capitation to compensate CalOptima for services rendered to Enrollees. CMS utilizes encounter data to assign Hierarchical Condition Categories ("**HCC**") to Enrollees. The Enrollee's HCC determines the payment amount received by CalOptima accounting for the variation in expenditures for Medicare Enrollees based on an Enrollee's health status.

1.2 Physician Group shall submit Enrollee-specific accurate encounter and service data. Encounters are to be submitted no less than monthly using the ANSI 837P and/or 837I format version 5010 as appropriate, or current format as required by CalOptima.

1.3 Physician Group shall support and aid CalOptima's review of encounters, including to production and/or access of supporting medical records.

1.4 To enhance encounter submission accuracy and completeness, CalOptima has initiated performance improvement activities ("**PIAs**"). These PIAs include Enrollee medical and behavioral health assessments provided in the home or a residential facility.

1.5 Physician Group has the option to perform these PIAs provided Physician Group can demonstrate that Physician Group's PIAs meet all CalOptima standards and guidelines. Should Physician Group not perform the PIAs or Physician Group's PIAs not meet CalOptima standards and guidelines as determined by CalOptima, CalOptima shall perform these activities on behalf of Physician Group and the cost for these PIAs shall be charged to or shared with Physician Group. CalOptima will provide sixty (60) days' notification prior to taking any such action.

2. ESRD Waiver Responsibilities

2.1 Physician Group shall demonstrate to CalOptima that Physician Group administers a CalOptima-approved complex case management program for all End Stage Renal Disease (ESRD) Enrollees, which is in accordance with CMS requirements and CalOptima Policies and standards.

2.2 CalOptima shall advise Physician Group if its ESRD complex case management program does not meet CMS requirements and CalOptima Policies and clinical standards. If Physician Group cannot meet requirements as provided by CalOptima, CalOptima shall have the option to de-delegate the Physician Group for the management of ESRD Enrollees and retain a portion of the Capitation Payment for ESRD Enrollees commensurate with the costs for providing or outsourcing such services.

2.3 CalOptima shall provide notification to Physician Group of the intent to de-delegate. Physician Group shall have the opportunity to submit a corrective action plan to CalOptima in accordance with CalOptima policy.

3. Appeals Rights

Physician Group may appeal CalOptima's decision to take the actions outlined above, by filing a complaint pursuant to CalOptima Policies. If Physician Group is dissatisfied with the result of any appeal; it shall proceed in accordance with CalOptima's legal claims and judicial review policy.

MEDICARE ADVANTAGE – HOSPITAL SERVICES CONTRACT

BETWEEN

ORANGE COUNTY HEALTH AUTHORITY DBA CALOPTIMA

AND

_____

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MEDICARE ADVANTAGE HOSPITAL SERVICES CONTRACT

This Medicare Advantage Hospital Services Contract ("**Contract**") is January 1, 2023 ("**Effective Date**") by and between Orange County Health Authority, a public agency dba CalOptima ("**CalOptima**"), and _____ ("**Hospital**"), a California corporation organized under the laws of the State of California. CalOptima and Hospital may each be referred to herein as a "**Party**" and collectively as the "**Parties**".

RECITALS

A. CalOptima is a County Organized Health System ("**COHS**") organized under Welfare & Institutions Section 14087.54 and Orange County Ordinance No. 3896.

B. CalOptima is licensed as a health care service plan by the California Department of Managed Health Care ("**DMHC**") under the Knox-Keene Health Care Service Plan Act of 1975 and its implementing regulations (collectively the "**Knox-Keene Act**") and authorized to offer a Medicare Advantage ("**MA**") plan pursuant to Title 42 of the United States Code, Chapter 7, Subchapter XVIII, Part C and its implementing regulations for individuals covered under the federal Medicare program.

C. CalOptima, as a dual–eligible special needs plan ("**DSNP**"), may only enroll those dual eligible individuals who meet all applicable Medicare Advantage eligibility requirements, and who are eligible to be enrolled in CalOptima's Medi-Cal Managed Care plan, as described in the contract between CalOptima and the California Department of Health Care Services ("**DHCS**").

D. Hospital is a licensed and experienced in providing hospital services to Medicare beneficiaries.

E. Hospital and the physician groups set forth in Addendum 1 ("**Physician Group**") have affiliated to operate as a physician-hospital consortium ("**PHC**"), which is an arrangement under which Hospital and Physician Group each participate in a risk pool for Covered Services provided to Enrollees as detailed in Section 2.7, for the purpose of providing or arranging for the provision of Covered Services to Enrollees under this Contract and Physician Group's contract with CalOptima ("**Physician Group Contract**"). Hospital and Physician Group may collectively be referred to herein as "**PHC Participants**".

F. Hospital recognizes that in order to comply with the requirements of this Contract, Hospital and Physician Group must operate in a manner that is mutually beneficial to both entities affiliated to operate as a PHC. Accordingly, Hospital agrees under this Contract and Physician Group has agreed under the Physician Contract to collectively and individually coordinate and cooperate with each other and with CalOptima in arranging for and providing Covered Services to Enrollees.

G. CalOptima and Hospital desire to enter into the Contract whereby Hospital will perform delegated administrative services and furnish health care items and services as described herein to certain Enrollees enrolled in CalOptima's MA plan.

F. Unless defined elsewhere in the Contract, the defined terms used in this Contract shall have the meanings set forth in Attachment A.

NOW, THEREFORE, in consideration of the promises and the mutual covenants herein stated, it is agreed by and between the Parties as follows:

I. HOSPITAL SERVICE OBLIGATIONS

1.1 **Covered Services**. Hospital shall provide Covered Services to Enrollees selecting, and assigned to, Hospital in accordance with all provisions of this Contract and CalOptima Policies. The Covered Services that are to be provided by and are the financial responsibility of Hospital are described in Attachment B. Hospital specifically agrees to accept financial risk and responsibility for injectables pursuant to Health & Safety Code Section 1375.8.

1.1.1 Hospital shall provide Covered Services: (i) in the same manner, in accordance with the same standards, and within the same time availability as offered to non-CalOptima patients; (ii) in accordance with professionally recognized standards of practice, (iii) in a culturally competent manner to all Enrollees, including those with limited English proficiency or reading skills and from diverse cultural and ethnic backgrounds; and (iv) not discriminate in the provision of such Covered Services because of an Enrollee's race, ethnicity, color, national origin, religion, sex, sexual orientation, age, medical or claims history, mental or physical disability, genetic information, or source of payment.

1.1.2 Hospital is prohibited from closing or otherwise limiting its acceptance of Enrollees as patients unless the same limitations apply to all of its commercially insured patients.

1.1.3 Hospital shall use its best efforts, where consistent with sound medical practice, to ensure that Covered Services are provided only by Participating Providers, except in cases of Emergency Services or Urgent Care Services, or if no such Participating Provider is available to perform the appropriate Covered Services.

1.1.4 Hospital shall be liable for the provision and payment of all Covered Services notwithstanding a delay in payment of the Capitation Payment.

1.1.5 Hospital acknowledges that the determination of whether a service or supply was/is a Covered Service delegated to Hospital rests with CalOptima, subject to the Evidence of Coverage and Appeals procedures established by the DMHC and CMS.

1.1.6 CalOptima may incorporate any change in Covered Services mandated by Laws into the Contract effective the date the change goes into effect. Whenever possible, CalOptima shall give the Hospital thirty (30) calendar days' prior notice of any such change to the Contract. CalOptima shall determine the effective date of the change in Covered Services. Attachment B shall not be amended during the current Term without mutual consent of the Parties, except as may be required for continued compliance with Laws.

1.1.7 Decisions concerning whether to provide or authorize Covered Services under this Contract shall be based solely on Medical Necessity. Hospital shall not deny Authorization for a Covered Service that the Enrollee or the Provider demonstrates is Medically Necessary. The actual provision of any Covered Service is subject to the professional judgment of the PCP or other physicians and/or Providers participating with Hospital as to the Medical Necessity of the Covered Service, except that each Physician shall provide assessment and evaluation services ordered by a court or legal mandate. Hospital acknowledges that disputes between the Hospital and Enrollees about Medical Necessity can be appealed pursuant to CalOptima Policies and Laws.

1.1.8 Hospital may not arbitrarily deny or reduce the amount, duration, or scope of a required Covered Service solely because of the diagnosis, type of illness, or condition. Hospital may place appropriate limits on a service on the basis of criteria such as Medical Necessity or for utilization control, provided the services furnished can reasonably be expected to achieve their purpose and such a limitation complies with Laws.

1.2 **Confidentiality**. Hospital and CalOptima agree to safeguard the confidentiality of Enrollee information and comply with all Laws (including, but limited to, the Health Insurance Portability and Accountability Act ("HIPAA"), 42 CFR Section 431.300 *et seq*., California Welfare and Institutions Code Section 14100.2, California Civil Code Section 56 *et seq.*, and the California Information Practices Act, Civil Code Section 1798) regarding the confidentiality and disclosure of Enrollee names, health, enrollment and personal information (including medical and Behavioral Health information contained in Medical Records). Hospital shall provide counseling to Enrollees on their right to confidentiality and obtain Enrollee consent prior to releasing confidential information unless such consent is not required pursuant to Title 22 CCR Section 51009.

1.3 **Emergency Services and Urgent Care**. Hospital shall insure that it provides and pays for all Emergency Services and Urgent Care, including those services provided by Non-Participating Providers, without prior Authorization, twenty-four (24) hours each day, seven (7) days a week, in accordance with Laws and CalOptima Policies. Hospital shall coordinate access to Emergency Services in accordance with CalOptima's emergency department protocol. Hospital shall ensure adequate follow-up care for those Enrollees who have been screened in the emergency room and require non-Emergency Services. Hospital may not specify what constitutes an Emergency Medical Condition on the basis of lists of diagnoses or symptoms.

1.4 **Clinical Laboratory Improvement Amendments**. Hospital shall only use laboratories with a Clinical Laboratory Improvement Amendments ("**CLIA**") certificate of waiver or a certificate of registration along with a CLIA identification number.

1.5 **CalOptima Formulary Compliance**. Participating Providers shall comply with the CalOptima Formulary and its associated drug utilization and disease management guidelines and protocols. Requests for items not included in the CalOptima Formulary shall require prior Authorization by CalOptima. The prescribing Physician shall be responsible for obtaining Authorization through CalOptima and/or its designated pharmacy benefit management contractor ("**PBM**"), as appropriate. The prescribing Physician shall provide CalOptima and/or the PBM with all information necessary to process Authorization requests.

1.6 **Enrollee Access**. Hospital and its Downstream Entities shall comply with all Laws and CalOptima Policies governing Enrollee access to Covered Services.

1.6.1 If Hospital is unable to provide necessary Covered Services to a particular Enrollee, Hospital must adequately and timely cover these services with Non-Participating Providers for the Enrollee, for as long as Hospital is unable to provide them. Hospital shall make prior arrangements with Non-Participating Providers for the provision of such services, shall be fully responsible for arranging and paying for such services, and shall comply with all applicable CalOptima Policies with regard to the payment and Authorization of Non-Participating Providers.

1.6.2 Hospital shall ensure that PCPs as well as Specialty Physicians are located so as to assure sufficient geographic and physical access of Enrollees to such providers as required by Laws and CalOptima Policies.

1.6.3 Hospital shall ensure that each Enrollee has a PCP who is available and physically present at the service site for sufficient time to ensure access for the assigned Enrollee when medically required. This requirement does not preclude an appropriately licensed professional from being a substitute for the PCP in the event of the PCP's vacation, illness, or other unforeseen circumstances.

1.6.4 Hospital shall ensure female Enrollees have direct access to a women's health specialist within the network to provide women's routine and preventative health care services. Such access may be in addition to the Enrollee's PCP.

1.6.5 Hospital shall cover family planning services for all Enrollees whether they are provided by a Participating Provider or Non-Participating Provider.

1.6.6 Hospital shall reasonably accommodate Enrollees and ensure programs and services are as accessible (including a sufficient number of Providers and geographic access) to an Enrollee with disabilities as they are to an Enrollee without disabilities in accordance with CalOptima Policies. Hospital's facilities shall comply with the requirements of Title III of the Americans with Disabilities Act of 1990 ("**ADA**") and shall ensure access for the disabled, including, but not limited to, ramps, elevators, restrooms, designated parking spaces, and drinking water provisions. Hospital shall have policies to ensure that physical, communication and programmatic barriers do not inhibit Enrollees with disabilities from obtaining all Covered Services, including addressing reasonable accommodations required by the CMS Contract and CalOptima Policies. Hospital will comply with CalOptima Policies and work plan requirements related to ADA compliance relevant to services under this Contract.

1.7 **Provider Network Maintenance**. Hospital agrees to employ or contract with a sufficient number of hospitals to ensure Enrollees of reasonable access to the full range of Covered Services.

1.7.1 During the Term, all Participating Providers of Covered Services must: (i) be and remain qualified in accordance with current applicable legal, professional, and technical standards; (ii) be and remain appropriately licensed, certified or registered; (iii) be and remain in good standing with Medicare and not be terminated or suspended from participation in the Medicare and/or Medi-Cal programs; and (v) have a valid NPI number, as applicable. Hospital shall ensure that PCPs are located so as to assure sufficient geographic and physical access of Enrollees to such Physicians under Laws and CalOptima Policies.

1.7.2 Hospital shall ensure that Participating Providers have the requisite training and experience in dealing with the medical problems frequently encountered in elderly, disabled, and special needs individuals.

1.7.3 Hospital shall use primary source verification to confirm the board certification in each clinical specialty area for which the Physician is being credentialed if the Physician lists such board certification on credentialing applications.

1.7.4 Hospital acknowledges that the requirements of this Section 1.9 apply to each individual Provider who is affiliated with and/or part of any medical group, independent physician associations ("**IPA**"), and/or other organization or entity that contracts with Hospital to furnish Covered Services to Enrollees.

1.7.5 Hospital will maintain accurate records, including records detailing the status, membership, and qualifications of the Participating Providers in the Hospital's network.

1.7.6 In the event a Provider who seeks to become a Participating Provider is denied a contract with Hospital or a Participating Provider is suspended or terminated for cause, Hospital shall provide the Provider with written notice of the reason for the action, as required by Laws, including any standards and profiling data Hospital used to evaluate the provider, the number and mix of similar health care Providers that Hospital needs (if applicable), and notice of the Provider's right to appeal the action, including notice of the process and timing to request a hearing. In the event Hospital terminates a contract with a Participating Provider for deficiencies in the quality of care provided, Hospital shall give notice of the action to CalOptima, as provided by CalOptima Policies, and to the appropriate licensing and disciplinary bodies, as provided by law.

1.7.7 In the event that a Provider, including a PCP, is terminated or leaves the Hospital for any reason, Hospital shall give written notification of termination of such Provider to CalOptima within fifteen (15) days after receipt or issuance of the termination notice.

1.7.8 In the event that a Provider, including a PCP, is terminated or leaves the Hospital for any reason, Hospital shall ensure that there is no disruption in services provided to Enrollees who are receiving treatment for a chronic or ongoing medical condition in accordance with applicable Laws.

1.7.9 Hospital shall notify CalOptima at least sixty (60) days before any significant change in Hospital's provider network that renders Hospital unable to provide one or more Covered Services within CalOptima's access to care standards. If such notice is not possible because the providers terminate their participation with less than sixty (60) days' notice or Hospital terminates the providers without prior notice as a result of their endangering the health and safety of Enrollees, providers committed criminal or fraudulent acts, or providers engaged in grossly unprofessional conduct, then Hospital shall notify CalOptima immediately upon receipt of notice of the termination, or sending notice to the providers of a Hospital-initiated termination.

1.7.10 Hospital shall ensure that no Provider who fails to meet the requirements of this section furnishes items and/or services to Enrollees, submits claims and/or receives reimbursement for any Covered Services.

1.7.11 Hospital agrees that each Participating Provider with whom Hospital contracts to provide Covered Services will be required to execute a contract with Hospital. Such an agreement will require all Participating Providers to comply with those aspects of this Contract relating to activities of Participating Providers and with Laws, including the standards of accrediting and regulatory agencies governing CalOptima's MA Program, and any and all provisions required by MA regulations. The Hospital agreement with Participating Providers shall be made available to CalOptima and its regulatory agencies for inspection and copying upon request. Hospital shall ensure that all contracts with Participating Providers allow for termination of the contract for failure to meet the requirements of this Section 1.9.

1.8 **Enrollment**. Hospital shall accept as Enrollees all persons indicated as Enrollees by the CalOptima information system and transmitted to Hospital and shall comply with requirements to provide notices to Enrollees in accordance with CalOptima Policies.

1.9 **Care Coordination**. Hospital shall offer care coordination and case management services to all Enrollees, which shall: (i) include coordination of care across the full continuum of service providers as appropriate to Covered Services under this Contract; (ii) ensure that care coordination services reflect a person-centered, outcome-based approach, consistent with the Model of Care and CalOptima Policies; (iii) follow Enrollee direction about level of involvement of his or her caregivers or medical providers; (iv) include the assignment of a qualified Care Coordinator to each Enrollee needing or requesting one; and (v) reflect access to appropriate community resources with a focus on providing services in the least restrictive setting and transitions between the facilities and the community.

1.10 **Model of Care**. Hospital shall furnish Covered Services in compliance with CalOptima's Model of Care. Hospital shall ensure the provision of discharge planning when an Enrollee is admitted to a Hospital or institution and continues into the post-discharge period. Discharge planning shall include ensuring that the necessary care, services, and supports are in place in the community for the Enrollee once he or she is discharged, including scheduling an outpatient appointment and/or conducting follow-up with the Enrollee or caregiver. Hospital shall comply with CalOptima Policies addressing minimum criteria requirements for discharge planning.

1.11 **Behavioral Health Services Referrals**. Hospital shall furnish and/or coordinate Behavioral Health services as specified in CalOptima Policies and this Contract.

1.12 **LTSS Referrals**. Hospital shall refer Enrollees to CalOptima for LTSS pursuant to CalOptima Policies.

1.13 **Facility Site and Medical Record Reviews**. Hospital shall participate in, and comply with requirements for, PCP site and medical reviews, including facility site physical accessibility reviews, in accordance with CalOptima Policies and guidance issued by CalOptima's Regulators, including requirements, if any, related to collaborative programs.

1.14 **Transfers**. Hospital agrees to assist CalOptima in facilitating the transfer of care of Enrollees if determined medically acceptable by attending Physicians and the CalOptima Medical Director. Hospital will be responsible for the cost of Covered Services provided if Hospital refuses to accept such transfer.

1.15 **Delegation by CalOptima to Hospital**. Hospital agrees to accept delegated responsibility for those activities listed in the Delegation Agreement and to perform the delegated activities in a manner consistent with the Delegation Criteria. Hospital warrants that it meets CalOptima's Delegation Criteria and acknowledges that delegation to another entity does not alter Hospital's ultimate obligations and responsibilities set forth in this Contract. Hospital agrees to notify CalOptima of any change in its ability to meet the Delegation Criteria within twenty-four (24) hours from the date it fails to meet such Delegation Criteria. At CalOptima's request, Hospital shall identify the Compliance Officer or other appropriate health network representative to be the liaison expressly responsible for oversight of delegated obligations.

1.15.1 Hospital acknowledges that it is CalOptima's responsibility to oversee, monitor and evaluate Hospital's ongoing eligibility for delegation according to the Delegation Criteria and performance of the delegated activities according to the Delegation Criteria. Hospital agrees to cooperate with CalOptima's oversight, monitoring, and evaluation of Hospital's eligibility and performance of delegated activities, including the provision of reasonable access during regular business hours to the Enrollee inquiry files, credentialing files, clinical and Medical Records of Enrollees, and all other information requested by

CalOptima. Hospital shall comply with corrective actions imposed by CalOptima and/or CalOptima's Regulators in the time and manner required by them.

1.15.2 Hospital acknowledges and agrees that CalOptima retains final authority and responsibility for activities delegated under this Contract. Activities not expressly delegated herein and in the Delegation Agreement by CalOptima or for which delegation is terminated are the responsibility of CalOptima.

1.15.3 Hospital agrees to provide CalOptima with periodic reports on delegated activities performed by Hospital as provided in the Delegation Criteria or specified in CalOptima Policies.

1.15.4 In the event CalOptima, DMHC, or CMS is dissatisfied with the performance of delegated functions and activities by Hospital or its Downstream Entities, CalOptima may, in its sole discretion, modify Hospital's delegated status (in respect to all or a particular delegated activity), including from fully delegated to delegated with corrective action, or may immediately revoke all or part of the delegated activities. In the event Hospital breaches its obligation to perform any delegated obligations, CalOptima shall have all remedies set forth in this Contract, including the right to revoke delegation of such function(s) and impose financial and other penalties. Moreover, CalOptima shall have the right to require Hospital to terminate any Downstream Entity for good cause, including breach of its obligations to perform any delegated duties. Nothing herein is intended to limit CalOptima's remedies as provided for in this Contract or at law.

1.15.5 Hospital acknowledges and agrees that CalOptima, in its sole and absolute discretion, may reduce Hospital's Capitation Payments to recoup additional administrative costs where CalOptima revokes or modifies activities or functions delegated to Hospital under this Contract.

1.16 **Delegation and Subcontracting of Administrative Services by Hospital**. Except as otherwise limited by this Contract and/or CalOptima Policies, Hospital may sub-delegate Administrative Services required of Hospital to a management services organization ("**MSO**"), medical group and/or IPA. Delegation shall not absolve Hospital of oversight responsibilities or its obligations under this Contract. All requests for delegation of Administrative Services (i) must be in writing; (ii) are subject to successful completion of CalOptima's readiness assessment requirements; and (iii) must be approved by CalOptima in advance of undertaking the Administrative Services. Hospital shall obtain written approval of delegation from CalOptima pursuant to the process detailed in CalOptima Policies.

1.17 **Subcontracts**. Hospital is required to inform CalOptima of the name and business addresses of all subcontracted Downstream Entities. Hospital is required to ensure that all such subcontracts are in writing and include all provisions required by this Contract to be incorporated into subcontracts. Hospital acknowledges that CalOptima's FDR subcontracts are subject to the review and approval of CMS.

1.18 **Payment to Providers**. CalOptima hereby delegates claims processing functions to Hospital. Hospital shall review, adjudicate, and pay (as appropriate) all claims in accordance with the benefits set forth in the Evidence of Coverage, the requirements established by Laws, and the terms of this Contract. In making payments to Providers, Hospital shall comply with the provisions of Attachment D, including requirements related to payment of Non-Participating Provider Emergency Services and Urgent Care claims.

1.19 **Documentation and Data Submission Integrity**. Hospital and its Downstream Entities shall not submit false claims or financial reports, encounter data, and other information to CalOptima, CMS or DMHC, whether by commission or omission. Hospital and applicable Downstream Entities shall implement and maintain policies and procedures that address correct completion of claims, financial reports, encounter data, and other documentation requirements and penalties for falsifying such reports and other information that require all new and current employees and/or agents compiling or providing this information to sign a statement of attestation that will acknowledge understanding and compliance with said Hospital policy.

1.20 **Advance Directives**. Hospital shall maintain written policies and procedures related to Advanced Directives in compliance with Laws. Providers shall document Advance Directives in patient records in accordance with Laws. Hospital shall not discriminate against any Enrollee on the basis of that Enrollee's Advance Directive status. Nothing in this Contract shall be interpreted to require an Enrollee to execute an Advance Directive or agree to orders regarding the provision of life-sustaining treatment as a condition of receipt of services.

1.21 **Enrollee Appeals**. Enrollees will be notified of all applicable MA and/or Medicare Appeal rights, the form and content of which is approved by CMS. . Medicare Appeal rights and protections will be maintained and enhanced for Medicare services. Hospital agrees to cooperate with CalOptima in resolving Appeals related to Hospital or Hospital's Participating Providers and will comply with CalOptima Policies related to Appeals.

1.22 **Organization Determination Process**. Hospital agrees to comply with CMS regulations and instructions and CalOptima Policies pertaining to timely organization determination by Hospital with regard to the provision, denial, reduction, or suspension of a Covered Service to an Enrollee. "**Organization determination**" is defined as a decision to provide or deny service based on CMS and CalOptima criteria. Such determinations shall be made in accordance with procedures and instructions set forth in the CalOptima Policies and Laws. Hospital shall immediately notify CalOptima of any request for an expedited initial organization determination and submit to CalOptima on a monthly basis a report which tracks the requests for standard and expedited organization determinations and the timeframe within which Enrollees were informed of decisions made by Hospital.

1.23 **Expedited Review Process**. Hospital shall comply with CMS regulations and CalOptima Policies pertaining to expedited initial organization determinations of Enrollee's medical care and reconsideration (Appeals) thereof in the time sensitive situations. Time sensitive situations are those outlined by CMS which include medical conditions that require initial determinations to be made within seventy-two (72) hours upon Hospital receiving a request for an expedited review from a Provider, Enrollee, or CalOptima.

1.24 **Linguistic and Cultural Sensitivity**. Hospital shall comply with all requirements related to the provision of linguistic and culturally sensitive services in accordance to this Contract, CalOptima's Cultural and Linguistic Services Program, and CalOptima Policies. Hospital shall address the special health needs of Enrollees who are of any minority, are homeless, are disabled (both congenital and acquired disabilities), or are part of other special populations served by the CalOptima MA Program, including the capacity to communicate with Enrollees in languages other than English, when necessary, as well as those Enrollees who are deaf, hard-of-hearing, and/or visually impaired. Physician shall, in policies, administration, and services, practice the values of: (a) honoring the Enrollees' beliefs, traditions and customs; (b) recognizing individual differences within a culture; (c) creating an open, supportive, and responsive organization in which differences are valued, respected and managed; (d) through cultural diversity training, foster in staff and

Participating Providers attitudes and interpersonal communication styles that respect Enrollees' cultural backgrounds and are sensitive to their special needs; and (e) referring Enrollees to linguistically and culturally sensitive programs. Pursuant to CalOptima Policies, Hospital shall provide translation of written materials in the Threshold Languages as provided by CalOptima Policies. Written materials to be translated include, but are not limited to, signage, the Enrollee services guide, Enrollee information, Explanation of Coverage, Enrollee forms, Enrollee notices, and Enrollee welcome packages.

1.25 **Provision of Interpreters**. Oral interpreters, signers, and bilingual Provider services shall be provided in all languages spoken by all MA Enrollees. Hospital shall provide linguistic interpreter/translator services for Enrollees as necessary at all Hospital sites to ensure the availability of effective communication regarding treatment, diagnosis, medical history, and health education to Enrollees. Hospital shall provide twenty-four (24)-hour access to interpreter services for all Enrollees. Upon an Enrollee or Participating Provider request for interpreter services in a specific situation where care is needed, Hospital shall make all reasonable efforts to provide an interpreter in time to assist adequately with all necessary Covered Services, including Urgent Care Services and Emergency Services, as required by Laws. Hospital shall routinely document all such efforts and make this documentation available to CalOptima at its request. Interpreters shall be used where needed where technical, medical, or treatment information is to be discussed. Hospital shall not require an Enrollee to use friends or family as interpreters. However, a family member or friend may be used when the use of the family member or friend: (i) is requested by the Enrollee; (ii) will not compromise the effectiveness of service; (iii) will not violate Enrollee's confidentiality; and (iv) the Enrollee is advised that an interpreter is available at no cost to the Enrollee. Hospital shall maintain a contract with an interpreter service agency that is on "on call" status to provide interpreter services.

1.26 **Identification of Hospital**. Hospital agrees that CalOptima may list the Hospital's name, address, and telephone number and that of its Downstream Entities in CalOptima's roster of Participating Providers that is given to Enrollees and prospective Enrollees, and CalOptima may use such names for advertising/marketing purposes. The use of Hospital's trademarks or logos by CalOptima is prohibited without Hospital's prior written approval.

1.27 **Liaisons**. Hospital shall designate an individual(s) who will assume the day-to-day responsibilities with regard to Hospital's obligations under this Contract and to serve as liaison with CalOptima. Hospital will also designate an individual(s) to be responsible for answering Enrollee inquiries and responding promptly to any Enrollee grievance in accordance with CalOptima's grievance procedures and Laws.

1.28 **Provider Private Contract**. Hospital understands that CalOptima is prohibited by CMS from paying capitation to, or including in its provider network, any provider that has entered into a private contract with a Medicare beneficiary for the provision of Covered Services.

1.29 **Provider Grievance Process**. Hospital shall establish and maintain a Provider dispute resolution process that at all times complies with the requirements of Laws. Hospital shall provide CalOptima with all necessary information and reports regarding the provider dispute resolution process as required by CalOptima to meet its obligations under the CMS Contract and Laws. If Hospital fails to maintain a process that complies with the requirements stated in Laws and CalOptima Policies, then following written notice of such deficiency from CalOptima to Hospital, CalOptima may revoke the delegation and assume responsibility for the administration of Hospital's Provider dispute resolution process.

1.30 **Provider Education**. Hospital acknowledges that CMS requires that CalOptima furnish to Participating Providers certain training, education, and orientation related to the MA Program in order to operate in full compliance with this Contract and Laws. Such training and education may address the MA Program, Enrollee rights, cultural competency and clinical protocols, evidence-based guidelines and cultural awareness and sensitivity instruction. Hospital and its Participating Providers shall participate in such training, education, and orientation programs, as required by CalOptima, and shall attest to compliance with training requirements as required by CalOptima.

1.31 **CalOptima's Regulator Requirements**. The MA Program is subject to oversight by CalOptima's Regulators, which mandate that CalOptima and its FDRs comply with certain terms and conditions in rendering services to Enrollees and that certain terms be incorporated in FDR subcontracts. Hospital acknowledges that it will comply with CalOptima's Regulators' requirements set forth in Attachment E.

1.32 **COB Obligations of Hospital**. Hospital agrees to coordinate with CalOptima for proper determination of COB and to bill and collect from other payers and third-party liens such charges for which the other payer is responsible pursuant to CalOptima Policies. Hospital agrees to establish procedures to effectively identify, at the time of service and as part of its claims payment procedures, individuals and services for which there may be a financially responsible party other than the CalOptima MA Program.

1.33 **CMS Lien Rights.** Hospital shall coordinate benefits either operating a cost avoidance method of paying claims, when the existence of private health coverage is known at the time the claim is processed, or using the method of post-payment recovery of the cost of services, if the coverage is identified retroactively, as set forth in CalOptima Policies. Nothing herein shall be interpreted to, in any manner, impair any lien rights retained by the U.S. Department of Health and Human Services ("**HHS**") through CMS. Hospital shall make no claim for the recovery of the value of Covered Services rendered to an Enrollee when such recovery would result from an action involving tort liability of a third party, recovery from the estate of deceased Enrollee, Workers' Compensation, or casualty liability insurance awards and uninsured motorist coverage. Hospital shall identify and notify CalOptima, within five (5) calendar days of discovery of potential third-party liability ("**TPL**") claims, and provide information relative to potential TPL claims, in accordance with CalOptima Policies.

1.34 **Notification of Inpatient Facility Discharge Appeal Rights**. Hospital and its Downstream Entities shall issue the advance written notice to Enrollees of their Hospital discharge rights upon admission and before discharge from the Hospital.

II. HOSPITAL FINANCIAL OBLIGATIONS

2.1 **Financial Security Requirements**. Hospital must establish and maintain, throughout the Term, financial security reserves, in the form of time certificates of deposit, irrevocable standby letters of credit, surety bonds naming CalOptima as beneficiary, and/or other forms of financial instruments acceptable by CalOptima, as required in CalOptima Policies.

2.2 **Financial Viability Standards and Reporting**. Hospital must establish and maintain a minimum reserve of twenty-five percent (25%) of one month's Capitation Payment. Physician shall have thirty (30) days upon receiving notice from CalOptima to cure any deficit. Hospital shall maintain a cash-to-claims ratio of no less than 0.75 at all times during the Term.

2.3 **Medical Loss Ratio**. Hospital shall ensure that it, as well as the PHC, maintains a minimum acceptable loss ratio (as defined by CalOptima Policies) of eight five percent (85%). Hospital shall comply with CalOptima requirements related to limitations on administrative costs, as set forth in CalOptima Policies.

2.4 **Termination of Hospital Health Network**. If this Contract terminates or expires for any reason, CalOptima may require that Hospital take certain actions and/or CalOptima may take certain actions to ensure that all items and services for which Hospital is delegated financial risk under this Contract are reimbursed by Hospital, including the following: (i) require Hospital to reserve sufficient funds to pay any claims run out; (ii) offset Hospital's future Capitation Payments or other amounts due from CalOptima to Hospital under this Contract or any other agreement, if any, in order to pay Hospital's claims; and/or (iii) withhold or offset Hospital's Capitation Payments or other amounts due from CalOptima to Hospital, including to pay-for-performance, quality incentives, and shared risk pool surpluses, if any, in order to pay amounts owed by Hospital to Providers.

2.5 **Conversion of Health Network Model**. If CalOptima approves a change in the delegated model of Hospital at any time during the Term, CalOptima may require additional financial protections as a condition precedent to such approval, including: (i) require Hospital to reserve sufficient funds to pay any claims run out related to claims which are the financial responsibility of Hospital under the existing delegated relationship; (ii) require Hospital to meet additional financial security requirements, including the maintenance of financial deposits; and/or (iii) withhold or offset Hospital's Capitation Payments or other amounts due from CalOptima to Hospital, including pay-for-performance, quality incentives and shared risk pool surpluses, if any, in order to pay amounts owed by Hospital to Providers.

2.6 **Cooperation with DMHC**. Hospital shall fully cooperate and comply with the DMHC's review and audit process and permit DMHC to obtain and evaluate supplemental financial information related to Hospital. Hospital shall also fully cooperate and participate in DMHC's and CalOptima's Corrective Action Plan process, if necessary.

2.7 **Risk Pools**. PHC in which Hospital and Physician Group participate shall have a risk pool arrangement between Hospital and Physician Group, as detailed in this Section 2.7 and Addendum 1 to this Agreement and the Physician Group Contract. During the Term, Hospital and Physician Group shall annually negotiate and agree upon the terms and conditions of the risk pool arrangement ("**Risk Pool**") and shall submit the Risk Pool to CalOptima by November 30 for the next year. Hospital shall corporate with Physician Group so that Physician Group can submit to CalOptima an attestation signed by an authorized signatory of PHC Participants indicating that both Physician Group's and Hospital's Boards of Directors approved the Risk Pool. CalOptima shall pre-approve the Risk Pool before it may go into effect for the next year beginning January l. The Risk Pool shall include the following:

2.7.1 Covered Services for which PHC Participants will share risk.

2.7.2 If any part of the Risk Pool is based on utilization, the Risk Pool shall additionally include:

(a) The expected utilization of Covered Services for which PHC Participants will share risk. Recommended measures are bed days/per 1,000 Enrollees for inpatient services and $ [insert amount] per Enrollee per month for other Covered Services.

(b) The price or value for each Covered Service for which PHC Participants will share risk. These are the amounts that each unit of service will be valued at and charged against the portion of Hospital's capitation payment that the Hospital receives under the Contract and uses to fund to the Risk Pool. Inpatient rates should be listed as per diem rates, while other Covered Services should be priced by fee schedules or as a percentage of billed charges.

(c) A pro forma settlement calculation, which shall state the amount of surplus that is expected to result if Hospital and/or Physician Group achieve their utilization targets and the agreed-upon pricing model employed for the Risk Pool.

(d) A description of audit and/or other procedures required to ensure the accuracy of the surplus or deficit calculations related to the cost and volume of services rendered under the Risk Pool and other revenues and expenses, including interest income, reinsurance premiums, and reinsurance recoveries associated with risk sharing.

(e) Defined responsibilities should deficits occur under the Risk Pool.

(f) Timing and documentation requirements for interim or final surplus distributions from the Risk Pool by Hospital, as agreed upon between the PHC Participants.

2.7.3 Physician Group shall submit [insert requirement for when these should be submitted] to CalOptima interim and final settlement calculations and attestations from all PHC Participants stating that (i) PHC Participants have met all the requirements of this Section 2.7, (ii) PHC Participants have performed all audit and reconciliation procedures, and (iii) the distribution amount to each PHC Participant is consistent with the terms of the Risk Pool, which (as approved by CalOptima annually during the Term) is incorporated into this Contract by this reference.

III. CALOPTIMA OBLIGATIONS

3.1 **CalOptima Services**. CalOptima agrees to provide certain Enrollee and Administrative Services, including processing Enrollee applications, maintaining eligibility records and a system of verifying eligibility, processing enrollments and dis-enrollments, responding to Enrollee complaints and grievances, informing Enrollees of CalOptima Policies, providing Enrollees with membership cards and informational material, and informing Enrollees of Health Networks.

3.2 **Enrollment**. CalOptima agrees to process all enrollment applications and ensure that each Enrollee selects or is assigned to Health Networks in accordance with CalOptima Policies. CalOptima reserves the right to assign Enrollees to a Health Networks other than that selected by Enrollee.

3.3 **Authorization Process**. CalOptima shall provide a written Authorization process for Covered Services pursuant to CalOptima Policies.

3.4 **Enrollee Grievance Process**. CalOptima will inform Enrollees that they may file a grievance through CalOptima or the CMS Ombudsman Program for complaints related to Medicare-covered benefits and services. Enrollees may also file a grievance through 1-800 Medicare.

3.5 **Enrollee Appeals**. Enrollees will be notified of all applicable MA Medicare Appeal rights through a single notice prior approved by CMS.

3.6 **CalOptima Formulary**. CalOptima shall publish and maintain the CalOptima Formulary pursuant to CalOptima Policies.

3.7 **Training and Education**. CalOptima agrees to provide Participating Provider education, training, and orientation in accordance with CMS requirements, including training regarding the CalOptima MA Program, Enrollee rights, clinical protocols, evidence-based practice guidelines, and CalOptima's cultural awareness and sensitivity instruction and cultural competency training, as applicable.

3.8 **Marketing**. Hospital acknowledges that CalOptima will be responsible for marketing the CalOptima MA Program to Medicare beneficiaries. Hospital acknowledges that it shall not conduct any marketing activities except as expressly approved in advance and in writing by CalOptima.

3.9 **Administration of Funds**. CalOptima will administer the funds and payments called for in this Contract to Hospital in accordance with provisions outlined in Article VI.

3.10 **No Refusal to Pay or Contract Based on Hospital Communications with Enrollees**. CalOptima will not refuse to contract or pay an otherwise eligible health care Provider for the provision of Covered Services solely because such Provider has, in good faith, communicated with or advocated on behalf of one or more of his or her prospective, current, or former patients regarding: (i) the provisions, terms or requirements of CalOptima's health care plans as they relate to the needs of such Provider's Enrollees; or (ii) the method by which such Provider is compensated by CalOptima for Covered Services rendered to the Enrollee.

3.11 **CalOptima Policies**. CalOptima will provide Hospital with CalOptima Policies as necessary for Group to provide Covered Services to Enrollees. Those CalOptima Policies shall describe all benefit plans, including copayments, limitations, and exclusions offered by CalOptima to Enrollees. The Provider Manual will be made available to Hospital to disseminate to Physicians.

3.12 **Listing of CalOptima**. CalOptima agrees that Hospital may list its name, address, telephone number, and a description of the CalOptima MA Program, along with CalOptima's name, in Hospital's promotional materials and advertisements. The use of CalOptima's trademarks and logos by Hospital is prohibited without CalOptima's prior written approval.

3.13 **CalOptima Oversight**. CalOptima shall monitor Hospital's performance under this Contract on an ongoing basis. CalOptima may conduct regularly scheduled audits as well as an annual evaluation of the delegated functions to determine Hospital's continued compliance with the Delegation Criteria. CalOptima may impose corrective action plans on Hospital and/or its Downstream Entities, as necessary.

3.14 **CalOptima Accountability**. The delegation of the functions and responsibilities stated in this Contract and the Delegation Agreement does not relieve CalOptima of any of its accountability to CMS and obligations to its Enrollees under Laws. CalOptima is authorized to perform and remains liable for the performance of such obligations, notwithstanding any delegation of some or all of those obligations to Hospital.

3.15 **COB Obligations of CalOptima**. CalOptima will cooperate in providing COB information to Hospital by collecting appropriate data from the Enrollee at the point of enrollment and supplying such data to Hospital.

3.16 **Enrollee Rights**. CalOptima shall ensure that Enrollee rights are fully respected and observed in accordance with Laws and CalOptima Policies. CalOptima shall notify Enrollees of their rights and protections at least annually and in a manner that accounts for cultural considerations, functional status, and language needs.

3.17 **Enrollee Grievances**. CalOptima retains responsibility for the Enrollee grievance process. Hospital will comply with CalOptima Policies related to Enrollee grievances, including timely reporting to CalOptima and resolution of Enrollee grievances. Enrollees may file an internal Enrollee grievance at any time with CalOptima or Hospital, including grievances related to reasonable accommodations and access to services under the ADA.

IV. QUALITY IMPROVEMENT PROGRAM AND CREDENTIALING

4.1 **CalOptima's Quality Improvement Program**. Hospital shall comply with, and participate in, CalOptima's Quality Improvement Program ("**QIP**"). Hospital shall immediately notify CalOptima of those Enrollees and cases that fall within the catastrophic and targeted case management guidelines and shall cooperate with CalOptima's case management program for catastrophic and targeted cases. Hospital and its Downstream Entities shall fully cooperate with CalOptima with regard to the HEDIS measurements and HEDIS audits, guideline development, preventive services utilization, disease/risk management, clinical service monitoring, and quality improvement studies and initiatives. Hospital shall comply with and accept as final the decisions of the CalOptima QIP and, pending resolution of any dispute through the dispute resolution process, comply with the decisions of the CalOptima Quality Improvement Committee.

4.2 **Quality Improvement Functions – Delegation to Hospital**. Hospital shall adopt a detailed written Quality Improvement ("**QI**") program, which shall include: (i) well defined goals and objectives; (ii) a well-defined scope that considers all different types and levels of care and service provided to Enrollees; and (iii) clearly defined accountability and responsibility for the QI program.

4.3 **Quality Improvement and Credentialing Program**. CalOptima delegates health delivery organization credentialing requirements to Hospital as provided in the Delegation Agreement. Hospital agrees to comply with CalOptima Policies regarding credentialing standards. In order to ascertain Hospital's continuous compliance with CalOptima standards, CalOptima retains the right to oversee Hospital's credentialing processes and to mandate changes thereto.

4.3.1 At least annually, Hospital shall provide CalOptima with a written credentialing program for the purpose of review and approval by CalOptima. Hospital shall also allow CalOptima, after reasonable prior notice, to conduct an on-site audit and review a sample of physician credentialing files to determine that delegation of the credentialing process is appropriate.

4.3.2 Hospital's credentialing program shall comply with the requirements specified in 42 CFR Sections 422.504, 423.505 and 438.214, as applicable, which include requirements addressing selection and retention of providers, credentialing and re-credentialing requirements, and nondiscrimination. Hospital's credentialing program shall include procedures used for credentialing and re-credentialing Participating Provider's according to current NCQA standards, in addition to procedures used for reducing, suspending or terminating Participating Provider's participation in the organization for reasons relating to quality of care, competence, professional conduct, or service-related issues; procedures for reporting to appropriate authorities serious quality deficiencies that could result in

suspension or termination of a Participating Provider's participation; and procedures for provider appeal, as afforded by Hospital's fair hearing plan and corrective actions.

4.3.3 Hospital shall make best efforts to notify CalOptima within thirty (30) days of any changes involving the rules, regulations, authorities, and responsibilities of the credentialing program. In accordance with CMS requirements, CalOptima also retains the right, based on quality-of-care and service issues, to approve, suspend, or terminate arrangements with practitioners, providers, and sites. In the event that this occurs, CalOptima will notify the Hospital of the quality-of-care and/or service issue, and Hospital shall take appropriate action, report to appropriate authorities any serious quality deficiencies in accordance with Laws, and provide all due process as afforded by the Hospital's fair hearing plan and Laws.

4.3.4 If CalOptima exercises its right to terminate a Provider's participation in the CalOptima MA program, CalOptima shall give the Provider a written statement of the reason or reasons for termination with cause and comply with the procedures required by Laws, if any.

4.4 **Release of Performance Information and Data**. Hospital acknowledges that the CalOptima MA Program focuses on improving the coordination and quality of medical, Behavioral Health, LTSS, and other services for Enrollees, and, in that regard, CalOptima's Regulators will implement capitation withholds to ensure performance consistent with established quality thresholds. Hospital acknowledges and agrees that CalOptima may release information and data related to the performance of Hospital under this Contract to CalOptima Regulators, Providers, Enrollees, and others without further notice to Hospital. The performance data will be used for purposes, including quality improvement activities, and public reporting to consumers, as identified in CalOptima Policies.

V. UTILIZATION MANAGEMENT PROGRAM

5.1 **CalOptima's Utilization Management Program**. CalOptima has implemented, and continuously updates, a UM program to ensure appropriate processes are used to review and approve the provision of Medically Necessary Covered Services to Enrollees in the timeframes required by CalOptima's Regulators. Hospital and its Downstream Entities shall comply with and cooperate in CalOptima's UM program, as established in CalOptima Policies and the CalOptima UM plan, regardless of CalOptima's delegation to Hospital under Section 5.2.

5.2 **UM Program Responsibility—Delegation to Hospital**. CalOptima is hereby delegating to Hospital the process of monitoring and evaluating on a prospective, concurrent, and retrospective basis, the utilization and Medical Necessity of Covered Services provided to Hospital's Enrollees.

5.2.1 Hospital's UM process shall include performing case management activities, referral management and discharge planning, and managing the denial sanction process, as well as conducting peer review for Medical Necessity and appropriateness. Hospital (and its Downstream Entities) shall ensure that its UM program complies with all criteria as set forth in CalOptima Policies and required by CalOptima's Regulators.

5.2.2 In accordance with 42 CFR §§ 438.6(h) and 422.208, compensation to individuals or entities that conduct UM activities must not be structured so as to provide incentives for Hospital or Downstream Entities to deny, limit, or discontinue Medically Necessary Covered Services to any Enrollee.

5.2.3 In the event Hospital (or its Downstream Entities) fails to comply with CalOptima standards and Laws and fails to correct deficiencies within the stated time required by those provisions, CalOptima retains the right to revoke delegation of UM activities.

5.3 **Utilization Management Plan**. Hospital will provide to CalOptima initially upon execution of this Contract, and annually thereafter, a written UM plan for review and approval by CalOptima.

5.3.1 Hospital shall notify CalOptima within thirty (30) days of any changes involving the rules, regulations, authorities, and responsibilities for the UM plan, which shall be subject to reasonable approval by CalOptima. CalOptima approval will be assumed unless Hospital is notified otherwise by CalOptima. Hospital shall comply with and accept as final, the decisions of CalOptima's UM program and, pending resolution of any dispute through the dispute resolution process, comply with the decisions of CalOptima's UM program.

5.3.2 The UM plan shall include procedures approved by CalOptima to identify, assess, establish, and implement a treatment plan for Enrollees with complex or serious medical conditions. The UM plan shall also contain procedures for direct access of Enrollees to services as mandated by CMS regulations and instructions. All Hospital denial letters shall provide Enrollees with timely notice and shall contain appropriate Enrollee appeals rights as approved by CMS and CalOptima. Hospital agrees to cooperate with CalOptima in furnishing the required reports identified in CalOptima' Policies

5.4 **Utilization Management Committee**. Hospital shall establish a UM committee that shall review and document the quality, appropriateness, level of care, and utilization of health care services provided to Enrollees. CalOptima's Medical Director and/or CalOptima staff may attend Hospital UM committee meetings.

5.5 **Process and Timeframes for Authorization**. Hospital (and its Downstream Entities) shall ensure that its process for initial and continuing Authorizations complies with CalOptima Policies, the UM plan and requirements established by CalOptima's Regulators, including timeframes for, and manner of, Authorization.

5.6 **No Prior Authorization**. Hospital (and its Downstream Entities) shall not require prior Authorization for the following services: (i) any services for Emergency Medical Conditions (which include emergency Behavioral Health care); (ii) Urgent Care sought outside the Service Area: (iii) Urgent Care under unusual or extraordinary circumstances provided in the Service Area when the Participating Provider is unavailable or inaccessible; (iv) preventative services; (v) family planning services; (vi) Out-of-Area renal dialysis services; (vii) basic prenatal care; (viii) sexually transmitted disease services; and (ix) HIV testing.

5.7 Second Opinions**. Hospital (and Downstream Entities) shall ensure that Enrollees have the right to second opinions from qualified health professionals at no cost to the Enrollee.**.

VI. COMPENSATION

6.1 **Hospital Compensation**. CalOptima shall compensate Hospital for Covered Services and Administrative Services delegated to Hospital, as set forth in Attachment C. Such Capitation Payments shall be payment in full for Covered Services and Administrative Services, except for amounts recovered through collection of Enrollee's Share of Cost, COBs, and Stop Loss Program, if applicable. Capitation Payment shall be sent on a monthly basis by the twentieth (20th) calendar day of the month, or if such day falls on a weekend or national holiday, on the first business day

thereafter, for all Enrollees eligible from the first (1st) of the month, and on whose behalf payment has been received by CalOptima from CMS by the nineteenth (19th) calendar day of the month. In the event CalOptima receives payment from CMS after the nineteenth (19th) calendar day of the month, capitation payment to Hospital will be made within five (5) working days of receipt of the monthly payment by CalOptima.

6.2 **Disputes Regarding Payments or Enrollment**. Any and all disputes related to Capitation Payments and/or enrollments shall be reported to CalOptima within ninety (90) calendar days of payment, and each dispute shall be clearly defined and include supporting documentation. Failure to dispute within the established time frame indicates acceptance of the Capitation Payment by Hospital.

6.3 **Capitation Rate Adjustments**. The Capitation Rates may be adjusted by CalOptima during the Contract period to reflect implementation of State of California ("**State**") or federal laws or regulations, changes in the CMS Contract or CMS policy, and/or changes in Covered Services. If CalOptima receives advance notice of adjustment from CalOptima's Regulators, CalOptima shall provide notice thereof to Hospital as soon as practicable. Capitation Rates may also be adjusted in the event of de-delegation of any function delegated under this Contract.

6.4 **Enrollee Non-Liability and Hold Harmless Requirements.** Hospital and its Downstream Entities shall accept CalOptima's payment as described in this Contract as payment in full. Hospital and its Downstream Entities for all Covered Services and Administrative Services under this Contract and shall not hold Enrollees liable to the Hospital or Providers for any sums owed to Hospital by CalOptima or owed to Providers by Hospital.

6.4.1 Hospital and its Downstream Entities shall hold harmless CMS, CalOptima, and Enrollees in the event Hospital and/or Downstream Entities cannot or will not pay for services performed by Hospital or Downstream Entities pursuant to this Contract or subcontract, as applicable.

6.4.2 Hospital and its Downstream Entities shall ensure that Enrollees will not be held liable for Medicare Part A and B cost sharing when the State is responsible for paying such amounts and that the Hospital will (i) accept Capitation Payment as payment in full under the Contract, or (ii) bill the appropriate State source, as required at 42 CFR §422.504(g)(1)(iii). Such services must be provided at zero cost-sharing to Enrollees.

6.4.3 Hospital shall not hold an Enrollee liable for the following: (i) debts of Hospital, in the event of 'Hospital's insolvency; (ii) Covered Services provided to the Enrollee in the event that CalOptima or Hospital fails to receive payment from CMS for such services; or (iii) payments to a clinical FDR or Downstream Entity in excess of the amount that would be owed by the Enrollee if Hospital had directly provided the services.

6.4.4 Hospital and its Downstream Entities shall not charge Enrollees coinsurance, co-payments, deductibles, financial penalties, or any other amount in full or part, for any service provided under this Contract, except as otherwise permitted under this Contract.

6.4.5 Hospital and its Downstream Entities shall not deny any service provided under this Contract to an Enrollee for Enrollee's (or any entity responsible for making payment on Enrollee's behalf) failure or inability to pay any applicable charge or shall not deny any service provided under this Contract to an Enrollee who, prior to becoming eligible, incurred a bill that has not been paid.

6.5 **Overpayments Discovered by Hospital**. Hospital shall disclose and return all overpayments to CalOptima within sixty (60) days of when Hospital identified the overpayment or should have identified the overpayment through the exercise of reasonable diligence.

6.6 **Recoupment for Ineligibility; Conlan Reimbursements**. CalOptima shall recoup payments made to Hospital when CMS has determined that an individual was not eligible for the MA Program and retroactively terminates the individual, including recouping any payments made for a deceased Enrollee. CalOptima may also recoup overpayments to Hospital owed by Hospital to Enrollees, including offsetting any such amounts owed against Hospital's Capitation Payments or other amounts due from CalOptima to Hospital under this Contract or any other agreement between the parties, if any. This Section 6.6 shall not be construed to limit CalOptima's right to recoup payment made to Hospital on any other basis for which recoupment is appropriate.

6.7 **CalOptima Right to Recover**.

6.7.1 Overpayments. Hospital acknowledges and agrees that, in the event that CalOptima determines that an amount has been overpaid or paid in duplicate, or that funds were paid which were not due under this Contract to Hospital, CalOptima shall have the right to recover such amounts from Hospital by recoupment or offset from current or future amounts due from CalOptima to Hospital under this Contract or any other agreement between the parties, after giving Hospital notice and an opportunity to return/pay such amounts.

6.7.2 Shared Risk Pool Payments Upon Termination. If this Contract terminates or expires for any reason and Hospital is responsible for a deficit under any shared risk program under this Contract based on the final shared risk pool report results ("**Deficit**"), such Deficit shall be due to CalOptima as follows, as allowed by Laws: CalOptima may elect to recoup such Deficit by either (1) offsetting such Deficit amounts, upon notice to Physician Group, from any current or future amounts owed by CalOptima to Physician Group under the Contract or any other agreement between the Parties, including capitation payments, financial security withholds, pay-for-performance amounts, quality incentives, and shared risk pool surpluses; or (2) sending an invoice to Physician Group that payment for such Deficits are due to CalOptima within thirty (30) days of Physician Group's receipt of the CalOptima invoice.

6.7.3 Regulator Recoupment Upon Termination. If following the termination or expiration of this Contract, CalOptima's Regulators find that Physician Group (or its Downstream Entities) has failed to comply with the requirements governing physician incentive plans and CalOptima's Regulators offset, recoup and/or otherwise seek recovery of FFP, as described in Section 1.33, CalOptima may elect to recoup such FFP amounts, as allowed by Laws, by either: (1) offsetting such FFP amounts, upon notice to Physician Group, from any current or future amounts owed by CalOptima to Physician Group under the Contract or any other agreement between the Parties, including capitation payments, financial security withholds, pay-for-performance amounts, quality incentives, or shared risk pool surpluses; or (2) sending an invoice to Physician Group that payment for such FFP amounts are due to CalOptima within thirty (30) days of Physician Group's receipt of the CalOptima invoice.

6.7.4 Dispute Resolution. Physician Group may use CalOptima's provider dispute resolution procedure, as described under CalOptima's Policies, and/or the dispute resolution procedures under this Contract to resolve any disputes related to the calculation or payment of such Deficits or FFP amounts.

6.7.5 Survival. This Section 6.7 shall survive the termination or expiration of the Contract.

6.8 **Retroactive Cancellation**. CalOptima will discourage retroactive cancellation of any Enrollee. However, CalOptima may make exceptions as required by CMS or due to legitimate administrative processing requirements of CMS. CalOptima may make retroactive additions or cancellations of Enrollees, as necessary for administrative or business reasons, and such retroactive additions or cancellations of Enrollees shall not exceed ninety (90) days.

VII. REPORTING REQUIREMENTS

7.1 **Data Reporting Requirements**. Hospital shall comply with the data reporting requirements set forth in this Contract, including the requirements specified in Standard Reporting Requirements set forth in CalOptima Policies and guidelines (referred to as the Timely and Appropriate Submission requirements). Hospital shall provide such additional data and modify the form, content, instructions, and timetables for the collection and reporting of data, as may be required by CalOptima Policies.

7.2 **Eligibility Reports**. CalOptima will maintain, update, and distribute monthly Enrollee eligibility reports for each month in which the persons included on such list are eligible for CalOptima MA Program. This report will identify the Hospital, PCP selected by the Enrollee, and the Enrollee's coverage. The report will be sent to Hospital and PCPs by the tenth (10th) of each month, identifying eligible Enrollees from the first (1st) of the month.

7.3 **Utilization Data**. Hospital shall, upon request, provide CalOptima with information on the utilization and cost of Covered Services provided to Enrollees in such detail as to allow CalOptima to conduct analysis of costs as required by CMS, as dictated by sound business practices and for the conduct of quality management and UM activities by CalOptima. Such information to be provided by Hospital will not include information beyond that customarily provided on a claim form (such as Form CMS-1500) and shall be provided in the form of a paper report, computer disc, computer tape, or electronic file, as agreed by the parties. Required data will be delivered by Hospital to CalOptima not later than forty-five (45) days following written request by CalOptima.

7.4 **Submission of Electronic Encounter Data**. Hospital must meet any claims, diagnosis, and Encounter Data reporting requirements, as determined from time to time by CalOptima and CalOptima's Regulators.

7.4.1 Hospital agrees to furnish CalOptima with complete, timely, reasonable, and accurate Encounter Data for Covered Services rendered to Enrollees. The Encounter Data will be furnished to CalOptima through Electronic Data Interchange (EDI) or a mutually acceptable format and shall be received by CalOptima per the Policy and Encounter Requirements Manual. Hospital also agrees to furnish Medical Records that may be required to obtain any additional information or corroborate the Encounter Data. Hospital further agrees to have its Chief Executive Officer (CEO) attest and certify the completeness and truthfulness of the Encounter Data submitted.

7.4.2 Hospital shall be subject to financial penalties and/or sanctions if CalOptima determines that Physician is reporting to CalOptima less than all professional encounters in the CalOptima required format and timelines. Financial penalties or sanctions shall be assessed upon Hospital should CalOptima determine that Hospital is not meeting the

standards defined in CalOptima Policies. This Section 7.4.2 shall survive the expiration or termination of this Contract, whether with or without cause, by rescission or otherwise, as to all Covered Services provided under this Contract prior to termination. Based on CalOptima's quarterly determinations and following thirty (30) days' prior notice to Hospital, CalOptima may withhold three (3%) percent of Capitation Payment if CalOptima determines that the monthly Encounter Data that Hospital must provide has not been received by CalOptima within the prior quarter. If at the quarterly determination following such withhold, CalOptima determines that Hospital has satisfactorily delivered to CalOptima the previously non-delivered Encounter Data; such withheld Capitation Payment shall be paid to Hospital, without interest. In the event that Hospital does not deliver such Encounter Data to CalOptima prior to such quarterly determination, CalOptima shall be entitled to retain such withheld Capitation Payment and may withhold three (3%) percent from each quarter's Capitation Payment until CalOptima receives the Encounter Data.

7.5 **Financial Statements**. Hospital agrees to provide CalOptima annually with a copy of Hospital's audited financial statements, including letters to management for the most recent fiscal year end along with an opinion letter on these statements from the accounting firm that completed an audit on these financial statements. Financial statements shall be presented in a form specified by CalOptima that clearly shows the financial position of Hospital as related to Enrollees. Hospital shall allow representatives of CalOptima, upon written request, to verify the financial reports. In the event audited statements are unavailable, Hospital agrees to provide CalOptima with the unaudited financial statements at Hospital's fiscal year end. The unaudited financial statements will include: balance sheets, income statement and statement of cash flows, notes to the financial statement, name of the person preparing these statements, and representation letters from the senior financial executives of the Hospital, attesting that these financial statements were prepared in accordance with GAAP and fairly present the financial condition of the Hospital.

7.6 **Reports Regarding Disclosure of Confidential Enrollee Information**. If Hospital, or any of its officers, employees, agents, or Downstream Entities, becomes aware of the unauthorized disclosure of confidential Enrollee information or of "personal information", within the meaning of California Civil Code Section 1798.3, Hospital shall report said unauthorized disclosure to CalOptima's Privacy Officer immediately upon discovery of said disclosure, providing information on the information disclosed and how the disclosure occurred. For purposes of this section, "unauthorized disclosure" includes any unauthorized access, whether such access was through inadvertence, mistake, theft, or other means, and whether or not Hospital had reasonable control to avoid the disclosure. Nothing herein is intended to limit or replace Hospital's separate obligations under the Business Associate Agreement and Laws.

7.7 **Additional Information Required by CalOptima's Regulators**. Hospital and Downstream Entities shall, at the request of CalOptima or CalOptima's Regulators, provide the following: (i) all information related to the performance of CalOptima's responsibilities, including non-medical information for the purposes of research and evaluation, to CalOptima's Regulators; (ii) any information required to comply with all Laws; and (iii) any information required for external rapid cycle evaluation, including program expenditures, service utilization rates, rebalancing from institutional to community settings, Enrollee satisfaction, Enrollee complaints and Appeals, and enrollment/disenrollment rates.

VIII. RECORD RETENTION, ACCESS AND CONFIDENTIALITY

8.1 **Disclosure of Records**. Hospital and its Downstream Entities agree to maintain and make available contracts, books, documents, records, and electronic systems, including, Medical Records, (collectively, the "**Records**") to CalOptima, HHS, CMS, the Comptroller General, the U.S. Government Accountability Office, any Quality Improvement Organization, or accrediting organizations, including NCQA, their designees, and other representatives of regulatory or accrediting organizations, for inspection, evaluation, and auditing. For purposes of utilization management, quality improvement, and other CalOptima administrative purposes, CalOptima and CalOptima's Regulators shall have access to, and copies of, at reasonable time upon request, the Medical Records, books, charts, and papers relating to the provision of health care services to Enrollees, the cost of such services, and payments received by Hospital or any of its Downstream Entities from Enrollees (or from others on their behalf). Copies of the Medical Record shall be provided at no charge to CalOptima. Unless a longer time is required under applicable law, the records described herein shall be maintained for at least ten (10) years from the final date of the Contract or from the completion of any audit, whichever is later.

8.2 **Medical Records**. Hospital will require that all Downstream Entities establish and maintain in an accurate and timely manner, for each Enrollee who has obtained Covered Services from a Group Provider or Downstream Entity, a legible Medical Record which shall be kept in detail consistent with good medical and professional practice in accordance with Laws and CalOptima Policies. Such Medical Records shall include a historical record of diagnostic and therapeutic services recommended or provided by, or under the direction of, the Provider. Such Medical Records shall be in such a form as to allow trained health professionals, other than the Provider, to readily determine the nature and extent of the Enrollee's medical problem and the services provided and permit peer review of the care provided. Hospital shall ensure that medical information is released in accordance with applicable Laws, or pursuant to valid court orders or subpoenas, subject to compliance with applicable privacy laws. Hospital shall ensure than an individual is delegated the responsibility of securing and maintaining Medical Records at each Hospital or Downstream Entity site.

8.3 **Right to Inspection**. Medical Records referred to in Section 8.2 above will be and remain the property of Hospital or Downstream Entities and will not be removed or transferred from their offices except in accordance with Laws. CalOptima or its designated representatives will have the right, in accordance with this Article 8, to inspect, review, and make copies of such records at Hospital's expense upon request to facilitate CalOptima's obligation to conduct quality management, utilization monitoring, and peer review activities.

8.4 **Records Related to Recovery for Litigation**. Upon request by CalOptima, Hospital and its Downstream Entities shall timely gather, preserve, and provide to CalOptima, in the form and manner specified by CalOptima, any information specified by CalOptima, subject to any lawful privileges, in Hospital's or its Downstream Entities' possession, relating to threatened or pending litigation by or against CalOptima, HHS, and CMS. If Hospital asserts that any requested documents are covered by a privilege, Hospital shall: (1) identify such privileged documents with sufficient particularity to reasonably identify the document while retaining the privilege; and (2) state the privilege being claimed that supports withholding production of the document. Such request shall include a response to a request for documents submitted by any party in any litigation by or against CalOptima. Hospital acknowledges that time may be of the essence in responding to such request. Hospital shall use all reasonable efforts to immediately notify CalOptima of any subpoenas, document production requests, or requests for records received by Hospital or its Downstream Entities related to this Contract or subcontracts entered into under this Contract.

8.5 **State and Federal Site Visits**. Hospital agrees to permit CalOptima, the DMHC, HHS, and/or CMS to conduct a site evaluation of Hospital and its facilities in accordance with Laws and to comply with the agencies' recommendations, if any.

8.6 **Enrollee Access to Records**. Hospital (including Hospital Providers) and its Downstream Entities shall ensure that Enrollees have access to their Medical Records in accordance with the requirements of Laws. An Enrollee shall be provided a copy of his or her Medical Records, upon request, and shall have the right to request corrections or amendments to their Medical Records as specified in 45 CFR Part 164. Hospital and Downstream Entities shall furnish a copy of the Enrollee's Medical Records to another treating or consulting Provider regardless of whether the requesting Provider is a Participating Provider, at no cost to CalOptima or the Enrollee when (i) such a transfer of Medical Records facilitates the continuity of that Enrollee's care; (ii) the Enrollee is transferring from one Provider to another for treatment; and (iii) an Enrollee seeks to obtain a second opinion on the diagnosis or treatment of a medical condition.

IX. INSURANCE AND LIABILITY

9.1 **Indemnification**. Each Party agrees to defend, indemnify, and the other Party and the State and CMS harmless, with respect to any and all claims, costs, damages, and expenses, including reasonable attorney's fees, that are related to or arise out of the negligent or willful performance or non-performance by the indemnifying Party, or any functions, duties, or obligations of such Party. Neither termination of the Contract nor completion of the acts to be performed under this Contract shall release either Party from its obligation to indemnify as to any claims or cause of action asserted so long as the event(s) upon which such claims or cause of action is predicated shall have occurred prior to the effective date of termination or completion. CalOptima and Hospital agree to promptly notify the other Party of any claims or demands that arise and for which indemnification hereunder is sought.

9.2 **Insurance Requirements**.

9.2.1 **Hospital and Downstream Entity Insurance**. Hospital agrees to procure and maintain, at its own expense, the insurance policies required by this Section 9.2 and Laws as necessary to insure it and its employees, agents, and representatives against any claim or claims for damages arising by reason of: (a) personal injuries or death occasioned in connection with the performance of any Covered Services provided hereunder; (b) the use of any property and Facilities of the Hospital; and (c) activities performed in connection with this Contract. Hospital shall require its Downstream Entities to maintain similar policies of insurance where Hospital's insurance does not cover its Downstream Entities.

9.2.2 **Professional/Medical Malpractice**. Hospital shall maintain a professional liability (medical malpractice) insurance policy with minimum limits of ten million dollars ($10,000,000) per incident and twenty million dollars ($20,000,000) in the aggregate per year.

9.2.3 **Commercial General Liability/Commercial Automobile Liability**. Hospital and each Participating Provider who has entered into a contract with Hospital to provide Covered Services under this Contract shall maintain a Commercial General Liability insurance policy and a Commercial Automobile Liability insurance policy with minimum limits as follows:

- Commercial General Liability: One million dollars ($1,000,000) per occurrence and three million dollars ($3,000,000) in the aggregate.

- Commercial Automobile Liability: One million, two hundred thousand dollars ($1,200,000) combined single limit for bodily injury or property damage covering any automobile, whether owned, leased, hired, or rented, on an ISO form CA 0001 or equivalent.

CalOptima must be named as an additional insured on Comprehensive General Liability and Commercial Automobile Liability insurance policies with respect to performance under this Contract.

9.2.4 **Workers' Compensation**. Hospital shall maintain a Workers' Compensation Insurance policy that provides statutory coverage with minimum limits as follows:

- Employers' Liability Insurance:
  - One million dollars ($1,000,000) Bodily Injury by Accident - each accident.
  - One million dollars ($1,000,000) Bodily Injury by Disease - policy limit
  - One million dollars ($1,000,000) Bodily Injury by Disease - each employee

9.2.5 **Managed Care Errors and Omissions**. Physician shall maintain a Managed Care Errors and Omissions Insurance policy with minimum limits as follows:

- Managed Care Errors and Omissions: Ten million dollars ($10,000,000) each claim/ten million dollars ($10,000,000) aggregate

9.2.6 **Electronic and Computer Crimes Insurance**. Hospital and its Downstream Entities shall maintain electronic and computer crimes insurance and employee fidelity insurance with limits of at least one million dollars ($1,000,000) if Hospital and/or its Downstream Entities will be paying claims or receiving funds on behalf of CalOptima, or will be storing, transmitting, and/or receiving personally identifiable and/or protected health information on a regular basis in carrying out its obligations under this Contract.

9.2.7 **Insurer Ratings**. Insurance required under this Article IX shall be provided by an insurer:

(a) Rated by A.M. Best with a rating of A V or better; and

(b) "Admitted" to do business in California or an insurer approved to do business in California by the California Department of Insurance and listed on the Surplus Lines Association of California List of Eligible Surplus Lines Insurers (LESLI); or

(c) An Unincorporated Interindemnity Trust Arrangement as authorized by the California Insurance Code 12180.7

9.2.8 **Captive Risk Retention Group/Self Insured**. Where any of the insurance(s) mentioned in this Article IX is provided by a captive risk retention group or self-insured, insurer ratings requirements above may be waived at the sole discretion of CalOptima, but only

after review of the captive risk retention group's or self-insured's audited financial statements.

9.2.9 **Cancellation or Material Change**. Hospital shall not of its own initiative cause such insurance as addressed in this Article IX to be cancelled or materially changed during the Term.

9.2.10 **Proof of Insurance**. Certificates of Insurance of the insurance policies and/or evidence of self-insurance required under this Article IX shall be provided to CalOptima prior to Effective Date, annually thereafter, and upon request.

X. COOPERATION

10.1 **Non-Interference**. Hospital and Downstream Entities may not prohibit of otherwise restrict a health care professional, acting within the lawful scope of practice, from freely communicating with Enrollees about their treatment and the following, regardless of benefit coverage limitations:

10.1.1 The Enrollee's health status, medical care, or treatment options (including any alternative treatments that may be self-administered), including the provision of sufficient information to provide an opportunity for the Enrollee to decide among all relevant treatment options;

10.1.2 The risks, benefits, and consequences of treatment or non-treatment; or

10.1.3 The opportunity for the Enrollee to refuse treatment and to express preferences about future treatment decisions.

10.2 **No Counseling to Dis-enroll**. Hospital will not, during the Term, provide advice to or counsel any Enrollee to dis-enroll from CalOptima, and Hospital will not solicit such Enrollee to become enrolled with any other health maintenance organization, preferred provider organization, or any other similar hospitalization, medical payment plan or insurance program.

10.3 **Cooperation**. CalOptima and Hospital agree that, to the extent compatible with the separate and independent management of each, they will at all times maintain an effective liaison and close cooperation with each other to provide maximum benefits to Enrollees at the most reasonable cost, consistent with quality standards of hospital and physician care.

10.4 **Signs**. Hospital agrees that CalOptima may post notices, mutually acceptable as to size, content and form in a prominent place instructing Enrollees as to proper procedures and limitations on coverage.

10.5 **Free Exchange of Information**. No provision of this Contract shall be construed to prohibit, nor shall any provision in any contract between Hospital and its employees or Downstream Entities, prohibit, the free, open, and unrestricted exchange of any and all information of any kind between Providers and Enrollees regarding the nature of the Enrollee's medical condition, the health care treatment options and alternatives available and their relative risks and benefits, whether or not covered or excluded under the Enrollee's Evidence of Coverage, and the Enrollee's right to appeal any adverse decision made by Hospital or CalOptima regarding coverage of treatment which has been recommended or rendered. Hospital and CalOptima agree not to penalize nor sanction any Provider in any way for engaging in such free, open, and unrestricted communication with an Enrollee nor for advocating for a particular service on an Enrollee's behalf.

XI. TERM AND TERMINATION

11.1 **Term of Contract**. The term of this Contract shall become effective on the Effective Date and continue in effect for five (5) years through _____ ("Initial Term") and five (5) additional one-year automatic extensions except as directed otherwise by the Board.

11.2 **Sanctions and Terminations for Cause**. If Hospital fails to fulfill any of its duties and obligations under this Contract, including: (i) committing acts to discriminate against Enrollees; (ii) engaging in any practice that would reasonably be expected to have the effect of denying or discouraging enrollment with the Hospital by Enrollees whose medical condition or history indicated a need for substantial future medical services; (iii) not providing Covered Services in the scope or manner required under this Contract; (iv) engaging in prohibited marketing activities; (v) failing to comply with CalOptima's compliance and fraud, waste and abuse programs; (vi) failing to meet financial requirements in Article II; (vii) committing fraud, waste or abuse relating to Covered Services or any and all obligations, duties, and responsibilities under this Contract; (viii) failure to enforce claims payment prohibitions on Providers who are denied the right to submit claims and/or receive reimbursement for services furnished to Enrollees; (ix) failure to comply with pharmacy requirements as determined by CalOptima; (x) failure to submit Encounter Data or comply with other reporting requirements pursuant to this Contract and CalOptima Policies; and/or (xi) failure to take corrective action related to any such obligation or duty in the time or manner required by CalOptima, CalOptima may take any one or more of the actions described in this Article XI.

11.3 **Corrective Action Plans**. CalOptima may require a Corrective Action Plan ("**CAP**") in the event that any report, audit, survey, site review or investigation indicates that the Hospital or any Downstream Entity is not in compliance with any provision of this Contract.

11.3.1 A CAP shall be required if CalOptima receives a substantiated complaint or grievance related to the standard of care provided by the Hospital or any Downstream Entities. CalOptima shall issue a written notice of deficiency and shall require that a CAP to be submitted within thirty (30) calendar days following the date of notice unless otherwise stated. The CAP shall include the time and manner in which the deficiency shall be corrected. CAPs are subject to approval by CalOptima, which may be approved as submitted, accepted with specific modifications, or rejected. CalOptima may extend or reduce the time allowed for completion of the CAP depending upon the nature of the deficiency.

11.3.2 Notwithstanding any request for a CAP, CalOptima may impose monetary penalties, suspend enrollment, reduce maximum enrollment, or impose other sanctions when the Hospital is not in compliance with the provisions of this Contract, CalOptima Policies, and minimum performance requirements as established by CalOptima. All monetary fines are payable to CalOptima within thirty (30) calendar days of receipt of written notice, unless otherwise stated in the notice. Failure to submit payment to CalOptima for any monetary fines within the thirty (30) calendar day period shall result in CalOptima deducting the penalty plus administrative fees from the Hospital's Capitation Payment.

11.3.3 CalOptima may apply sanctions pursuant to this Contract and CalOptima Policies to all PHC Participants independent of the PHC Participant whose action(s) caused sanctions to be applied by CalOptima.

11.4 **CalOptima Termination for Cause**. Notwithstanding and in addition to any other provisions of this Contract, CalOptima may terminate this Contract for cause effective upon thirty (30) calendar

days' written notice; cause shall include, but shall not be limited to, the actions set forth in Section 11.2. CalOptima's rights and remedies provided in this provision shall not be exclusive and are in addition to any other rights and remedies provided by law or this Contract.

11.5 **Hospital Termination for Cause**. Hospital may terminate this Contract for cause only upon thirty (30) calendar days' written notice and only in the event that CalOptima fails to make payments due under this Contract within fifteen (15) calendar days of when such amounts are due and payable.

11.6 **Immediate Terminations**. In addition to all other sanction and termination rights, CalOptima may terminate Contract immediately upon delivery of written notice to Hospital if:

11.6.1 Hospital and/or its Downstream Entities are unable to secure the necessary governmental licenses, approvals, and/or certificates required for the performance of their duties;

11.6.2 CalOptima determines that the health, safety, or welfare of Enrollees is jeopardized by continuation of this Contract;

11.6.3 Hospital commits fraud, waste, or abuse; or

11.6.4 CMS fails to authorize or reauthorize CalOptima to operate a MA Program for a period that overlaps the Term.

11.6.5 This Contract shall terminate upon the termination of the Physician Group Contract. Notification of termination to any PHC Participant shall constitute notification of termination to all PHC Participants.

11.7 **Without Cause Termination**. Following the Initial Term, either Party may terminate this Contract for convenience, without cause, by giving written notice to the other Party of at least one hundred and eighty (180) calendar days' prior to the effective date of such termination.

11.8 **Bankruptcy**. If during the Term there is filed by or against Hospital in any court pursuant to any statute of the United States or any state, a petition in bankruptcy or insolvency or for reorganization or for the appointment of a receiver or trustee or conservator of all or a portion of Hospital's assets, or if Hospital makes an assignment for the benefit of creditors, or if Hospital becomes unable, admits in writing its inability, or fails generally to pay its debts as they become due, this Contract may, at the option of CalOptima, be canceled and terminated. In the event of the filing of a petition for bankruptcy by or against Hospital, Hospital shall assure that all of Hospital's functions and duties related to the Contract are performed in accordance with the terms of the Contract. CalOptima shall have the right to withhold any and all amounts otherwise due to Hospital until Hospital fully discharges its obligations under the Contract. CalOptima shall also have the immediate right of offset by permanently retaining any and all withheld amounts as necessary to ensure that all Hospital obligations have been met.

11.9 **Termination of CMS Contract.** In the event the CMS Contract with CalOptima is terminated or not renewed, the provisions of this Contract shall automatically terminate unless otherwise specified by CalOptima and subject to any provisions that survive termination. Any term provided in the Contract is subject to CMS's continuing approval of CalOptima's MA Program. Hospital agrees to assist CalOptima with such transfer of care requirements mandated by CMS in the event of termination of the CMS Contract.

11.10 **Continuation of Benefits**. Hospital and its Downstream Entities agree that, in the event of CalOptima's insolvency or cessation of operations, benefits to Enrollees will continue through the period for which capitation has been paid or until the discharge of Enrollee from an inpatient facility, whichever time is greater. Covered Services to an Enrollee confined in an inpatient facility on the date of insolvency or other cessation of operations will continue until their appropriate discharge.

11.11 **Hospital Obligations Following Termination**. In the event of termination of this Contract, at CalOptima's sole option, Hospital will continue to provide Covered Services, and CalOptima shall reimburse for such services per the Medicare fee schedule, to Enrollees until CalOptima has made arrangements with alternative Providers to render care to Enrollees. Hospital shall cooperate and assist CalOptima in the transfer of Enrollee care in the event this Contract or any relevant Downstream Entity subcontract is terminated for any reason. Hospital shall provide a plan for the orderly termination of services under this Contract, in form and substance acceptable to CalOptima.

11.12 **Prohibition on Use of Certain Providers**. Hospital agrees that CalOptima reserves the right to require Hospital, upon notification from CalOptima, to prohibit any Provider or Downstream Entity from providing services, whether Covered Services or otherwise, to Enrollees when CalOptima deems such prohibition to be in the best interests of the Enrollees, provided that imposition of the foregoing prohibition shall not terminate this Contract.

11.13 **PHC Primary Hospital Usage Requirement**. In order to qualify as a PHC, PHC Participants must ensure that, during every annual contract year period during the Term, at least seventy percent (70%) of the bed days for those Enrollees assigned to the PHC who require inpatient hospitalization during the previous calendar year must have occurred at Hospital or within the same hospital system as Hospital, except as otherwise provided under CalOptima Policies. For purposes of calculating the bed day percentage, only bed days in Orange County hospitals shall count. Failure to meet this requirement shall be cause for termination by CalOptima under Section 11.4 of this Contract. Termination as a result of breaching this Section 11.13 shall have no effect on any fee-for-service contract between CalOptima and Hospital. In the event of termination under the equivalent of this section in the Physician Group Contract, Physician Group shall be offered the opportunity to continue be a Participating Provider through a separate risk-sharing arrangement with CalOptima, subject to meeting all applicable financial, operational, and other criteria for such an arrangement.

XII. GENERAL PROVISIONS

12.1 **Dispute Resolution**.

12.1.1 **Provider Appeals Process**. CalOptima maintains a Provider dispute resolution process. Hospital may appeal any aspect of the CalOptima MA Program, including a decision to impose a sanction, terminate this Contract, or take other actions against Hospital, by filing a complaint pursuant to CalOptima Policies. Hospital shall exhaust all administrative remedies and any government claims requirements, as applicable, before commencing arbitration.

12.1.2 **Meet and Confer**. For any dispute not subject to or resolved by the provider appeals process, or if either Party has a dispute it seeks to address informally, the Parties shall use reasonable efforts to informally meet and confer to try and resolve the dispute. The Parties shall meet and confer within thirty (30) days of a written request submitted by either Party in an effort to settle any dispute. At each meet-and-confer meeting, each Party shall be represented by persons with final authority to settle the dispute. If either Party fails to meet

within the thirty (30)-day period, that Party shall be deemed to have waived the meet-and-confer requirement, and at the other Party's option, the dispute may proceed immediately to arbitration under Section 12.1.3.

12.1.3 **Arbitration**. If the Parties are unable to resolve any dispute arising out of or relating to this Contract under Sections 12.1.1 and 12.1.2, either Party may submit the dispute for resolution exclusively through confidential, binding arbitration, instead of through trial by court or jury, in Orange County, California. The Parties may agree in writing prior to commencing the arbitration on the dispute resolution rules and arbitration service that will be used to resolve the dispute. If the Parties cannot reach such an agreement, the arbitration will be conducted by Judicial Arbitration and Mediation Services ("**JAMS**") in accordance with the commercial dispute rules then in effect for JAMS; provided, however, that this Contract shall control in instances where it conflicts with JAMS's (or the applicable arbitration service's) rules. The arbitration shall be conducted on an expedited basis by a single arbitrator. The Parties prefer that the arbitrator be a retired judge of the California Superior, Appellate, or Supreme Court or of a United States court sitting in California. If no such retired judge is available, the arbitrator may be an attorney with at least fifteen (15) years of experience, including at least five (5) years in managed health care. If the Parties are unable to agree on the arbitrator within thirty (30) days of the date that the arbitration service accepts the arbitration, the arbitrator shall be selected by the arbitration service from a list of four potential arbitrators (all of whom shall be on arbitration services' panel of arbitrators) submitted by the Parties, two from each side; provided, however, that nothing stated in this section shall prevent a Party from disqualifying an arbitrator based on a conflict of interest. In making decisions about discovery and case management, it is the Parties' express agreement and intent that the arbitrator at all times promote efficiency without denying either Party the ability to present relevant evidence. In reaching and issuing decisions, the arbitrator shall have no jurisdiction to make errors of law and/or legal reasoning. The Parties shall share the costs of arbitration equally, and each Party shall bear its own attorneys' fees and costs.

12.1.4 **Exclusive Remedy**. With the exception of any dispute that under Laws may not be settled through arbitration, arbitration under Section 12.1.3 is the exclusive method to resolve a dispute between the Parties arising out of or relating to this Contract that is not resolved through the provider appeals or meet-and-confer processes.

12.1.5 **Waiver**. By agreeing to binding arbitration as set forth in Section 12.1.3, the Parties acknowledge that they are waiving certain substantial rights and protections which otherwise may be available if a dispute between them was determined by litigation in a court, including the right to a jury trial, attorneys' fees, and certain rights of appeal.

12.2 **Interpretation of Contract Language**. CalOptima has the right to final interpretation of the Contract language when disputes arise. Hospital has the right to appeal disputes concerning Contract language to CalOptima.

12.3 **Waiver**. The waiver by either Party of a breach or violation of any provision of this Contract will not operate as or be construed to be a waiver of any subsequent breach thereof. To be effective, a waiver must in writing signed by the Parties.

12.4 **Assignment**. This Contract and the rights, interests, duties, and obligations hereunder shall not be assigned, transferred, pledged, or hypothecated in any way by Hospital nor shall the duties and obligations imposed herein be subcontracted or delegated without the prior written consent of

CalOptima, which consent may be withheld in CalOptima's sole and absolute discretion for any reason or no reason. Hospital acknowledges and agrees that CalOptima's consent, if any, to assignment and/or delegation is subject to the approval of CMS. Therefore, any assignment and/or delegation of this Contract, including the rights, interests, duties, and obligations hereunder, shall be void unless prior written consent is obtained from CalOptima and CMS. Hospital further acknowledges and agrees that CalOptima may require Hospital and the proposed assignee/sub-delegate to cooperate in due diligence and sub-delegation assessment activities as part of its review of any request for consent to assignment of this Contract and the rights, interests, duties, and obligations hereunder. Hospital agrees to cooperate and provide such information as requested by CalOptima. Hospital acknowledges and agrees that (i) CalOptima's due diligence and/or assessment activities related to any proposed assignment may take one hundred eighty (180) days or more; (ii) in no event shall CalOptima's due diligence and/or delegation assessment activities be construed as CalOptima's consent to assignment; and (iii) any consent to assignment by CalOptima must be reflected in a separate writing executed by CalOptima and other relevant parties. CalOptima may, from time to time, establish policies and procedures regarding its processes for initiating review and approval of any proposed assignment of this Contract. For purposes hereof, the term "**assignment**" shall include any of the following: (i) the change of more than twenty-five percent (25%) of the ownership or equity interest in Hospital (whether in a single transaction or in a series of transactions); (ii) the change of more than twenty-five percent (25%) of the directors or trustees of Hospital; (iii) the merger, reorganization, or consolidation of Hospital with another entity with respect to which Physician is not the surviving entity; and/or (iv) a change in the management of Hospital from management by persons appointed, elected, or otherwise selected by the governing body of Hospital (e.g., the Board of Directors) to a third-party management person, company, group, team or other entity.

12.5 **Independent Parties**. None of the provisions of this Contract are intended to create nor will be deemed or construed to create any relationship between the Parties other than that of independent contractors, solely for the purposes of effecting the provisions of the Contract. Neither of the Parties nor any of their respective officers, directors, or employees shall act as nor be construed to be the agent, the employee, or the representative of the other Party.

12.6 **Integration of Entire Contract**. This Contract contains all of the terms and conditions agreed upon by the Parties regarding the subject matter of this Contract. Any prior agreements, promises, negotiations or representations of or between the Parties, either oral or written, relating to the subject matter of this Contract that are not expressly set forth in this Contract are null and void and of no further force or effect.

12.7 **Invalidity or Unenforceability**. The invalidity or unenforceability of any terms or provisions hereof will in no way affect the validity or enforceability of any other term or provision.

12.8 **Amendment**. CalOptima may amend this Contract immediately upon written notice to Hospital in the event such amendment is required in order to maintain compliance with Laws. CalOptima may deem all other amendments to the Contract effective after at least forty-five (45) business days' notice or earlier if agreed to by Hospital. All amendments of this Contract are subject to CMS approval.

12.9 **No Waiver of Immunity or Privilege**. Any information delivered, exchanged, or otherwise provided hereunder shall be delivered, exchanged, or otherwise provided in a manner, which does not constitute a waiver of immunity or privilege under applicable law.

12.10 **Choice of Law; Jurisdiction and Venue**. This Contract shall be governed by and construed in accordance with all State and federal laws and regulations governing the CMS Contract. The Parties consent to the jurisdiction of the California Courts with venue in Orange County California.

12.11 **Force Majeure**. Either Party, upon prompt written notice to the other Party, shall be excused from performance hereunder for any period that it is prevented from meeting the terms of this Contract as a result of a catastrophic occurrence or natural disaster, including, but not limited to, an act of war and excluding labor disputes ("**Force Majeure Event**");

12.12 **No Liability of County of Orange**. As required under Ordinance No. 3896, as amended, of the County of Orange, State of California, CalOptima and the Hospital hereby acknowledge and agree that the obligations of CalOptima under this Contract are solely the obligations of CalOptima, and the County of Orange, State of California, shall have no obligation or liability therefor.

12.13 **Confidential and Proprietary Information**. Hospital agrees to maintain confidential the following information (the "**Confidential Information**"): (a) eligibility lists and any other information containing the names, addresses and telephone numbers of CalOptima Enrollees; (b) CalOptima's administrative service manuals and all forms related thereto; (c) the financial arrangements between CalOptima and any Participating Provider; and (d) any other information compiled or created by CalOptima that is proprietary to CalOptima and that CalOptima identifies as proprietary to Hospital in writing. Hospital shall not disclose or use the Confidential Information for its own benefit or gain either during the Term or after the date of termination of this Contract. Hospital may use the Confidential Information to the extent necessary to perform its duties under this Contract or upon express prior written permission of CalOptima. Upon the effective date of termination of this Contract, Hospital shall promptly return to CalOptima the Confidential Information in its possession, upon CalOptima's notice.

12.14 **Third Party Beneficiaries**. Nothing in this Contract, express or implied, is intended to or shall confer upon any other person or entity, any right, benefit or remedy of any nature whatsoever.

12.15 **Survival**. The terms set forth in the following sections shall survive the expiration or termination of this Contract, whether with or without cause, by rescission or otherwise, as to all Covered Services provided under this Contract prior to termination: Sections 6.2, 6.5, 7.8, Article 8, 9.1, 11.10, 11.11, 12.1, 12.2, 12.3, 12.5, 12.6, 12.7, 12.9, 12.10, 12.12, 12.13, 12.14, and any other sections that, by their terms, are intended to survive termination of the Contract.

12.16 **Recitals and Exhibits**. The recitals, exhibits, and addenda set forth in this Contract are made a part of the Contract by this reference.

12.17 **Without Limitation**. Any reference in the Contract to "include(s)" or "including" means inclusion without limitation, unless otherwise distinguished within the text.

12.18 **Notices**. All notices shall be in writing and shall be deemed to have been duly given on the date of service if personally served on the Party to whom notice is given, or seventy-two (72) hours after mailing by electronic mail transmission, United States priority mail, United States mail first class (Certified Mail or Registered Mail), addressed to the Party to whom notice is to be given and such party's address as set forth below or such other address provided by notice.

To: CalOptima

Attention: Chief Operating Officer

505 City Parkway West
Orange, California 92868

To: Hospital

_____

_____

_____

XIII. CONDITIONS PRECEDENT TO CONTRACT COMMENCEMENT

13.1 **Contract Effectiveness**. The Contract is subject to CalOptima's determination, in its sole discretion, that the following conditions have been met prior to the Effective Date: (i) Hospital has successfully met all criteria in CalOptima's readiness assessment, including financial viability and delegated function criteria; Hospital has signed CalOptima's Business Associate Agreement; and (iii) Hospital has furnished all required documentation and data requested by CalOptima (e.g., insurance documents, licenses).

13.2 **Additional CalOptima Regulator Requirements**. CalOptima, in its sole discretion, may condition this Contract upon Hospital's ability to meet other criteria imposed by CalOptima Regulators.

XIV. SIGNATURES

SUBJECT TO (I) THE UNITED STATES GOVERNMENT PROVIDING FUNDS FOR THE TERM OF THIS CONTRACT AND FOR THE PURPOSES WITH RESPECT TO WHICH IT IS ENTERED INTO; AND (II) THE APPROVAL OF THIS CONTRACT BY DMHC AND CMS, THIS CONTRACT SHALL BECOME EFFECTIVE ON THE EFFECTIVE DATE AND SHALL TERMINATE ON AS PROVIDED IN THIS CONTRACT.

IN WITNESS WHEREOF, CalOptima and Hospital have executed this Contract as indicated below.

FOR Hospital:	FOR CALOPTIMA:
_____	_____
SIGNATURE	SIGNATURE
_____	Yunkyung Kim
PRINT NAME	PRINT NAME
_____	Chief Operations Officer
TITLE	TITLE
_____	_____
DATE	DATE

ADDENDUM 1

Entities Comprising the PHC

ATTACHMENT A
DEFINITIONS

1. "**Administrative Services**" means those non-clinical, administrative functions that are the responsibility of the Hospital as set forth under the Contract and in CalOptima Policies.

2. "**Advance Directive**" means an individual's written directive or instruction, such as a power of attorney for health care or a living will, recognized under state law (whether statutory or as recognized by the courts of the state) for the provision of that individual's health care if the individual is unable to make his or her health care wishes known.

3. "**Appeals**" means an Enrollee's actions, both internal and external to CalOptima, requesting review of the denial, reduction, or termination of benefits or services from CalOptima.

4. "**Authorization/Authorized**" means the approval of CalOptima, or its delegate (which may include Hospital), for the provision or referral of Covered Services, obtained in accordance with, and as further described in, the Provider Manual and this Contract.

5. "**Behavioral Health**" means the mental health services and substance use disorder services arranged for or provided to Enrollees by a separate Mental Health Plan, CalOptima, or their subcontractors.

6. "**CalOptima Formulary**" means the CalOptima Approved Drug List, the Disposable Medical Equipment/Supplies List, the CalOptima OneCare Formulary, and any additional formularies as may be designated by CalOptima and provided to CalOptima's designated pharmacy benefits manager "**PBM**". There is no applicable CalOptima Formulary for the PACE program.

7. "**CalOptima Policies**" means CalOptima policies and procedures, including CalOptima's Provider Manual, that are amended from time to time at the sole discretion of CalOptima and incorporated into this Agreement by this reference.

8. "**CalOptima's Regulators**" means those government agencies that regulate and oversee CalOptima's and its FDRs' activities and obligations under this Contract including the Department of Health and Human Services, CMS, and the DMHC and other government agencies that have authority to set standards and oversee the performance of the parties to this Contract, as well as their respective agents and contractors quality improvement organizations.

9. "**Capitation Payment**" means the monthly payment paid to Hospital by CalOptima for delivery for Covered Services to Enrollees, which is determined by multiplying the applicable Capitation Rate by Hospital's monthly enrollment.

10. "**Capitation Rate**" means the rate set by CalOptima for the delivery of Covered Services to an Enrollee.

11. "**Care Coordinator**" means a clinician or other trained individual employed by or contracted with Hospital who is accountable for providing care coordination services for Enrollees, as required by CalOptima Policies and who services on one or more ICTs.

12. "**C.C.R.**" means the California Code of Regulations.

13. "**C.F.R.**" means the Code of Federal Regulations.

14. "**CMS**" means the Center for Medicare & Medicaid Services.

15. "**CMS Contract**" means the agreement between CMS and CalOptima under which CalOptima can establish its MA Program for Enrollees.

16. "**COB**" refers to the coordination of benefits and determination of order of financial responsibility that applies when two or more health benefit plans provide coverage of items and services for an individual.

17. "**Compliance Program**" means the program (including the compliance manual, code of conduct and CalOptima Policies) developed and adopted by CalOptima to promote, monitor, and ensure that CalOptima's operations and practices and the practices of its Board members, employees, contractors, and Providers comply with applicable law and ethical standards. The Compliance Program includes CalOptima's Fraud, Waste and Abuse ("**FWA**") plan.

18. "**Covered Services**" means those health care items, drugs, and services that an Enrollee is entitled to receive pursuant to a Program applicable to that Enrollee. Covered Services must generally be referred and Authorized in confirming with CalOptima's Policies, including its utilization management program."

19. "**Delegation**" means the process by which CalOptima expressly grants, by formal written agreement to another entity, the authority to carry out a function that would otherwise be required to be performed by CalOptima in order to meet its obligations under the CMS Contract.

20. "**Delegation Agreement**" means the formal written agreement by which CalOptima grants to another entity the authority to carry out a function that would otherwise be required to be performed by CalOptima to meet its obligations under the CMS Contract.

21. "**Delegation Criteria**" means those criteria adopted by CalOptima, for the delegation of activities in the areas of UM, medical records audits, the Office Site Review, 'Enrollee's rights and responsibilities, and credentialing, as set forth in CalOptima Policies.

22. "**DMHC**" means the California Department of Managed Health Care.

23. "**Downstream Entity**" means all Providers and other persons or entities with which Hospital has entered into a written subcontract (acceptable to CMS) to perform administrative functions and/or health care services to satisfy Hospital's obligations to CalOptima under this Contract, continuing down to the ultimate provider of services. The term "Hospital" as used in the terms of this Contract shall also include its subcontractors when such subcontractors are Downstream Entities, even if not expressly referenced in the particular provision.

24. "**Emergency Medical Condition**" means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, with an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in: (i) placing the health of the individual (or with respect to a pregnant woman, the health of the woman and her unborn child) in serious jeopardy; or (ii) serious impairment to bodily functions; or (iii) serious dysfunction of any bodily organ or part.

25. "**Emergency Services**" means those covered inpatient and outpatient services that are (i) furnished by a Provider qualified to furnish Emergency Services; and (ii) needed to evaluate and/or stabilize an Enrollee's Emergency Medical Condition.

26. "**Encounter Data**" means the record of an Enrollee receiving any item(s) or service(s) provided through Medicaid or Medicare under a prepaid, capitated, or any other risk basis payment methodology submitted to CMS. The encounter data record shall incorporate HIPAA security, privacy, and transaction standards and be submitted in ASCX12N 837 or any successor format required by CalOptima's Regulators.

27. "**Enrollee**" means an eligible individual who is enrolled in the CalOptima MA Program.

28. "**Evidence of Coverage**" means the document approved by CalOptima's Regulators and issued by CalOptima to Enrollees that describes Enrollee's benefits under the CalOptima MA Program.

29. "**FDR**" means a party that enters into a written agreement (acceptable to CMS) to provide administrative or health care services to CalOptima and/or its Enrollees that are governed by the CMS Contract.

30. "**FQHC**" means an entity that meets all of the requirements for designation as a federally qualified health center under § 1861(aa)(3) of the Social Security Act and is approved for participation in the MA program.

31. "**Grievance**" means an oral or written expression of dissatisfaction, including any compliant, dispute, request for reconsideration, or appeal, made by an Enrollee.

32. "**Health Network**" means Hospital, a PHC, or health care service plan (such as an HMO) that is contracted with CalOptima to provide items and services to Enrollees on a capitated basis.

33. "**HEDIS**" means the set of standardized performance measures sponsored and maintained by the NCQA.

34. "**HRA**" means the health risk assessment tool that identifies an Enrollee's primary, acute, LTSS, Behavioral Health, and functional needs.

35. "**HIPAA**" means the Health Insurance Portability and Accountability Act of 1996, Public Law 104-191, the Health Information Technology for Economic and Clinical Health Act, Public Law 111-005, and regulations promulgated thereunder by the U.S. Department of Health and Human Services, including Title 45 of the C.F.R, Parts 160 and 164.

36. "**ICP**" means the plan of care developed by an Enrollee and/or his/her ICT or CalOptima.

37. "**Indian Enrollee**" means an Enrollee who is an Indian (as defined in the Indian Health Care Improvement Act of 1976 [25 U.S.C. §§ 1603(13), 1603 (13 and 23), or 1679(a)] or who has been determined as an Indian under 42 C.F.R. § 136.12.

38. "**Indian Health Care Provider**" means a health care program operated by the Indian Health Services or by an Indian Tribe, Tribal Organization, or Urban Indian Organization, as those terms are defined in Section 4 of the Indian Health Care Improvement Act (25 U.S.C. § 1603).

39. "**ICT**" means an interdisciplinary care team comprised of the primary care provider and Care Coordinator and other Providers at the discretion of the Enrollee that work with the Enrollee to develop, implement, and maintain the ICP.

40. "**Laws**" means any local, State, or federal statute, regulation, rule, or executive or agency order applicable to this Contract.

41. "**LTSS**" means the range of long-term services and supports that help Enrollees meet their daily needs for assistance and improve the quality of their lives and which include: (i) In-Home Supportive Services ("**IHSS**"); (ii) Community-Based Adult Services ("**CBAS**"); (iii) Multi-purpose Senior Services Program ("**MSSP**") services; and (iv) skilled nursing facility services and sub-acute care services.

42. "**Medically Necessary**" or "**Medical Necessity**" means when addressing Covered Services: (i) under Medicare, reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member, or otherwise medically necessary under 42 U.S.C. Section 1395y.

43. "**Medical Record**" means any record kept or required to be kept by any Provider that documents medical services received by the Enrollee, including inpatient, outpatient, emergency care, referral requests, and Authorizations in accordance with applicable laws including Title 28 C.C.R. § 1300.80(b), Title 42 U.S.C. § 1396a(w), 42 C.F.R. § 456.111 and 42 C.F.R. § 456.211 and CalOptima Policies.

44. "**Mental Health Plan**" means the entity that has contracted with DHCS to provide Specialty Mental Health Services to individuals, including Enrollees.

45. "**Model of Care**" means the component of CalOptima's quality improvement framework that is evidence-based, includes certain clinical and non-clinical elements, and is in addition to the comprehensive care coordination requirements specified in CalOptima Policies.

46. "**Non-Covered Services**" means those services that are not benefits under the CalOptima MA Program in accordance with CalOptima's Evidence of Coverage and applicable state and federal laws and regulations.

47. "**Non-Participating Provider**" means an institution, professional, or other Provider of health care services who has not entered into an agreement, either with CalOptima or Hospital, to provide medical and other services to Enrollees.

48. "**Out-of-Area**" means that area that is outside the Service Area.

49. "**Participating Provider**" means an institution, professional, or other provider of health care services who has entered into an agreement, either with CalOptima or Hospital, to provide health care services to Enrollees.

50. **"Physician"** means a person with an unrestricted license to practice medicine or osteopathy in the state in which they practice.

51. "**Post-Stabilization Care Services**" means services related to an Emergency Medical Condition that are provided after an Enrollee is Stabilized in order to maintain the Stabilized condition, or under some circumstances, to improve or resolve the condition.

52. "**Preclusion List**" means the CMS-compiled list of providers and prescribers who are precluded from receiving payment for MA items and services or Part D drugs furnished or prescribed to Medicare beneficiaries.

53. "**PCP**" means a primary care physician responsible for supervising, coordinating, and providing initial and primary care to Enrollees; for serving as the medical home; for processing initial referrals for Specialist Physician care; and for maintaining the continuity of patient care.

54. "**Program**" is health care benefit program offered by CalOptima to Enrollees. Programs and their designs are subject to change periodically.

55. "**Provider**" means a physician, nurse, nurse mid-wife, nurse practitioner, medical technician, physician assistant, hospital, laboratory, health maintenance organization ("**HMO**"), or other person or institution who furnishes health care items or services.

56. "**Provider Manual**" means that comprehensive online document, as amended from time to time, and describes CalOptima's Policies and procedures affecting Hospital Physicians' services under this Contract.

57. "**Referral**" means the process by which the Participating Provider Physician directs an Enrollee to seek and obtain Covered Services from a health professional or for care at a facility.

58. "**Rural Health Clinic (RHC)**" means an entity that meets all of the requirements for designation as a rural health clinic under § 1861(aa)(1) of the Social Security Act and is approved for participation in the MA program.

59. "**Service Area**" means the geographic area within Orange County, California.

60. "**Specialist Physician**" means any physician who is not a PCP, has the requisite training and education, and meets all other requirements set by CalOptima Policies for specialists.

61. "**Stabilize**" or "**Stabilized**" means, with respect to an Emergency Medical Condition, to provide such medical treatment of the condition to assure within reasonable medical probability that no material deterioration of the condition is likely to result or occur during the transfer of the individual from a facility, or in the case of a pregnant woman, that the woman has delivered the child and placenta.

62. "**Threshold Language"** means those languages as determined by CalOptima's Regulators from time to time and identified in guidance on translation requirements provided to CalOptima.

63. "**Urgent Care**" means services required to prevent serious deterioration of health following the onset of an unforeseen condition or injury and are medical services required promptly to prevent impairment of health due to symptoms that do not constitute an Emergency Medical Condition but that are the result of an unforeseen illness, injury or condition for which medical services are immediately required.

ATTACHMENT B
CALOPTIMA SENIOR PLAN
MATRIX OF FINANCIAL RESPONSIBILITY
January 1, 2023

HOSPITAL	RESPONSIBLE PARTY		
SERVICES	**GROUP**	**HOSPITAL**	**PLAN**
Medicare Part A Services – Not Otherwise Assigned Herein or in Any Agreement Incorporating This Exhibit:			
Inpatient		**X**	
Outpatient		**X**	
Medicare Part B Services Not Otherwise Assigned Herein or in Any Agreement Incorporating This Exhibit	**X**		
Some of the main services and those related to the Risk Sharing Program are listed below:			
Acupuncture (Medicare covered)	**X**		
Allergy			
Testing and Treatment	**X**		
Serum	**X**		
Ambulance – Air and Ground			
Emergency		**X**	
Inter-facility Transfers (all vehicle types)		**X**	
Amniocentesis			
Facility Component			
Outpatient (if not provided in physician office setting)		**X**	
Professional Component	**X**		
Audiologic			
Diagnostic	**X**		
Biofeedback	**X**		
Blood & Blood Products/Blood Transfusions (including professional component)			
Autologous Blood Donation		**X**	
From Blood Bank		**X**	
Cataract Surgery			
Professional Component	**X**		
Facility Component (Hospital Based Outpatient – Including Implanted Lenses)		**X**	
Facility Component (Ambulatory Surgery Center – Including Implanted Lenses)		**X**	

SERVICES	GROUP	HOSPITAL	PLAN
Chemical Dependency Rehabilitation and Detox (Medicare Covered)			
Professional Component	**X**		
Facility Component		**X**	
Methadone outpatient clinics			**X**
Chemotherapy			
Drugs – Outpatient (Part B)		**X**	
Drugs – Outpatient (Part D)			**Rx**
Professional Component	**X**		
Facility Component		**X**	
Chiropractic (Medicare covered)	**X**		
Dental Services (Medical)			
Professional Component	**X**		
Facility Component		**X**	
Facility Component (Non-Hospital) Based	**X**		
Diabetic Supplies			
Insulin and syringes (Rx Benefit)-see Medication-Outpatient Prescription Drug Benefit			**Rx**
Home Glucose Monitoring Equipment and Supplies)	**X**		
Diagnostic Testing			
Technical Component (Outpatient)	**X**		
Professional Component	**X**		
Durable Medical Equipment (DME)			
Outpatient	**X**		
Emergency Room			
Facility Component		**X**	
Professional Component (including interpretive reports)	**X**		
Endoscopy			
Facility Component		**X**	
Professional Component	**X**		
Family Planning			
Therapeutic Abortion Services, Tubal Ligation, Vasectomy, etc.			
Facility Component		**X**	
Professional Component	**X**		
Fetal Monitoring			
Facility Component		**X**	

SERVICES	GROUP	HOSPITAL	PLAN
Professional Component	X		
Genetic Testing/Counseling	X		
Health Education	X		
Hemodialysis/Dialysis			
Outpatient (Includes drugs per Medicare guidelines)		X	
Professional Component	X		
Home Health Care			
Medicare covered home health services (Including home IV therapy, excluding Part D drugs)		X	
Home Health Supplies (see medical supplies)		X	
Hospice	**Medicare FFS has primary responsibility**		
Hospitalization			
Facility Component (Including pre-admission diagnostic services)		X	
Interpretive Reports	X		
Professional Component (Including hospital-based physicians)	X		
Immunization and Inoculations (Part B)	X		
Immunization and Inoculations (Part D)			**Rx**
Infusion Therapy			
Professional Component	X		
Facility Component		X	
Part B drugs		X	
Part D drugs			**Rx**
Injectables -- (Outpatient) (see also Chemotherapy)			
Part B drugs		X	
Part D drugs			**Rx**
Lithotripsy			
Professional Component	X		
Facility Component		X	
Mammography	X		
Maternity/Obstetrics			
Facility Component		X	
Professional Component	X		
Medical supplies (includes catheters)			

SERVICES	GROUP	HOSPITAL	PLAN
Outpatient	X		
Medication			
Outpatient – Prescription Drug Benefit (Part D)			**Rx**
Outpatient medications (Part B)		X	
Mental Health			
Facility Component (includes Partial Hospitalization)		X	
Professional Component			X
Nuclear Medicine			
Inpatient, Facility Component (therapeutic)		X	
Outpatient, Facility Component	X		
Professional Component	X		
Nutrition			
Nutritional/Dietetic Counseling (Medicare Covered)	X		
Parenteral Nutrients, Supplies, Kits and Pumps			
Part B		X	
Part D			X
Enteral Nutrients, Supplies, Kits and Pumps			
Outpatient			X
Organ Transplants			
Pre Evaluation (All Inclusive)	X		
Organ Acquisition		X	**Medicare FFS for Kidney only**
Transplant Professional Component	X		
Transplant Facility Component (includes organ acquisition)		X	
Post Transplant (up to one year for transplant related services)			
Professional Component	X		
Post Transplant Facility Component (Inpatient)		X	
Post Transplant Facility Component (Outpatient – if provided in physician office setting)	X		
Orthotics and Prosthetics (Medicare Covered)			
Outpatient (Medicare defined coverage applies)		X	
Ostomy Supplies			
Outpatient	X		

SERVICES	GROUP	HOSPITAL	PLAN
Out of Area (Emergent and Urgently Needed Services)			
Facility Component		X	
Professional Component	X		
Outpatient Diagnostic Tests and Services (All Inclusive)	X		
Outpatient Surgery			
Facility Component (Hospital Based)		X	
Facility Component (Freestanding Ambulatory Surgery Center)		X	
Professional Component	X		
Cardiac catheterization and Angiograms (Professional)	X		
Cardiac catheterization and Angiograms (Facility)		X	
Physical Therapy (See Rehabilitation)			
Pain Management			
Professional	X		
Facility (if provided in other than physician office setting)		X	
Physician Visits/Consultations (inclusive of all settings)	X		
Podiatry Services (Medicare covered)	X		
Radiation Therapy			
Professional	X		
Facility, outpatient facility		X	
Radiology Services			
Outpatient, Preoperative, and Inpatient Professional Component	X		
Inpatient (facility component)		X	
Rehabilitation (Short Term e.g.: PT, OT, Speech, Cardiac)			
Outpatient Facility Component	X		
Professional Component	X		
Skilled Nursing Facility (SNF)			
Facility Component (All Inclusive)		X	
Professional Component	X		
Social Services – Medical	X		
Surgically Implanted Devices – All Categories		X	
Vision Care			
Annual routine exam			X
Glasses			X
Lenses and Frames incidental to cataract surgery (Medicare covered)	X		
Screening, Physician Office	X		

SERVICES	GROUP	HOSPITAL	PLAN
Notes:			
1. Financial responsibility is based on Medicare benefit interpretations and limitations.			
2. The symbol "Rx" denotes outpatient prescription drug services.			
Assignment of financial responsibility as outlined in this document is independent of the questions of medical necessity, coverage or benefits.			

ATTACHMENT C
CAPITATION RATES AND RISK SHARING

1. **Capitation Allocation**

1.1 **Allocation of Non-Part D CMS Revenue**. Each month, CalOptima shall allocate both the non-Part D related capitation that CalOptima receives from CMS for Enrollees affiliated with Hospital and any applicable premiums that CalOptima charges Enrollees affiliated with Hospital (collectively, the "**Total Revenues**") as follows:

- Facility and Other Services ("**Hospital Budget**") xx.x%
- Physician Group Capitation Fees xx.xx%

1.2 **MLR**. In accordance with Section 2.3, "Medical Loss Ratio", of the Contract, Hospital shall maintain a minimum acceptable loss ratio of eighty-five percent (85%). Should Hospital not meet the minimum eighty-five percent (85%) MLR, CalOptima reserves the right to require Hospital to return to CalOptima the difference between eighty-five percent (85%) of Capitation Payments and the allowed medical expenses.

1.3 **Sequestration**. If CMS reduces payment to CalOptima under the CMS Contract by more than two percent (2%) at any time during the Term, CalOptima may, upon written notice to Hospital, reduce payment to Hospital under this Attachment C by the same percentage that CMS reduced payment to CalOptima. This provision applies each time CMS reduces payment to CalOptima by more than two percent (2%) during the Term.

ATTACHMENT D
CLAIMS PROCESSING AND COMPLIANCE OBLIGATIONS

I. DEFINITIONS

1.1 "**Clean Claim**" means one that can be processed without obtaining additional information from the provider of the service or from a third party. Clean claim shall have the same meaning as "complete claim" as that term is defined in Title 28, CCR Section 1300.71(a)(2). Clean Claim does not include a claim from a Provider who is under investigation for fraud or abuse, or a claim under review for Medical Necessity.

1.2 "**Unclean Claim**" means any claim other than as defined in Section 1.1 of this attachment.

1.3 "**Denied Claim**" means a claim where (a) one or more services will not be paid by Hospital and (b) payment is the responsibility of the Enrollee. Examples of claims that are not denials and should not be reported, submitted, or presented to CalOptima as Denied Claims include claims:

1.3.1 For patients who remain enrolled with CalOptima but have transferred to another Hospital and Hospital is forwarding the claim,

1.3.2 For which payment responsibility belongs to another contracting entity, and Hospital is forwarding the claim,

1.3.3 That are duplicates,

1.3.4 That are encounter only/capitated claims and no patient liability is involved, and

1.3.5 That involve reduced payment amounts due to contract terms or allowed Medicare fee schedules.

II. GENERAL TERMS

2.1 **Hospital Claims Processing**. Hospital shall process claims for Provider services according to all CMS requirements and, as applicable, in accordance with the requirements of the Knox-Keene Act. This Attachment D is intended to comply with all DMHC and CMS standards and requirements. Should this Attachment D be out of compliance with any existing or newly enacted DMHC or CMS standard or requirement, the DMHC and/or CMS standard or requirement will supersede this Attachment D. CalOptima will communicate any changes in requirements to Hospital in writing.

2.2 If Hospital enters into a contract with a Downstream Entity whereby the responsibility for claims processing is delegated to that Downstream Entity, Attachment D provisions shall apply. Hospital will have contractual provisions to ensure such Downstream Entity conforms to all DMHC and CMS requirements and oversight provisions as outlined herein and in CalOptima Policies.

2.3 Hospital and any applicable Downstream Entity shall be required to have an oversight program for claims processing that includes written policies and procedures, a process for reporting fraudulent or unethical conduct, and an executive accountable for review of claims data and attesting to its accuracy. The oversight program shall include internal auditing of claims functions, and self-reporting as outlined in CalOptima Policies.

III. CLAIMS PROCESSING

3.1 **Timely Provider Payments**.

3.1.1 Hospital and Downstream Entities, if, and as applicable, must make timely payments to Participating Providers consistent with 42 CFR § 447.45.

3.1.2 Hospital shall reimburse Clean Claims, or any portion of any Clean Claim, for Covered Services, as soon as practical, but no later than thirty (30) calendar days after receipt of the claim by Hospital, unless the claim or portion thereof is reasonably contested, in which case the claimant shall be notified in writing that the claim is contested or denied within forty-five (45) business days after receipt of the claim by Hospital in accordance with CalOptima Policies.

3.1.3 Hospital must ensure that ninety percent (90%) of claims from Providers who are in individual or group practice, which can be processed without obtaining additional information from the Provider or from a third party, will be paid within thirty (30) days of the date of receipt of the claim.

3.1.4 Hospital must ensure that ninety-nine percent (99%) of all Clean Claims from Providers for Covered Services will be paid within ninety (90) days of the date of receipt of the claim.

3.1.5 Generally, the date of receipt is the date the Hospital receives the claim, as indicated by its date stamp on the claim. The date of payment is the date of the check or other form of payment.

3.1.6 **"30-Day" Claim Timeliness**. Hospital shall adjudicate nine-five percent (95%) of all Clean Claims from Non-Participating Providers or suppliers within thirty (30) calendar days of receiving the claim. Adjudicate a claim shall be deemed to mean to have processed the claim (paid or denied) and mailed the remittance advice by the thirtieth (30^{th}) calendar day since the earliest receipt by Hospital or CalOptima's contracting Providers.

3.1.7 **"60-Day" Claim Timeliness**. Hospital shall pay or deny Unclean Claims from Non-Participating Providers or suppliers, claims from Participating Providers or suppliers, and claims from Medicare fiscal intermediaries and carriers within sixty (60) calendar days of receipt of such claims. Processing shall be deemed to mean either to have paid or denied and mailed the remittance advice by the sixtieth (60^{th}) calendar day since the earliest receipt by Hospital or CalOptima's contracting Providers, or to have denied the claim, and have mailed the denial letter to the Enrollee by the sixtieth (60^{th}) day. In accordance with federal law and CMS regulations, failure to process such claims within sixty (60) calendar days of receipt automatically constitutes an "adverse" initial determination, which the Enrollee may appeal; thus, a denial notice must be mailed to the Enrollee.

3.1.8 **Payment Accuracy**. When paying Non-Participating Providers, Hospital shall employ only those Medicare fee schedules that MA plans are allowed to use by law and shall comply with 42 CFR § 422.214.

3.1.9 **Denied Claims**. Decisions to deny claims that result in liability for the Enrollee must be made in accordance with CMS guidelines. Whenever such decisions are made, the currently CMS approved Notice of Denial of Payment or Integrated Denial Notice must be used, including approved denial reasons. Under no circumstances shall Hospital deny a claim for the second time as a consequence of responding to a request for reconsideration from an Enrollee; instead, Hospital must direct the Enrollee to submit the request directly

to CalOptima as appropriate.

3.2 **Claims for Emergency and Post-Stabilization Services.**

3.2.1 Hospital shall not retroactively deny a claim for Emergency Services because the condition, which appeared to be an Emergency Medical Condition, turned out to be non-emergency in nature. Hospital shall ensure that its claims processing actions do not conflict with Hospital actions required to comply with the Emergency Medical Treatment and Active Labor Act ("**EMTALA**").

3.2.2 If there is a disagreement between Hospital or any Participating Provider and any Non-Participating Provider regarding Medically Necessity of Covered Services in an emergency, the judgment of the attending physician(s) actually caring for the Enrollee at the treating facility shall prevail.

3.2.3 Hospital shall ensure that an enrollee with an Emergency Medical Condition will be seen on an emergency basis and that Emergency Services will be available and accessible within the Service Area twenty-four (24) hours a day. Hospital shall cover Emergency Services without prior Authorization pursuant to Title 28 CCR Section 1300.67(g), Title 22 CCR Section 53216, and Section 1932(b)(2) of the Social Security Act. Hospital shall coordinate access to Emergency Services in accordance with 42 CFR § 438.114 and the Hospital's emergency department protocol.

3.2.4 An Enrollee who has an Emergency Medical Condition may not be held liable for payment of subsequent screening and treatment needed to diagnose the specific condition or Stabilize the Enrollee.

3.2.5 Hospital may not deny payment for treatment obtained under either of the following circumstances: an Enrollee had an Emergency Medical Condition, including cases in which the absence of immediate medical attention would not have had the outcomes specified in the definition of an Emergency Medical Condition; or the Hospital representative instructs the Enrollee to seek Emergency Services. The attending emergency Physician, or the Provider actually treating the Enrollee, is responsible for determining when the Enrollee is sufficiently Stabilized for transfer or discharge, and that determination is binding on the entities as responsible for coverage and payment.

3.2.6 Hospital must cover and pay for Post-Stabilization Care Services. Hospital is financially responsible for Post-Stabilization Care Services obtained within or outside the organization that are pre-approved by a Physician Group Provider or other Hospital representative. Hospital is financially responsible for Post-Stabilization Care Services obtained within or outside the Hospital organization that are not pre-approved by a Participating Provider or other Hospital representative, but are administered to maintain the Enrollee's Stabilized condition within one (1) hour of a request to the Hospital for pre-approval of further Post-Stabilization Care Services. Hospital is financially responsible for Post-Stabilization Care Services obtained from within or outside the Hospital that are not pre-approved by a Participating Provider or other Hospital representative, but administered to maintain, improve, or resolve the Enrollee's Stabilized condition if the Hospital: does not respond to a request for pre-approval within one (1) hour; cannot be contacted; or the Hospital representative and the treating physician cannot reach an agreement concerning the Enrollee's care and a Participating Provider is not available for consultation. In this situation, the Hospital must give the treating Physician the opportunity to consult with a

Participating Provider and the treating Physician may continue with care of the Enrollee until a Participating Provider is reached or one criteria in 42 C.F.R. § 113(c)(3) is met. Hospital must limit charges to Enrollees for Post-Stabilization Care Services to an amount no greater than what the Hospital would charge the Enrollee if he or she had obtained the services through Hospital. Hospital financial responsibility for Post-Stabilization Care Services it has not pre-approved ends when: a Participating Provider with privileges at the treating hospital assumes responsibility for the Enrollee's care; a Participating Provider assumes responsibility for the Enrollee's care through transfer; Hospital representative and the treating Physician reach an agreement concerning the Enrollee's care; or; the Enrollee is discharged.

3.2.7 Hospital shall reimburse those hospitals providing Emergency Services and Urgent Care services with which Hospital has a contract according to the terms of that contract.

3.2.8 Hospital must reimburse a Non-Participating Provider for Emergency Services or Urgent Care services at the prevailing Medicare fee-for-service ("**FFS**") rate as applicable for that service. Where the Covered Service would traditionally be covered under Medicare FFS, the Medicare FFS rate applies. Hospital shall ensure that Enrollees maintain balance billing protections as provided in Section 6.4 of this Contract.

3.3 **Hospital Financial Responsibility**. If CalOptima receives a claim for Covered Services that are the financial responsibility of Hospital, CalOptima shall forward such claim to Hospital for payment, in accordance with the procedures set forth in Title 28 CCR Section 1300.71, "Claims Settlement Practices." CalOptima shall not pay for services that are Hospital's financial responsibility unless Hospital fails to make payment within the time allowed by State and federal laws and regulations, and CalOptima is required by law to make such payment. In such cases, CalOptima, after written notice to Hospital and reasonable opportunity to cure, will make payment, and Hospital shall reimburse CalOptima for such payments. If Hospital fails to reimburse CalOptima, CalOptima may offset an uncontested payment(s) against Capitation Payments or other amounts due from CalOptima to Hospital, if any.

3.4 **Collection of Share of Cost**. Hospital shall collect Medicare share of cost unless prohibited under this Contract.

3.5 **Capitation Payments**. Hospital and/or Downstream Entities shall distribute monthly Capitation Payments to capitated Participating Providers within fifteen (15) calendar days following the date on which Physician receives payment from CalOptima.

3.6 **Claims Adjudication**. Except as provided in Section 3.1.1, Hospital shall accept and adjudicate claims for Covered Services provided to Enrollees in accordance with the provisions of Sections 1371, 1371.1, 1371.2, 1371.22, 1371.35, 1371.36, 1371.37, 1371.38, 1371.4 and 1371.8 of the California Health & Safety Code, and Sections 1300.71, 1300.71.38, 1300.71.4, and 1300.77.4 of Title 28 of the CCR and CalOptima Policies. Waiver of any right or obligation specific to the Health and Safety Code and Title 28 related to claims processing and payment shall be prohibited.

3.7 **Dispute Resolution.** Hospital shall establish and maintain a fair, fast and cost-effective dispute resolution mechanism to process and resolve provider disputes in accordance with the provisions of Sections 1371, 1371.1, 1371.2, 1371.22, 1371.35, 1371.36, 1371.37, 1371.38, 1371.4 and 1371.8 of the California Health & Safety Code, and Sections 1300.71, 1300.71.38, 1300.71.4, and 1300.77.4 of Title 28 of the CCR and CalOptima Policies.

3.8 **Right of Appeal**. Hospital shall afford Providers an unconditional right of appeal and de novo review for claims disputes involving issues of Medical Necessity. Any Provider that submits a claim dispute to Hospital's dispute resolution mechanism involving an issue of Medical Necessity or utilization review shall have an unconditional right of appeal for that claim dispute to CalOptima's dispute resolution process for a de novo review and resolution for a period of sixty (60) working days from Physician's Date of Determination.

3.9 **CalOptima Payment On Behalf Of Physician**. If CalOptima receives a copy of an unpaid Clean Claim as part of a Provider grievance that is thirty (30) working days old or more, CalOptima will follow all notification and acknowledgement procedures pursuant to CalOptima Policies. If Hospital does not either notify CalOptima that the claim is reasonably contested, as set forth in CalOptima Policies, or pay the Clean Claim within the thirty (30) working day period, CalOptima shall pay the Claim on behalf of Physician, plus interest, as required by the Knox-Keene Act, and deduct the amounts reimbursed, plus processing costs, from the Capitation Payment, in accordance with CalOptima Policies.

3.10 **Quarterly Claims Payment Performance Report.**

3.10.1 Hospital shall submit, in a format specified by CalOptima Policies, a quarterly claims payment performance report ("**Quarterly Claims Report**") to CalOptima within thirty (30) calendar days of the close of each calendar quarter. The Quarterly Claims Report shall, at a minimum, disclose Hospital's compliance status with Sections 1371, 1371.1, 1371.2, 1371.22, 1371.35, 1371.36, 1371.37, 1371.4, and 1371.8 of the California Health and Safety Code and Sections 1300.71, 1300.71.38, 1300.71.4 and 1300.77.4 of Title 28 of the CCR.

3.10.2 Hospital shall ensure that each Quarterly Claims Report is signed by, and includes the written verification of, a principal officer, as defined by Section 1300.45(o) of Title 28 of the CCR, of Hospital, stating that the report is true and correct to the best knowledge and belief of the principal officer.

3.10.3 Hospital's Quarterly Claims Report shall include a tabulated record of each Provider dispute it received, categorized by date of receipt, and including the identification of the Provider, type of dispute, disposition and working days to resolution, as to each Provider dispute received. Each individual dispute contained in a Provider's bundled notice of Provider dispute shall be reported as a separate dispute to CalOptima.

3.11 **Forwarding of Misdirected Claims.**

3.11.1 Hospital shall have the ability to receive a standard ANSI 837I and ANSI 837P claim file format for retrieving misrouted claims that are the financial responsibility of the Hospital. Hospital will receive and forward misdirected claims per CalOptima Policy.

3.11.2 Hospital shall have the ability to create a standard ANSI 837I and ANSI 837P claim file for forwarding claims that are the financial responsibility of CalOptima within ten (10) working days of receipt of the claim. CalOptima shall receive these files per CalOptima policy and load them into its system to ensure timely claims processing. Hospital shall forward any claims that are not its payment responsibility to CalOptima within eight (8) calendar days of receipt, so that a total of only ten (10) working days will elapse prior to the claims being in the proper hands.

3.12 **Assumption of Delegated Functions**. In the event that Hospital fails to timely and accurately reimburse its claims (including the payment of interest and penalties), CalOptima may, at its sole discretion, revoke the delegation and assume responsibility from Hospital for claims payment, or terminate this Contract as provided for in Article XI. CalOptima's assumption of responsibility for the processing and timely reimbursement of Provider claims may be altered to the extent that Hospital has established an approved CAP consistent with Section 1375.4 (b)(4) of the Health and Safety Code and Section 11.3 of the Contract.

3.13 **Recoupment for Assumption of Claims Processing Obligations**. CalOptima, in its sole and absolute discretion, may reduce Hospital's Capitation Payments to recoup additional administrative costs for the assumption of the claims processing obligations of Hospital, as described in this Article III of Attachment D, as well as any amounts, including interest due, on claims unpaid at the assumption of such obligations by CalOptima.

IV. CLAIMS COMPLIANCE

4.1 **Claims Compliance Monitoring**. Hospital understands that claims compliance programs are required by CalOptima's Regulators and agrees that delegation is contingent upon Hospital's compliance with required monitoring and oversight activities, as outlined in CalOptima Policies. Hospital agrees that CalOptima reserves the right to monitor Hospital's claims compliance activities, notwithstanding any other audit, compliance, or contractual issue between Hospital and CalOptima. In the event Hospital demonstrates an inability to meet CalOptima's claims payment standards, CalOptima reserves the right to revoke and assume the delegated responsibilities described above.

4.2 **Claims Non-Compliance**. In the event that CalOptima determines that Hospital is not in ninety-five percent (95%) compliance with any of the requirements of Attachment D the following actions will be applied:

4.2.1 Within thirty (30) days of an audit that documents non-compliance, CalOptima will issue a written warning to Hospital that describes the non-compliance. Hospital will respond within fifteen (15) working days of receiving the non-compliance notification with a written CAP to comply. Such CAP will describe the actions to be taken and the schedule by which those actions will be completed. CalOptima will review the CAP and advise Hospital whether or not actions or time schedules are acceptable within fifteen (15) days of receiving it. CalOptima will conduct a follow-up audit of Hospital's claims operation within ninety (90) days from the date of serving the non-compliance notification to verify compliance with Attachment D. If CalOptima does not receive a CAP within fifteen (15) calendar days, the consequences outlined in Subsection 4.2.2 of this attachment for continued non-compliance will apply.

4.2.2 If, as a result of CalOptima's follow-up audit, Hospital is found to still be non-compliant with Attachment D within fifteen (15) calendar days of making that determination, CalOptima will notify Hospital in writing of the continued non-compliance and may elect to provide consultative or other assistance to help establish, maintain and monitor continued administrative compliance or assume "joint administration" of Hospital's claims operations, involving itself only with Enrollees' claims and allowing the operation to remain on Hospital's premises. The Parties agree to meet and develop a mutually agreeable work plan for added staffing and work stations, the cost of which will be Hospital's sole responsibility. CalOptima will develop a CAP with Hospital's participation to assure maximum compatibility with Hospital's ongoing operations. CalOptima will cooperate

with Hospital in implementing changes across all risk claims processed at that site, should Hospital so request. Within fifteen (15) calendar days of receiving the second notice of non-compliance, Hospital will provide a written response stating the specific action to be taken to establish compliance with the help of CalOptima. If CalOptima does not receive a CAP within fifteen (15) calendar days, the consequences outlined in Subsection 4.2.3 for continued non-compliance will apply. Within ninety (90) days from the date of serving the second notice of non-compliance, CalOptima will re-audit Hospital's claims process and documents to determine final compliance or non-compliance.

4.2.3 If, as a result of its second follow-up audit, CalOptima reasonably determines that Hospital is still non-compliant, CalOptima reserves the right to terminate this Contract for material breach upon ten (10) days' prior written notice and opportunity to cure.

4.2.4 Hospital may resume sole administrative responsibility for claims processing if CalOptima determines that Hospital has corrected the deficiencies that caused the non-compliance, and, as a result of resuming responsibility for claims processing, demonstrates compliance with the timely provider payments requirements set forth in Section 3.1 of this Attachment D.

4.2.5 With respect to the requirements of Attachment D, Hospital will be subject to regular site-audits conducted by CalOptima to monitor all claims requirements.

V. CLAIMS FORWARDING

Hospital shall forward any claims that are not its payment responsibility to CalOptima within ten (10) calendar days of receipt.

VI. SELF-MONITORING & REPORTING

Hospital shall develop, implement and demonstrate upon request, a claims quality assurance process, including regular, scheduled, automated, or manual reports, self-testing procedures, and internal reporting to Hospital's executive management of timeliness, payment accuracy, and denial accuracy (as required herein). Such self-monitoring and internal reporting shall involve use of industry standard tools and shall measure actual performance against the standards for DMHC and CMS compliance. CalOptima strongly recommends check issuance and mailing occur not less frequently than weekly and that Hospital's internal reporting intervals match the intervals at which checks are issued, except that weekly reporting would be sufficient if checks are issued more often than weekly. At a point early in the beginning of operations under the Contract and in accordance with industry-wide CMS requirements, CalOptima will require that Hospital submit monthly reports to CalOptima using the industry-standard Monthly Report of Claims Processing Timeliness and Overall Percent of Denial Accuracy format. Those reports must be received by CalOptima not later than the fifteenth (15th) calendar day of each month.

VII. AUDITS & AUDIT PREPARATION

Article IV, above, provides detailed, specific processes involving claims non-compliance. Even when Hospital does meet compliance standards and successfully concludes any time periods where denials must be submitted to CalOptima for review, CalOptima will continue to schedule (1) periodic audits, (2) random, focused audits, and (3) focused reviews based on appeals and grievance results to monitor Hospital's compliance with CMS regulations. Prior to the scheduled arrival of CalOptima's auditor, Hospital shall retrieve claims and related documents in accordance with instructions provided to Hospital by CalOptima in its letter confirming the appointment.

VIII. SPECIAL STUDIES

8.1 In the event DMHC and/or CMS requires that CalOptima conduct any special compliance study or effort, Hospital shall support the study and will be subject to any DMHC and/or CMS specified time schedules or deadlines for corrective actions.

IX. FEDERALLY QUALIFIED HEALTH CENTERS AND RURAL HEALTH CLINICS

9.1 Hospital shall meet federal requirements for access to FQHC services, including those in 42 U.S.C. § 1396 b(m). Hospital shall reimburse FQHCs and RHCs in accordance with current Laws. If FQHC and RHCs services are not available in the Provider network, Hospital shall authorize out-of-network services subject to the prevailing MA payment requirements for out-of-network services.

9.2 Hospital shall ensure that its payments to FQHCs and RHCs for services to Enrollees are no less than the sum of the level and amount of payment that the Health Network or CalOptima would make for such services if the services had been furnished by an entity providing similar services that was not an FQHC and RHC. The intent of these provisions is to ensure that Hospital pays FQHCs and RHCs amounts consistent with Medicare managed care policies while preserving the opportunity for FQHCs to separately claim supplemental payments under such policies.

X. INDIAN HEALTH CARE PROVIDERS

10.1 Hospital shall pay non-network Indian Health Care Providers that are FQHCs for the provision of services to an Indian Enrollee at a rate equal to the rate that Hospital would pay to a network FQHC that is not an Indian Health Care Provider, including any supplemental payment from the State to make up the difference between the contract amount and what the Indian Health Care Provider would have received FFS.

10.2 When the amount the Participating Provider Indian Health Care Provider receives from the Hospital is less than the amount the Indian Health Care Providers would receive FFS, the State must make a supplemental payment to the Indian Health Care Provider that the Indian Health Care Provider would receive FFS or the applicable encounter rate.

10.3 Hospital shall not impose enrollment fees, premiums, or similar charges on Indians served by an Indian Health Care Provider or through referral under contract health services. Hospital must exempt from all cost-sharing any Indian who is currently receiving or has ever received an item or service furnished by an Indian Health Care Provider or through referral under contract health services.

10.4 Hospital shall reimburse Indian Health Care Providers promptly who provide Covered Services to Indian Enrollees, who are eligible to receive Covered Services, at the most current and applicable outpatient per-visit rate published in the Federal Register by the Indian Health Service, and Hospital shall ensure any retroactive outpatient per visit rates are appropriately reimbursed to the Indian Health Care Provider.

ATTACHMENT E
STATUTORY AND REGULATORY COMPLIANCE TERMS

1. **Compliance with State and Federal Laws**. Hospital acknowledges that CalOptima is subject to certain State and federal laws, regulations, and instructions governing its MA Program. Hospital shall comply with all Laws and DMHC and CMS administrative bulletins, plan letters and instructions. Hospital understands that payments made by CalOptima are, in whole or in part, derived from federal funds, and therefore Hospital and any Downstream Entities are subject to certain laws that are applicable to individuals and entities receiving federal funds, including the following: (i) Title VI of the Civil Rights Act of 1964; (ii) Sections 503 and 504 of the Rehabilitation Act of 1973; (iii) the Age Discrimination Act of 1975; (iv) the Americans with Disabilities Act of 1990; (v) the Vietnam Era Veteran's Readjustment Assistance Act; and (vi) Title IX of the Education Amendments of 1972. Any provision required to be in this Contract by the CMS Contract, the Knox-Keene Act, Title 28 of the California Code of Regulations, Medicare laws and regulations, DMHC or CMS instructions and reporting requirements and other applicable laws, shall bind CalOptima, Hospital, and Downstream Entities, whether or not specifically set forth in this Contract.

2. **Compliance with CalOptima's Contractual Obligations**. All services and other activities furnished by Hospital and Downstream Entities must be performed in accordance with CalOptima's contractual obligations to CMS.

3. **Compliance with FWA Requirements**. Hospital, and its employees, agents and Downstream Entities performing services under this Contract, shall comply with CalOptima's Compliance Program including, its FWA plan. Prior to performing services under this Contract, Hospital shall complete and submit to CalOptima, any CMS-required training and/or CalOptima-required attestations related to such training and other compliance obligations. Hospital agrees to comply and will have any Downstream Entity agree to comply with CalOptima standards and policies.

4. **Fraud and Abuse Reporting**. Hospital shall, in accordance with all Laws, report to CalOptima all cases of suspected fraud and/or abuse relating to the rendering of Covered Services within five (5) days of the date when Hospital first becomes aware of or is on notice of such activity.

5. **CMS Participation Requirements**. Hospital represents and warrants that: (i) neither Hospital nor any of its Downstream Entities, employees or agents furnishing services under this Contract are excluded from participating in any federal or state healthcare program as defined in 42 U.S.C. Section 1320a-7b(f) ("**Federal Health Care Program(s)**"); (ii) Hospital has not arranged or contracted (by employment or otherwise) with any employee, contractor or agent that Hospital knows or should know are excluded or precluded from participation in Federal Health Care Programs; (iii) no action is pending against Hospital or any of its Downstream Entities, employees, or agents performing services under this Contract to suspend or exclude such persons or entities from participation in any Federal Health Care Program; and (iv) Hospital will immediately notify CalOptima if it learns that it is or has employed or contracted with a person or entity that is excluded from participation in any Federal Health Care Program. If Hospital fails to comply with this Section 5 of this attachment, CalOptima reserves the right to require Hospital to pay immediately to CalOptima the amount of any sanctions or other penalties that may be imposed on CalOptima by CMS for violation of this prohibition, and Hospital shall be responsible for any resulting overpayments. Hospital shall not make payment for a healthcare item or service furnished by an individual or entity that is excluded by the Office of the Inspector General or is included on the Preclusion List. Hospital shall provide written notice to the Enrollee who received the services and the excluded Provider or Provider listed on the Preclusion List that payment will not be made, in

accordance with CMS requirements. Hospital shall ensure that all Participating Providers that provide Covered Services do not appear on the CMS Preclusion List in order to receive reimbursement for claims or otherwise participate in the Medicare program.

6. **Confidentiality of Enrollee Information**. Hospital, its Downstream Entities, and their employees and agents shall comply with the specific confidentiality obligations set forth below.

6.1 Hospital, Downstream Entities, and their employees and agents 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 them as a result of services performed under this Contract, except for statistical information not identifying any such person. Hospital, Downstream Entities, and their employees and agents shall not use such identifying information for any purpose other than carrying out Hospital's obligations under this Contract.

6.2 Hospital, Downstream Entities, and their employees and agents shall promptly transmit to CalOptima all requests for disclosure of such identifying information not emanating from the Enrollee. Hospital shall not disclose, except as otherwise specifically permitted by this Contract or authorized by the Enrollee, any such identifying information to anyone other than CMS, DMHC, 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.

6.3 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*., Welfare and Institutions Code Section 14100.2, and regulations adopted thereunder. For the purpose of this Contract, all information, records, data, and data elements collected and maintained for the operation of the Contract and pertaining to Enrollees shall be protected by Hospital from unauthorized disclosure. Hospital may release Medical Records in accordance with Laws pertaining to the release of this type of information. Hospital is not required to report requests for Medical Records made in accordance with Laws.

6.4 With respect to any identifiable information concerning an Enrollee under this Contract that is obtained by Hospital or its Downstream Entities from CalOptima's Regulators, Hospital will, at the termination of this Contract, return all such information to CalOptima's Regulators if required by them, or maintain such information according to written procedures provided to Hospital by CalOptima and/or CalOptima's Regulators for this purpose.

7. **Offshore Subcontracts**. Hospital shall provide, and ensure that Downstream Entities provide, to CalOptima information and attestations related to the provision of any services under this Contract in a country other than the United States ("**Offshore Subcontractor**") to enable CalOptima to comply with CMS reporting obligations. Such information shall be submitted to CalOptima prior to engaging any Offshore Subcontractor for purposes of this Contract, and such Offshore Subcontractors are subject to approval by CalOptima.

8. **Required Disclosures**. In accordance with 42 CFR Section 1002.3, Hospital shall immediately notify CalOptima in the event any sanctioned person (as defined in 42 CFR Section 1001.1001(a)(1)) owns or controls Hospital.

9. **Equal Opportunity**. Hospital and Downstream Entities shall comply with the following Equal Opportunity requirements set forth below.

9.1 Hospital and its Downstream Entities 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. Hospital and its Downstream Entities will take affirmative action to ensure that qualified applicants are employed, and that employees are treated during employment, without regard to their race, color, religion, sex, national origin, physical or mental handicap, disability, age, or status as a disabled veteran or veteran of the Vietnam era. Such action shall include the following: Employment, upgrading, demotion or transfer; recruitment or recruitment advertising; layoff or termination; rates of pay or other forms of compensation; and career development opportunities and selection for training, including apprenticeship. Physician and its Downstream Entities agree to post in conspicuous places, available to employees and applicants for employment, notices to be provided by the federal government, 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 Hospital and its Downstream Entities' 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.

9.2 Hospital and its Downstream Entities will, in all solicitations or advancements for employees placed by or on behalf of Hospital and its Downstream Entities, 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.

9.3 Hospital and its Downstream Entities will send to each labor union or representative of workers with which it has a collective bargaining agreement or other contract or understanding a notice, to be provided by the federal government or the State, advising the labor union or workers' representative of Hospital and its Downstream Entities' commitments under the provisions herein and shall post copies of the notice in conspicuous places available to employees and applicants for employment.

9.4 Hospital and its Downstream Entities 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.

9.5 Hospital and its Downstream Entities 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 Hospital 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.

9.6 In the event of Hospital and its Downstream Entities' noncompliance with the requirements of the provisions herein or with any federal rules, regulations, or orders which are referenced in this Article IX, this Contract may be cancelled, terminated, or suspended in whole or in part, and Hospital and its Downstream Entities may be declared ineligible for further State and Federal 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.

9.7 Hospital and its Downstream Entities will include the provisions of Sections 10.1 through 10.7 of this attachment 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. Section 4212) of the Vietnam Era Veteran's Readjustment Assistance Act, so that such provisions will be binding upon each Downstream Entity. Physician and its Downstream Entities will take such action with respect to any subcontract or purchase order as the Director of the Office of Federal Contract Compliance Programs or CMS may direct as a means of enforcing such provisions, including sanctions for noncompliance; provided, however, that in the event Hospital and/or its Downstream Entities become involved in, or are threatened with litigation by a other Downstream Entity or vendor as a result of such direction by CMS, Hospital and its Downstream Entities may request in writing to CMS, 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.

10. **Non-Discrimination**. Hospital and Downstream Entities shall comply with the non-discrimination requirements set forth below.

10.1 During the performance of this Contract, neither Hospital nor any Downstream Entities shall unlawfully discriminate, harass, or allow harassment against any employee or applicant for employment because of sex, race, religion, color, national origin, ancestry, religious creed, physical disability, (including Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS), AIDS-Related Complex (ARC)), medical condition (including cancer), mental disability, marital status, age (over 40), or the use of family and medical care leave and pregnancy disability leave. Hospital and

Downstream Entities shall insure that the evaluation and treatment of their employees and applicants for employment are free of such discrimination and harassment. Hospital and Downstream Entities shall comply with the provisions of the Fair Employment and Housing Act (Government Code, Section 12900, *et seq*.) and the applicable regulations promulgated thereunder (Title 2 CCR Section 7285.0, *et seq*.). The applicable regulations of the Fair Employment and Housing Commission implementing Government Code, Section 12990, set forth in Chapter 5 of Division 4 of Title 2 of the CCR are incorporated into this Contract by reference and made a part hereof as if set forth in full. Hospital and Downstream Entities shall give written notice of their obligations under this clause to labor organizations with which they have a collective bargaining or other agreement. Hospital shall include the non-discrimination and compliance provisions of this Section 10.1 in all Downstream Entity subcontracts to perform work under this Contract.

10.2 Hospital and all Downstream Entities shall abide by 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 1972 (regarding education programs and activities); Title 45 CFR Part 91 and the Age Discrimination Act of 1975 (discrimination based on age); and all other laws regarding privacy and confidentiality. Neither the Physician nor Downstream Entities shall discriminate against Enrollees because of race, color, creed, religion, ancestry, marital status, sexual orientation, national origin, age, sex, or physical or mental handicap in accordance with Title VI of the Civil Rights Act of 1964, 42 U.S.C., Section 2000d (race, color, national origin); 45 CFR Part 84 (physical or mental handicap); Government Code Section 11135 (ethnic group identification, religion, age, sex, color, physical or mental handicap); Civil Code Section 51 (all types of arbitrary discrimination); rules and regulations promulgated pursuant thereto, or as otherwise provided by Laws.

10.3 For the purpose of this Contract, if based on any of the foregoing criteria, the following constitute unlawful discriminations: (i) denying any Enrollee any Covered Services or availability of a facility; (ii) providing to an Enrollee any Covered Service that is different or is provided in a different manner or at a different time from that provided to other similarly situated Enrollees under this Contract, except where medically indicated; (iii) subjecting an Enrollee to segregation or separate treatment in any manner related to the receipt of any Covered Service; (iv) restricting an Enrollee in any way in the enjoyment of any advantage or privilege enjoyed by others receiving any Covered Service; or (v) treating an Enrollee differently from others similarly situated in determining compliance with admission, enrollment, quota, eligibility, or other requirements or conditions that individuals shall meet in order to be provided any Covered Service or assigning the times or places for the provision of Covered Services.

10.4 Hospital shall take affirmative action to ensure that all Enrollees are provided Covered Services without unlawful discrimination, except where medically indicated. For the purposes of this Section 10.4, physical handicap includes the carrying of a gene that may, under some circumstances, be associated with disability in that person's offspring, but which causes no adverse effects on the carrier. Such genetic handicap shall include, but not be limited to, Tay-Sachs trait, sickle cell trait, thalassemia trait, and X-linked hemophilia.

10.5 Physician shall act upon all complaints alleging discrimination against Enrollees in accordance with CalOptima's Policies and shall forward copies of all such grievances to CalOptima within five (5) days of receipt of same.

11. **Smoke Free Workplace**. Public Law 103-227, also known as the Pro Children Act of 1994 ("**Pro Children Act**"), requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health, day care, early childhood development services, education, or library services to children under the age of 18, if the services are funded by federal programs either directly or through state or local governments, by federal grant, contract, loan, or loan guarantee. The law also applies to children's services that are provided in indoor facilities that are constructed, operated, or maintained with such federal funds. The law does not apply to children's services provided in private residences; portions of facilities used for inpatient drug or alcohol treatment; service providers whose sole source of applicable federal funds is Medicare or Medicaid; or facilities where WIC coupons are redeemed. Failure to comply with the provisions of the law may result in the imposition of a civil monetary penalty of up to $1,000 for each violation and/or the imposition of an administrative compliance order on the responsible party. By signing this Contract, Hospital certifies that it will comply with the requirements of the Pro Children Act and will not allow smoking within any portion of any indoor facility used for the provision of services for children as defined by the Pro Children Act. Physician further agrees that it will insert this certification into any subcontracts entered into that provide for children's services as described in the Pro Children Act.

12. **Air or Water Pollution Requirements**. Any federally funded agreement and/or subcontract in excess of $100,000 must comply with the following provisions unless said agreement is exempt under 40 CFR 15.5. Hospital 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.

13. **Lobbying Restrictions and Disclosure Certification**. Any federally funded contracts in excess of $100,000 per Section 1352 of the 31, U.S.C. must comply with the following lobby restrictions and disclosures.

13.1 Each person (or recipient) who requests or receives a contract, subcontract, grant, or sub-grant, which is subject to 31 U.S.C. Section 1352 and which exceeds $100,000 at any tier, shall file a certification (in the form set forth in **Attachment E-1**, consisting of one page, entitled "Certification Regarding Lobbying") that the recipient has not made, and will not make, any payment prohibited by Subsection 13.6 of this attachment.

13.2 Each recipient shall file a disclosure (in the form set forth in **Attachment E-2**, entitled "Standard Form-LLL 'Disclosure of Lobbying Activities'") if such recipient has made or has agreed to make any payment using non-appropriated 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 Section 13.6 of this attachment if paid for with appropriated funds.

13.3 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 Section 13.2 of this attachment. An event that materially affects the accuracy of the information reported includes: (i) 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; (ii)

a change in the person(s) or individuals(s) influencing or attempting to influence a covered federal action; or (iii) 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.

13.4 Each person (or recipient) who requests or receives, from a person referred to in Section 13.1 of this attachment, a contract, subcontract, grant or sub-grant 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.

13.5 All disclosure forms (but not certifications) shall be forwarded from tier to tier until received by the person referred to in Section 13.1 of this attachment.

13.6 31 U.S.C. Section 1352 provides in part that no appropriated funds may be expended by the recipient of a federal contract, grant, loan, or cooperative agreement to pay any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with any of the following covered federal actions: the awarding of any federal contract, the making of any federal grant, the making of any federal loan, entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any federal contract, grant, loan, or cooperative agreement.

14. **Debarment Certification**. Hospital agrees to comply with applicable Federal suspension and debarment regulations including 7 CFR § 3017, 45 CFR §76, 40 CFR § 32, or 34 CFR § 85.

14.1 Hospital certifies to the best of its knowledge and belief, that it and its principals:

(i) Are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded by any Federal department or agency;

(ii) Have not within a three (3)-year period preceding this Contract have been convicted of or had a civil judgment rendered against them for commission of fraud or a criminal offense in connection with obtaining, attempting to obtain, or performing a public (Federal, State or local) transaction or contract under a public transaction; violation of Federal or State antitrust statutes or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, or receiving stolen property;

(iii) Are not presently indicted for or otherwise criminally or civilly charged by a governmental entity (federal, State or local) with commission of any of the offenses enumerated in sub-provision (ii) herein;

(iv) Have not within a three (3)-year period preceding this Contract had one or more public transactions (Federal, State or local) terminated for cause or default;

(v) Shall not knowingly enter into any lower tier covered transaction with a person who is proposed for debarment under Federal regulations (i.e., 48 CFR 9, subpart 9.4), debarred, suspended, declared ineligible, or voluntarily excluded from participation in such transaction, unless authorized by the State; and

(vi) Will include a clause entitled, "Debarment and Suspension Certification'' that essentially sets forth the provisions herein, in all lower tier covered transactions and in all solicitations for lower tier covered transactions.

14.2 If Hospital is unable to certify to any of the statements in this certification, the Physician shall submit an explanation to CalOptima.

14.3 The terms and definitions in this Section 14 have the meanings set out in the Definitions and Coverage sections of the rules implementing Federal Executive Order 12549.

14.4 If Hospital knowingly violates this certification, in addition to other remedies available to the federal government, CalOptima may terminate this Contract for cause or default.

15. **Downstream Entity Contracts**. If any services under this Contract are to be provided by a Downstream Entity subcontracted by Hospital, Hospital shall ensure that such subcontracts comply with 42 CFR Sections 422.504, 423.505 and 438.6(l). Such subcontracts shall include all language required by CMS as provided in Attachment F**.**

16. **Other Statutory and Compliance Terms**. Hospital shall not contract with, or otherwise pay for any items or services (other than an emergency item or service, not including items or services furnished in an emergency room of a hospital):

16.1 Furnished by Hospital by any individual or entity during any period when the individual or entity is excluded from participation under Titles V, XVIII, or XX, or under Title XIX pursuant to sections 1128, 1128A, 1156 or 1842(j)(2);

16.2 Furnished at the medical direction or the prescription of a physician, during the period when such physician is excluded from participation under Titles V, XVIII, or XX, or under Title XIX pursuant to sections 1128, 1128A, 1156, or 1842(j)(2) and when the person furnishing such item or service knew, or had some reason to know, of the exclusion (after a reasonable time period and after reasonable notice has been furnished to the person);

16.3 Furnished by an individual or entity to whom the State has suspended payments to during any period when there is a pending investigation of a credible allegation of fraud against the individual or entity, unless the State determines there is good cause not to suspend such payments;

16.4 Hospital may not pay for an item or service with respect to any amount expended for which funds may not be used under the Assisted Suicide Funding Restriction Act of 1997

ATTACHMENT E-1
CERTIFICATION REGARDING LOBBYING

STATE OF CALIFORNIA
DEPARTMENT OF HEALTH CARE SERVICES
CERTIFICATIN 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 Hospital	Printed Name of Person Signing for Hospital
Contract / Grant Number	Signature of Person Signing for Hospital
Date	Title

After execution by or on behalf of Hospital, please return to:

CalOptima
Attn: Regulatory Affairs
505 City Parkway West
Orange, California 92868

ATTACHMENT E-2

CERTIFICATION REGARDING LOBBYING

Approved by OMB

Complete this form to disclose lobbying activities pursuant to 31 U.S.C. 1352
0348-0046 (See reverse for public burden disclosure)

<table>
<tr><td>1. Type of Federal Action:
contract
grant
cooperative agreement loan
loan guarantee
loan insurance</td><td>2. Status of Federal Action:
bid/offer/application initial
award post-award</td><td>3. Report Type:
initial filing
material change

For Material Change Only:
Year _____ quarter_____
date of last report</td></tr>
<tr><td colspan="2">4. Name and Address of Reporting Entity:
Prime Subawardee Tier, if known:</td><td rowspan="2">5. If Reporting Entity in No. 4 is Subawardee, Enter Name and Address of Prime:

Congressional District, If known:</td></tr>
<tr><td colspan="2">Congressional District, If known:</td></tr>
<tr><td colspan="2">6. Federal Department/Agency:</td><td>Federal Program Name/Description:
CDFA Number, if applicable:</td></tr>
<tr><td colspan="2">8. Federal Action Number, if known:</td><td>9. Award Amount, if known:</td></tr>
<tr><td colspan="2">10. a. Name and Address of Lobbying Entity
(If individual, last name, first name, MI):
(attach Continuation Sheets(s)</td><td>b. Name and Address of Lobbying Entity
(If individual, last name, first name, MI):
SF-LLL-A, If necessary)</td></tr>
<tr><td colspan="2">Amount of Payment (check all that apply):
$ actual planned</td><td rowspan="3">13. Type of Payment (check all that apply):
a. retainer
b. one-time fee
c. commission
d. contingent fee
e. deferred
f. other, specify:</td></tr>
<tr><td colspan="2">Form of Payment (check all that apply):
a. cash
b. in-kind, specify: Nature</td></tr>
<tr><td colspan="2">Value</td></tr>
</table>

14. Brief Description of Services Performed or to be Performed and Dates(s) of Service, including Officer(s), Employee(s), or Member(s) Contracted for Payment indicated in item 11: (Attach Continuation Sheet(s) SF-LLL-A, If necessary)	
15. Continuation Sheet(s) SF-LLL-A Attached: Yes No	
16. Information requested through this form is authorized by Title 31, U.S.C., Section 1352. This disclosure of lobbying activities is a material representation of fact upon which reliance was placed by the tier above when this transaction was made or entered into. This disclosure is required pursuant to Title 31, U.S.C., Section 1352. This information will be reported to the Congress semiannually and will be available for public inspection. Any person who fails to file the required disclosure shall be subject to a civil penalty of not less than $19,000 and not more than $100,000 for each such failure.	Signature: Print Name: Title: Telephone No.: Date:
Federal Use Only	

INSTRUCTIONS FOR COMPLETION OF SF-LLL, DISCLOSURE OF LOBBYING ACTIVITIES

This disclosure form shall be completed by the reporting entity, whether subawardee or prime federal recipients at the initiation or receipt of a covered federal action, or a material change to a previous filing, pursuant to Title 31, U.S.C., Section 1352. The filing of a form is required for each payment or agreement to make payment to any lobbying entity for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with a covered federal action. Use the SF-LLL-A Continuation Sheet for additional information if the space on the form is inadequate. Complete all items that apply for both the initial filing and material change report. Refer to the implementing guidance published by the Office of Management and Budget for additional information.

Identify the type of covered federal action for which lobbying activity is and/or has been secured to influence the outcome of a covered federal action.

Identify the status of the covered federal action.

Identify the appropriate classification of this report. If this is a follow-up report caused by a material change to the information previously reported, enter the year and quarter in which the change occurred. Enter the date of the last previously submitted report by this reporting entity for this covered federal action.

Enter the full name, address, city, state, and ZIP code of the reporting entity. Include Congressional District, if known. Check the appropriate classification of the reporting entity that designates if it is, or expects to be, a prime or subaward recipient. Identify the tier of the subawardee, e.g., the first subawardee of the prime is the 1st tier. Subawards include but are not limited to subcontracts, subgrants, and contract awards under grants.

If the organization filing the report in Item 4 checks "Subawardee," then enter the full name, address, city, state, and ZIP code of the prime federal recipient. Include Congressional District, if known.

Enter the name of the federal agency making the award or loan commitment. Include at least one organizational level below agency name, if known. For example, Department of Transportation United States Coast Guard.

Enter the federal program name or description for the covered federal action (Item 1). If known, enter the full Catalog of Federal Domestic Assistance (CDFA) number for grants, cooperative agreements, loans, and loan commitments.

Enter the most appropriate federal identifying number available for the federal action identified in Item 1 (e.g., Request for Proposal (RFP) number; Invitation for Bid (IFB) number; grant announcement number; the contract grant, or loan award number; the application/proposal control number assigned by the federal agency). Include prefixes, e.g., "RFP-DE-90401."

For a covered federal action where there has been an award or loan commitment by the federal agency, enter the federal amount of the award/loan commitment for the prime entity identified in Item 4 or 5.

10. (a) Enter the full name, address, city, state, and ZIP code of the lobbying entity engaged by the reporting entity identified in Item 4 to influence the covered federal action.

10. (b) Enter the full names of the Individual(s) performing services and include full address if different from 10.(a). Enter last name, first name, and middle initial (MI).

Enter the amount of compensation paid or reasonably expected to be paid by the reporting entity (Item 4) to the lobbying entity (Item 10). Indicate whether the payment has been made (actual) or will be made (planned). Check all boxes that apply. If this is a material change report, enter the cumulative amount of payment made or planned to be made.

Check the appropriate box(es). Check all boxes that apply. If payment is made through an in-kind contribution, specify the nature and value of the in-kind payment.

Check the appropriate box(es). Check all boxes that apply. If other, specify nature.

Provide a specific and detailed description of the services that the lobbyist has performed, or will be expected to perform, and the date(s) of any services rendered. Include all preparatory and related activity, not just time spent in actual contact with federal officials, identify the federal official(s) or employee(s) contacted or the officer(s), employee(s), or Member(s) of Congress that were contacted.

Check whether or not a SF-LLL-A Continuation Sheet(s) is attached.

The certifying official shall sign and date the form, print his/her name, title, and telephone number.

Public reporting burden for this collection of information is estimated to average 30 minutes per response, including time for reviewing instruction, searching existing data sources, gathering and maintaining the data needed, and completing and renewing the collection of information. Send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to the Office of Management and Budget, Paperwork Reduction Project, (0348-0046), Washington, DC 20503.

ATTACHMENT F
SUBCONTRACT REGULATORY TERMS

A. **General Terms**: Language addressing the following matters shall be included in Downstream subcontracts:

1. The right of CalOptima's Regulators to monitor, audit, evaluate, inspect and have access to books, records and other information as provided in this Contract.
2. CalOptima's Regulators' right to inspect, evaluate, and audit any pertinent information related to the Contract for a period of ten (10) years from the final date of the contract period or from the date of completion of any audit as provided in this Contract.
3. Prohibitions against holding Enrollees liable for payment of any fees that are the obligation of CalOptima or the Hospital, as applicable.
4. The services are in accordance with CalOptima's obligations to CMS and applicable CalOptima Policies.
5. The obligations of Downstream Entities to protect Enrollee privacy and confidentiality including health records, as provided in this Contract.
6. The obligation to comply with all federal and state laws, regulations and CMS instructions, including those laws that must be incorporated into such Downstream subcontracts as indicated in this Contract.
7. Language related to the obligations to submit timely and accurate Encounter Data and other data and reports required by CalOptima and CalOptima's Regulators as provided in this Contract and in CalOptima's Policies.
8. All requirements included in Attachment E not expressly addressed herein.

B. **Delegation Terms**. If, and to the extent that sub-delegation is permitted by CalOptima and Hospital obtains CalOptima's approval as provided in this Contract, Downstream Entity subcontracts must include:

1. Language that specifies (i) the delegated activities and reporting requirements; (ii) that provides for revocation of the delegated activities and other remedies in the event CalOptima or CalOptima's Regulators find that the delegated party as not performed satisfactorily; (iii) that the performance of the parties is monitored by CalOptima on an ongoing basis; and (iv) that CalOptima may impose corrective action as necessary.
2. If the subcontract relates to credentialing of medical providers, language that the credentials of medical professionals affiliated with the party or parties will either be reviewed by CalOptima or the credential process will be reviewed and approved by CalOptima and that CalOptima must audit the process on an ongoing basis.
3. If the subcontract delegates selection of providers it must include language that CalOptima retains the right to approve, suspend or terminate any such arrangement and that CalOptima shall provide a written statement to a provider of the reason or reasons for the termination with cause.

C. **Medical Provider Downstream Subcontract Terms**.

All subcontracts or arrangements with medical providers shall include provisions addressing:

1. The term of the contract, including the beginning and ending dates as well as methods of extension, renegotiation and termination and full disclosure of the method and amount of compensation or other consideration.

2. The obligation to pay contracted medical providers under the terms of the contract and prompt payment provision, the terms of which are developed and agreed to by the parties.

3. The obligations to provide services in a culturally competent manner to all Enrollees, including those with limited English proficiency or reading skills, and diverse culturally and ethnic background and provide interpreter services for Enrollees at all provider sites.

4. The obligation to (i) abide by all federal and state laws and regulations regarding confidentiality and disclosure of medical records, or other health and enrollment information; (ii) to ensure that medical information is released in accordance with applicable federal or state law, or pursuant to court orders or subpoenas; (iii) to maintain Enrollee records and information in an accurate and timely manner; and (iv) to ensure timely access by Enrollees to the records and information that pertain to them.

5. The obligation to hold CalOptima, CalOptima's Regulators and Enrollees harmless in the event that Hospital cannot or will not pay for services performed by the Downstream Entity and for Medicare Part A and B cost sharing. Specifically, Medicare Parts A and B services must be provided at zero cost-sharing to Enrollees.

6. Medical providers' EMTALA obligations and that they must not create any conflicts with hospital actions required to comply with EMTALA.

7. Language prohibiting providers, including PCPs, from closing or otherwise limiting their acceptance of Enrollees as patients unless the same limitations apply to all commercially insured Enrollees.

8. Language that prohibits the Downstream Entity from refusing to contract or pay an otherwise eligible health care Provider for the provision of Covered Services solely because such Provider has in good faith: (a) Communicated with or advocated on behalf of one or more of his or her prospective, current or former patients regarding the provisions, terms or requirements of the 'Downstream Entity's health benefit plans as they relate to the needs of such Provider's patients; or (b) communicated with one or more of his or her prospective, current or former patients with respect to the method by which such Provider is compensated by the Downstream Entity for services provided to the patient.

9. Language that states the Provider is not required to indemnify the Hospital for any expenses and liabilities, including judgments, settlements, attorneys' fees, court costs and any associated charges, incurred in connection with any claim or action brought against the Hospital based on its management decisions, utilization review provisions or other policies, guidelines or actions.

10. The obligation of the medical provider to assist CalOptima in the transfer of care, including in the transfer of care in the event of sub-subcontract termination for any reason.

11. Acknowledgement that assignment or delegation of the subcontract will be void unless prior written approval is obtained from CMS and CalOptima.

12. 'The Provider's right to submit a grievance and a description of the formal process to resolve the Provider's grievances.

13. The obligation to participate and cooperate in Hospital's Quality Improvement System.

14. Language addressing requirements related to payment of Non-Participating Provider emergency and post-stabilization services.

ATTACHMENT G
CMS SPECIFIC PROGRAM PERFORMANCE REQUIREMENTS

1. HCC Coding Requirements and Performance Improvement Activities

1.1 CMS pays CalOptima health-based capitation to compensate CalOptima for services rendered to Enrollees. CMS utilizes encounter data to assign Hierarchical Condition Categories ("**HCC**") to Enrollees. The Enrollee's HCC determines the payment amount received by CalOptima accounting for the variation in expenditures for Medicare Enrollees based on an Enrollee's health status.

1.2 Hospital shall submit Enrollee-specific accurate encounter and service data. Encounters are to be submitted no less than monthly using the ANSI 837P and/or 837I format version 5010 as appropriate, or current format as required by CalOptima.

1.3 Hospital shall support and aid CalOptima's review of encounters, including to production and/or access of supporting medical records.

1.4 To enhance encounter submission accuracy and completeness, CalOptima has initiated performance improvement activities ("**PIAs**"). These PIAs include Enrollee medical and behavioral health assessments provided in the home or a residential facility.

1.5 Hospital has the option to perform these PIAs provided Hospital can demonstrate that Hospital's PIAs meet all CalOptima standards and guidelines. Should Hospital not perform the PIAs or Hospital's PIAs not meet CalOptima standards and guidelines as determined by CalOptima, CalOptima shall perform these activities on behalf of Hospital and the cost for these PIAs shall be charged to or shared with Hospital. CalOptima will provide sixty (60) days' notification prior to taking any such action.

2. ESRD Waiver Responsibilities

2.1 Hospital shall demonstrate to CalOptima that Hospital administers a CalOptima-approved complex case management program for all End Stage Renal Disease (ESRD) Enrollees, which is in accordance with CMS requirements and CalOptima Policies and standards.

2.2 CalOptima shall advise Hospital if its ESRD complex case management program does not meet CMS requirements and CalOptima Policies and clinical standards. If Hospital cannot meet requirements as provided by CalOptima, CalOptima shall have the option to de-delegate the Hospital for the management of ESRD Enrollees and retain a portion of the Capitation Payment for ESRD Enrollees commensurate with the costs for providing or outsourcing such services.

2.3 CalOptima shall provide notification to Hospital of the intent to de-delegate. Hospital shall have the opportunity to submit a corrective action plan to CalOptima in accordance with CalOptima policy.

3. Appeals Rights

Hospital may appeal CalOptima's decision to take the actions outlined above, by filing a complaint pursuant to CalOptima Policies. If Hospital is dissatisfied with the result of any appeal; it shall proceed in accordance with CalOptima's legal claims and judicial review policy.

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken February 3, 2022
Regular Meeting of the CalOptima Board of Directors

Report Item
19. Authorize Amendments to the CalOptima Community Network Professional Services Contracts to Add OneCare as a Covered CalOptima Program

Contact
Yunkyung Kim, Chief Operating Officer (714) 246-8408

Recommended Action
Authorize amendment to the CalOptima Community Network (CCN) Professional Services Contracts to add OneCare as a covered CalOptima program, effective January 1, 2023.

Background & Discussion
Staff requests that the CalOptima Board of Directors (Board) authorize amending the CCN Professional Services Contracts to add OneCare as a covered program, effective January 1, 2023.

In 2014, the California Department of Health Care Services (DHCS) launched the Cal MediConnect (CMC) pilot to coordinate delivery of medical, behavioral health, long-term care, and home- and community-based services and integrate Medi-Cal and Medicare benefits for dual eligible beneficiaries into a single delivery system.

CalOptima participates in CMC via OneCare Connect (OCC), which was implemented on July 1, 2015. CMC was extended past its original termination date of December 31, 2017 but is now scheduled to end on December 31, 2022. As the CMC pilot winds down, OCC members will transition into OneCare (CalOptima's Dual Eligible Special Needs Plan) on January 1, 2023.

CCN providers are not currently contracted to provide services to OneCare members. For a seamless member transition and to minimize any potential disruption to members' access to care, staff is recommending amending the CCN provider agreements to include OneCare participation beginning in CY 2023.

To ensure continuity of care for OCC members as Cal MediConnect sunsets, staff requests the Board authorize amending the CCN Professional Services Contract to add OneCare as a covered program, effective January 1, 2023

Fiscal Impact
The recommended action to add OneCare to the scope of the existing professional services contracts is operational in nature, with no additional fiscal impact anticipated during the current fiscal year. Management will include medical and administrative expenses associated with these actions to support member transition to OneCare in the CalOptima Fiscal Year 2022-23 Operating Budget.

Rationale for Recommendation

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Amending the CCN contracts to cover OneCare will ensure that CalOptima OCC members have a comprehensive OneCare provider network to provide a seamless transition of care for CalOptima members currently participating in OneCare Connect.

Concurrence
Gary Crockett, Chief Counsel

Attachments

1. Presentation: 2021-09-02 Board Meeting OneCare Connect Transition.pptx
2. CMC 3-way Contract with CMS and DHCS: 2019.10.9_CA 3-Way Contract-H8016 CalOptima-Final Eff. 9-1-19 to 12-31-2022
3. CalAIM-Proposal-03-23-2021
4. CCN OneCare Amendment

/s/ Michael Hunn *01/27/2022*
Authorized Signature **Date**

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Better. Together.

OneCare Connect (OCC) Transition

Board of Directors Meeting
September 2, 2021

Ladan Khamseh, Chief Operating Officer
Ravina Hui, Director, Program Implementation (Medicare)

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Background

- On April 1, 2014, the Department of Health Care Services (DHCS) implemented the Coordinated Care Initiative (CCI)
  - Introduced Cal MediConnect (CMC) duals demonstration
    - Coordinated delivery of medical, behavioral health, long-term care, and home- and community-based services
    - Delivered coordinated Medi-Cal and Medicare benefits in a single delivery system

Background (cont.)

- On July 1, 2015, CalOptima implemented OneCare Connect (OCC) Cal MediConnect Plan (Medicare-Medicaid Plan)
  - Based on three-way contract between the Centers for Medicare & Medicaid Services (CMS), DHCS and CalOptima
  - Qualified OneCare members cross-walked into OCC
    - OneCare program retained for duals who didn't qualify for OCC

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Background (cont.)

- CMC demonstration period
  - Initially set to end December 31, 2017
  - CalOptima received state and federal authority for several CMC extensions
    - Three-way contract amended
      - January 1, 2018, demonstration year (DY) extended through December 31, 2019
      - September 1, 2019, DY extended through December 31, 2022
  - CMC will sunset on December 31, 2022

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Member Transition

- CalOptima received state and federal authority to transition current OCC members into the OneCare Program
  - Via CalAIM legislation
  - Proposes enrollment of CMC plan to a Dual Eligible Special Needs Plan (D-SNP) managed by the same parent organization
    - OCC members will be cross-walked into OneCare on January 1, 2023

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2023 Anticipated OneCare Provider Network

- Offer the same provider network options between OCC and OneCare
  - Supports seamless member transition
  - Minimizes disruption to member's access to care
- Expect all existing OCC health networks to participate in OneCare, including CalOptima Community Network (CCN)
  - Consistent with the current OC risk arrangement, OCC full risk health networks will transition to shared risk model
  - Provides better program viability for health networks and CalOptima

Current Health Network Participation

2021 OneCare Connect Health Networks	2021 OneCare Participation	2023 Anticipated OneCare Participation (as Shared Risk)
AltaMed Health Services Corporation	Participating	Participating
AMVI Care Health Network, Inc.*	Participating as AMVI/ Prospect Medical Group, a California general partnership between AMVI/IMC Health Network, Inc., a Medical Corporation and Santa Ana/Tustin Physician's Group, Inc.	Participating as AMVI Care Health Network, Inc.
Prospect Health Plan*		Participating as Prospect Medical Group, Inc.
Arta Western California Inc.	Participating	Participating
CalOptima Community Network	Not participating	Participating
Family Choice Medical Group, Inc.	Participating	Participating
Heritage Provider Network, Inc.*	Not participating	Participating
Monarch Health Plan Inc.*	Participating as Monarch Healthcare, a Medical Group, Inc.	Participating as Monarch Healthcare, a Medical Group, Inc.
Orange County Physicians IPA Medical Group, Inc. dba Noble Community Medical Associates, Inc. of Mid-Orange County	Participating	Participating
Talbert Medical Group, P.C.	Participating	Participating
United Care Medical Group, Inc.	Participating	Participating

*OCC Full Risk Health Networks

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Next Steps

Deliverables	Time Frame
Request Board authority to extend OneCare contracts to OCC health networks and amend the CCN provider contracts to include OneCare	• December 2021 Board (CCN) • May 2022 Board (health networks)
Release contracts to health networks and CCN providers	• January 2022 (CCN) • May 2022 (health networks)
Contract execution by OneCare health networks and CCN providers (effectuated in CY 2023)	• No later than May 31, 2022
Conduct readiness assessment for health networks transitioning to OneCare	• Q4 2022
OneCare Connect sunsets with members transitioning to OneCare	• January 1, 2023

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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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Contract

Between

United States Department of Health and Human Services
Centers for Medicare & Medicaid Services

In Partnership with

California Department of Health Care Services

and

Orange County Health Authority

Effective: September 1, 2019

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This Contract, effective September 1, 2019 is between the Department of Health and Human Services, acting by and through the Centers for Medicare & Medicaid Services (CMS), the state of California, acting by and through the Department of Health Care Services (DHCS) and Orange County Health Authority (the Contractor). The Contractor's principal place of business is 505 City Parkway West, Orange, CA 92868.

WHEREAS, CMS is an agency of the United States, Department of Health and Human Services, responsible for the administration of the Medicare, Medicaid, and State Children's Health Insurance Programs under Title XVIII, Title XIX, Title XI, and Title XXI of the Social Security Act;

WHEREAS, DHCS is an agency responsible for operating a program of medical assistance under 42 U.S.C. § 1396 et seq and California Welfare and Institutions Code § 14000 et seq, designed to work closely with health care professionals, county governments and health plans to provide a health care safety net for California's low-income and persons with disabilities;

WHEREAS, a purpose of this Contract is to test a new model of payment and service delivery pursuant to 1115A of the Social Security Act;

WHEREAS, the Contractor is in the business of ensuring access to care needed to improve health and quality of life, and CMS and DHCS desire to purchase services from the Contractor to offer quality, accessible care; improve care coordination among medical care, behavioral health, and long-term services and supports; and further the goals of the *Olmstead* Decision;

WHEREAS, the Contractor agrees to furnish these services in accordance with the terms and conditions of this Contract and in compliance with all federal and state laws and regulations;

WHEREAS, this Contract replaces in its entirety, the Contracted entered into by CMS , DHCS, and the Contractor executed December 18, 2013 and re-executed on January 1, 2018, provided, however, that any duties, obligations, responsibilities, or requirements that are imposed upon the Contractor in this revised Contract, but that were not imposed upon the Contractor either in the original version of this Contract executed on December 18, 2013, as amended, or under applicable laws or regulations, shall be prospective in nature only (effective September 1, 2019).

NOW, THEREFORE, in consideration of the mutual promises set forth in this Contract, the parties agree as follows:

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1. Definition of Terms

1.1. **Actual Non-Service Expenditures –** The Contractor's actual amount incurred for non-service expenditures, including both administrative and care management costs, for Enrollees during each Demonstration Year. These costs will exclude costs incurred by the Contractor prior to the start of the Demonstration. Any reinsurance costs reflected here will be net reinsurance costs.

1.2. **Actual Service Expenditures –** The Contractor's actual amount paid for Covered Services (as defined in Appendix A) delivered during each Demonstration Year. Actual Service Expenditures shall be priced at the Contractor fee level and should include all payments to providers for Covered Services, including pay-for-performance payments, risk-sharing arrangements, or sub-capitation payments.

1.3. **Adjusted Final Capitation Rate Revenue –** The Adjusted Interim Capitation Rate Revenue with the Minimum Savings Percentages, rather than the County-Specific Interim Savings Percentages, applied. This is determined by multiplying the Adjusted Interim Capitation Rate Revenue by (1- the Minimum Savings Percentage) / (1- the County-Specific Interim Savings Percentage).

1.4. **Adjusted Interim Capitation Rate Revenue –** The Total Capitation Rate Revenue excluding the monthly capitation payments for Medicare Part D services, and any risk adjustment or reconciliation associated with Medicare Part D payments.

1.5. **Adjusted Non-Service Expenditures –** The Contractor's Actual Non-Service Expenditures, adjusted to reflect the following:
-At the discretion of the State and CMS, exclusion of any costs, including care management, associated with Medicare Part D services as identified in CMS bid instructions and other guidance;
- Exclusion of costs greater than one hundred twenty five percent (125%) of the median cost per member per month across all participating Contractors during the Demonstration Year. Consideration will be given to any Contractor with significant non-typical membership mixes that may cause this exclusion to come into effect;
- Exclusion of reinsurance costs (net of reinsurance premiums); and
- Adjustments resulting from CMS and the State's review of the Contractor's

non-service expenditures to address any inappropriate or excessive non-service expenditures (including executive compensation and stop loss expenditures).

1.6. **Adjusted Service Expenditures –** The Contractor's Actual Service Expenditures, adjusted to reflect the following:
- Exclusion of the net cost of all services provided under Medicare Part D;
- Reductions to reflect any recoveries from other payors outside of claims adjudication, including those pursuant to coordination of benefits, third party liability, rebates, supplemental payments, adjustments in claims paid, adjustments from providers including adjustments to claims paid, and Enrollee contributions to care. These adjustments shall exclude any adjustments associated with coverage of Medicare Part D services; and
- Adjustments resulting from CMS and the State review of Contractor reimbursement methodologies and levels to address any excessive pricing.

1.7. **Advance Directive –** An individual's written directive or instruction, such as a power of attorney for health care or a living will, recognized under State law (whether statutory or as recognized by the courts of the State) for the provision of that individual's health care if the individual is unable to make his or her health care wishes known.

1.8. **Adverse Benefit Determination --** (i) The denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for medical necessity, appropriateness, setting or effectiveness of a Covered Service; (ii) the reduction, suspension, or termination of a previously authorized service; (iii) the denial, in whole or in part, of payment for a service; (iv) the failure to provide services in a timely manner; (v) the failure of the Contractor to act within the required timeframes for the standard resolution of Grievances and Appeals; (vi) for a resident of a rural area with only one Contractor, the denial of an Enrollee's request to obtain services outside of the Network; or (vii) the denial of an Enrollee's request to dispute a financial liability.

1.9. **Appeal** - In general, an Enrollee's actions, both internal and external to the Contractor requesting review of the Contractor's denial, reduction or termination of benefits or services, from the Contractor. Appeals relating to Medi-Cal covered benefits and services shall proceed pursuant to the laws and regulations governing Medi-Cal Appeals. Appeals relating to Medicare covered benefits and services shall proceed pursuant to the laws and

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regulations governing Medicare Appeals. A Medi-Cal based Appeal is defined as review by the Contractor of an Adverse Benefit Determination.

1.10. **Behavioral Health —** An all-inclusive term referring to mental health services provided through the mental health plan (MHP) or Contractor and substance use disorder services.

1.11. **Cal MediConnect —** California's State-specific name for the Capitated Financial Alignment Model Demonstration.

1.12. **Cal MediConnect Plan (also, Contractor) —** A health plan or other qualified entity jointly selected by the State and CMS for participation in this Demonstration.

1.13. **Cal MediConnect Ombuds Program-** The independent contractor established to safeguard the rights and dignity of all beneficiaries supported by Cal MediConnect. This office will be responsible for assisting and resolving issues that Enrollees may encounter with Cal MediConnect Plans.

1.14. **California (or State) —** For purposes of this document, California (or State) is generally used to refer to DHCS, though it may encompass collectively CDA, DHCS, DMHC, and DSS.

1.15. **Capitated Financial Alignment Model Demonstration ("the Demonstration") —** A model in which a state, CMS, and a Contractor enter into a three-way Contract, and the Contractor receives a prospective blended capitation payment to provide comprehensive, coordinated care.

1.16. **Capitated Financial Alignment Model Memorandum of Understanding (CFAM-MOU) —** For purposes of this Contract, this is a document between CMS and California regarding a Federal-State Partnership to Test a Capitated Financial Alignment Model (signed March 27, 2013). This MOU document details the principles under which CMS and the State plan to implement and operate the Demonstration. It also outlines the activities CMS and the State plan to conduct in preparation for implementation of the Demonstration, before the parties execute this Contract setting forth the terms and conditions of the Demonstration and initiate the Demonstration.

1.17. **Capitation Rate —** The sum of the monthly capitation payments (reflecting coverage of Medicare Parts A & B services, Medicare Part D services, and Medicaid services, pursuant to Appendix A of this Contract). Total Capitation Rate Revenue will be calculated as if all Contractors had received the full

quality withhold payment.

1.18. **Care Coordination** –Delineated through requirements, processes and the care model throughout this Contract, Care Coordination is also detailed in WIC Sections 14182.17(d)(4) and 14186(b).

1.19. **Care Coordinator** — A clinician or other trained individual employed or contracted by the PCP or the Contractor who is accountable for providing Care Coordination services, which include assuring appropriate referrals and timely two-way transmission of useful Enrollee information; obtaining reliable and timely information about services other than those provided by the Primary Care Provider; participating in the initial assessment; and supporting safe transitions in care for Enrollees moving between settings. The Care Coordinator serves on one (1) or more Interdisciplinary Care Teams (ICT), coordinates and facilitates meetings and other activities of those ICTs. The Care Coordinator also participates in the Initial Assessment of each Enrollee on whose ICT he or she serves.

1.20. **Care Plan Option (CPO) Services** – A CPO Service is optional under the beneficiary's Individualized Care Plan (ICP). A CPO Service is designed to only supplement, not replace, the required Medi-Cal services under the beneficiary's Individualized Care Plan (ICP). CPO Services are offered entirely at the Contractor's discretion.

1.21. **Centers for Medicare & Medicaid Services (CMS)** — The federal agency under the United States Department of Health and Human Services responsible for administering the Medicare and Medicaid programs.

1.22. **Chronic Mental Disorder** — To be considered to have a Chronic Mental Disorder, the Enrollee shall have one or more of the following diagnoses or its successor diagnoses included in the most recent version of the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association: (a) Pervasive Developmental Disorders, (b) Attention Deficit and Disruptive Behavior Disorders, (c) Feeding and Eating Disorder of Infancy, Childhood, or Adolescence, (d) Elimination Disorders, (f) Schizophrenia and Other Psychiatric Disorders, (g) Mood Disorders, (h) Anxiety Disorders, (i) Somatoform Disorders, (j) Factitious Disorders, (k), Dissociative Disorders, (l) Paraphilias, (m) Gender Identity Disorders, (n) Eating Disorders, (o) Impulse Control Disorders Not Elsewhere Classified (p) Adjustment Disorders, (q) Personality Disorders, or (r) Medication-Induced

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Movement Disorders.

1.23. **Community Based Adult Services (CBAS) —** Outpatient, facility-based program that delivers skilled nursing care, social services, therapies, personal care, family/caregiver training and support, nutrition services, and transportation to eligible Medi-Cal beneficiaries, aged 18 years and older, blind, or disabled.

1.24. **Contract —** The participation agreement that CMS and DHCS have with a Contractor, for the terms and conditions pursuant to which a Contractor may participate in this Demonstration.

1.25. **Contract Management Team (CMT) —** A group of CMS and DHCS representatives responsible for overseeing the contract management functions outlined in Section 3.1.1 of the Contract.

1.26. **Contract Operational Start Date —** The first date on which enrollment into the Contractor's Cal MediConnect coverage is effective.

1.27. **Contractor —** An entity approved by CMS and DHCS that enters into a Contract with CMS and DHCS in accordance with, and to meet, the purposes specified in this Contract.

1.28. **County Organized Health System (COHS) —** A type of Medi-Cal managed care delivery model in which DHCS contracts with a single health plan created by the County Board of Supervisors.

1.29. **County Social Services Agency**- Local county agency that administers the IHSS program.

1.30. **Covered Services —** The set of services to be offered by the Contractor as defined in Appendix A.

1.31. **Department of Aging (CDA) –** In California, CDA administers programs that serve older adults, adults with disabilities, family caregivers, and residents in long-term care facilities throughout the State. CDA administers funds allocated under the federal Older Americans Act, the Older Californians Act, and through the Medi-Cal program. CDA certifies CBAS centers for participation in the Medi-Cal Program and provides administrative oversight for the MSSP waiver.

1.32. **Department of Health Care Services (DHCS) –** The State department in California responsible for administration of the federal Medicaid Program (referred to as Medi-Cal in California). DHCS is generally referred to as the

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State in this document**.**

1.33. **Department of Managed Health Care (DMHC**) – The State department charged with overseeing health care service plans licensed under the Knox-Keene Act.

1.34. **Department of Social Services (CDSS)** – The State department responsible for overseeing and providing social services, including the In Home Support Services (IHSS) program.

1.35. **Developmental Disability –** A disability which originates before the individual attains age 18, continues, or can be expected to continue, indefinitely, and constitutes a substantial disability for that individual as defined in the California Code of Regulations.

1.36. **Drug Medi-Cal Benefits –** The substance use disorder Medi-Cal benefits that are listed in Title 22, California Code of Regulations, section 51341.1(d) and Welfare and Institutions Code section 14132.03 .

1.37. **Dual-Plan Letter (DPL) -** DPLs convey information or interpretation of changes in policy or procedure at the federal or State levels, and about changes in federal or State law and regulations. DPLs provide instruction to the Contractor on how to implement these changes on an operational basis, and about how federal or State law affect the way in which they operate, or deliver services to Enrollees. The Department shall notify and consult with stakeholders, including the Contractor, prior to the issuance of a DPL in compliance with the provisions of Welfare and Institutions Code section 14186.4(c).

1.38. **Emergency Medical Condition —** A medical condition that manifests itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in: (1) placing the health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; (2) serious impairment to bodily functions; or (3) serious dysfunction of any bodily organ or part.

1.39. **Emergency Services** – Inpatient and outpatient services covered under this Contract that are furnished by a Provider qualified to furnish such services and that are needed to evaluate or stabilize an Enrollee's Emergency Medical

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Condition.

1.40. **Encounter Data -** The record of an Enrollee receiving any item(s) or service(s) provided through Medicaid or Medicare under a prepaid, capitated, or any other risk basis payment methodology submitted to CMS. This record must incorporate the Health Insurance Portability and Accountability Act of 1996 (HIPAA) security, Privacy, and transaction standards and be submitted in the ASC X12N 837 format or any successor format.

1.41. **Enrollee —** Any Medicare-Medicaid eligible individual who is enrolled with a Contractor.

1.42. **Enrollee Communications —** Materials designed to communicate Covered Services, policies, processes and/or Enrollee rights to Enrollees. This includes pre-enrollment, post-enrollment, and operational materials.

1.43. **Enrollment Broker —** Entity contracted by DHCS through the Health Care Options Program to provide information and enrollment assistance to Medicare-Medi-Cal beneficiaries.

1.44. **Exempt Grievance –** Grievances received by telephone that are not coverage disputes, disputed health care services involving medical necessity, or experimental or investigational treatment and that are resolved by the next business day following receipt.

1.45. **External Quality Review Organization --** An independent entity that contracts with the State and evaluates the access, timeliness, and quality of care delivered by the Contractor to their Enrollees.

1.46. **Federally-Qualified Health Center (FQHC) —** An entity that has been determined by CMS to satisfy the criteria set forth in 42 U.S.C. § 1396d(a)(2)(C).

1.47. **First Tier, Downstream and Related Entity —** An individual or entity that enters into a written arrangement that is acceptable to CMS and DHCS with the Contractor, to provide administrative or health care services to the Contractor under this Contract.

1.48. **Geographic Managed Care (GMC) County —** A county in which DHCS contracts with two or more Knox Keene licensed health plans for Medi-Cal managed care.

1.49. **Grievance:**" Any complaint or dispute, other than one that constitutes an organization determination under 42 C.F.R. § 422.566 or other than an

Adverse Benefit Determination under 42 C.F.R. § 438.400, expressing dissatisfaction with any aspect of the Contractor's or Provider's operations, activities, or behavior, regardless of whether remedial action is requested pursuant to 42 C.F.R. § 422.561. A Grievance is filed and decided at the Contractor level. (Possible subjects for Grievances include, but are not limited to, the quality of care or services provided and aspects of interpersonal relationships such as rudeness of a Provider or employee, or failure to respect the Enrollee's rights as provided for in Appendix B of this Contract). Also called a "Complaint."

1.50. **Health Care Options Program (HCO)** -- A program within the California Department of Health Care Services which operates as an Enrollment Broker providing enrollment assistance to eligible MMP beneficiaries.

1.51. **Health Outcomes Survey (HOS) —** Beneficiary survey used by CMS to gather valid and reliable health status data in Medicare managed care for use in quality improvement activities, plan accountability, public reporting, and improving health.

1.52. **Health Plan Management System (HPMS) —** A system that supports contract management for Medicare health plans and prescription drug plans and supports data and information exchanges between CMS and health plans. Current and prospective Medicare health plans submit applications, information about Provider Networks, plan benefit packages, formularies, and other information via HPMS.

1.53. **Health Risk Assessment —** An assessment tool which identifies primary, acute, long-term services and supports, and Behavioral Health and functional needs.

1.54. **Healthcare Effectiveness Data and Information Set (HEDIS) —** Tool developed and maintained by the National Committee for Quality Assurance that is used by health plans to measure performance on dimensions of care and service in order to maintain and/or improve quality.

1.55. **High Risk Enrollee —** For risk stratification purposes, an Enrollee who is at increased risk of having an adverse health outcome or worsening of his or her health status if he or she does not receive initial contact by the Contractor within forty-five (45) calendar days after coverage date. The higher risk Enrollees who should be identified from the fee for service utilization data,

include but are not limited to Enrollees who:

- Have been on oxygen within the past ninety (90) days,
- Have been hospitalized within the last ninety (90) days, or have had three (3) or more voluntary and/or involuntary hospitalizations within the past year related to Behavioral Health illnesses,
- Have had three (3) or more emergency room visits in the past year in combination with other evidence of high utilization of services (e.g. multiple prescriptions consistent with the diagnoses of chronic diseases),
- Have In Home Supportive Services (IHSS) greater than or equal to one hundred ninety five (195) hours/month,
- Are enrolled in the Multipurpose Senior Service Program (MSSP),
- Are receiving Community Based Adult Services (CBAS),
- Have ESRD, AIDS, and/or a recent organ transplant,
- Have been currently being treated for cancer,
- Have been prescribed anti-psychotic medication within the past ninety (90) days,
- Have been prescribed fifteen (15) or more medications in the past ninety (90) days, or
- Have other conditions as determined by the Contractor, based on local resources.

1.56. **Indian Enrollee —** An Enrollee who is an Indian (as defined at 25 USC 1603(13), 1603(28), or 1679(a), or who has been determined eligible as an Indian, under 42 C.F.R. § 136.12.) This includes an Enrollee is a member of a Federally recognized tribe; resides in an urban center and meets one or more of four criteria including: is member of a tribe, band, or other organized group of Indians, including those tribes, bands, or groups terminated since 1940 and those recognized now or in the future by the State in which they reside, or who is a descendant, in the first or second degree, of any such member; is an Eskimo or Aleut or other Alaska Native; is considered by the Secretary of the Interior to be an Indian for any purpose; or is determined to be an Indian under regulations issued by the Secretary; is considered by the Secretary of the Interior to be an Indian for any purpose; or is considered by the Secretary of Health and Human Services to be an Indian for purposes of eligibility for Indian Health Services, including as a California Indian, Eskimo, Aleut, or other Alaska Native Enrollee.

1.57. **Indian Health Care Provider –** A health care program operated by the Indian Health Services (IHS) or by an Indian Tribe, Tribal Organization, or Urban Indian Organization (I/T/U) as those terms are defined in Section 4 of the

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Indian Health Care Improvement Act (25 U.S.C. § 1603).

1.58. **Individualized Care Plan (ICP or Care Plan)** — The plan of care developed by an Enrollee and/or an Enrollee's Interdisciplinary Care Team or health plan.

1.59. **Interdisciplinary Care Team (ICT)** — A team comprised of the Primary Care Provider and Care Coordinator, and other providers at the discretion of the Enrollee, that works with the Enrollee to develop, implement, and maintain the ICP.

1.60. **In-Home Supportive Services (IHSS)** — Pursuant to Article 7 of California Welfare and Institutions Code (Welf. & Inst. Code) (commencing with section 12300 of Chapter 3, and sections 14132.95, 14132.952, and 14132.956), IHSS is a program that provides in-home care for people who cannot safely remain in their own homes without assistance.

1.61. **Long Term Services and Supports (LTSS)** — A wide variety of services and supports that help eligible beneficiaries meet their daily needs for assistance and improve the quality of their lives. Examples include assistance with bathing, dressing and other basic activities of daily life and self-care, as well as support for everyday tasks such as laundry, shopping, and transportation. LTSS are provided over an extended period, predominantly in homes and communities, but also in facility-based settings such as nursing facilities. As described in California Welfare and Institutions Code section 14186.1, Medi-Cal covered LTSS includes all of the following:

- In-Home Supportive Services (IHSS);
- Community-Based Adult Services (CBAS);
- Multipurpose Senior Services Program (MSSP) services; and
- Skilled Nursing Facility services and subacute care services.

1.62. **Low Risk Enrollee** —Enrollee who does not meet the minimum requirements of a High Risk Enrollee.

1.63. **Marketing, Outreach, and Enrollee Communications** — Any informational materials targeted to Enrollees that are consistent with the definitions of communication materialsand marketing materials at 42 C.F.R. § 422.2260.

1.64. **Medicaid** — The program of medical assistance benefits under Title XIX of the Social Security Act and various Demonstrations and waivers thereof. California's State-specific name for this program is Medi-Cal.

1.65. **Medi-Cal Dental –** Adult dental benefits provided through Medi-Cal

(California's Medicaid program).

1.66. **Medi-Cal Managed Care Behavioral Health Services -** Behavioral Health services specified in the Welfare and Institutions Code section 14132.03 that will be provided by the Contractor.

1.67. **Medi-Cal Managed Care Plan** – A health plan directly contracted with the California Department of Health Care Services to provide Medi-Cal services to eligible beneficiaries.

1.68. **Medi-Cal Appeal** - A request for a fair hearing in accordance with California Code of Regulations Title 22, section 51014.1 and Welfare and Institutions Code section 10950.

1.69. **Medically Necessary Services** — Services must be provided in a way that provides all protections to the Enrollee provided by Medicare and Medi-Cal. Per Medicare, services must be reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member, or otherwise medically necessary under 42 U.S.C. § 1395y. In accordance with Title XIX law and related regulations, and per Medi-Cal, medical necessity means reasonable and necessary services to protect life, to prevent significant illness or significant disability, or to alleviate severe pain through the diagnosis or treatment of disease, illness, or injury under the Welfare and Institutions Code section 14059.5.

1.70. **Medi-Cal Specialty Mental Health Services** — The Medi-Cal services specified in California Code of Regulations, Title 9 section 1810.247. Specialty mental health services do not include the Medi-Cal Managed Care Behavioral Health Services specified in the Welfare and Institutions Code section 14132.03 that will be provided by the Contractor. Specialty mental health services are provided through a MHP, in accordance with California Code of Regulations, Title 9, Chapter 11 of Division 1 and include:

A. Rehabilitative services, which includes mental health services, medication support services, day treatment intensive, day rehabilitation, crisis intervention, crisis stabilization, adult residential treatment services, crisis residential services, and psychiatric health facility services;
B. Psychiatric inpatient hospital services;
C. Targeted Case Management;
D. Psychiatrist services; and
E. Psychologist services.

1.71. **Medicare —** Title XVIII of the Social Security Act, the federal health insurance program for people age 65 or older, people under 65 with certain disabilities, and people with End Stage Renal Disease (ESRD) or Amyotrophic Lateral Sclerosis. Medicare Part A provides coverage of inpatient hospital services and services of other institutional providers, such as skilled nursing facilities and home health agencies. Medicare Part B provides supplementary medical insurance that covers physician services, outpatient services, some home health care, durable medical equipment, and laboratory services and supplies, generally for the diagnosis and treatment of illness or injury. Medicare Part C provides Medicare beneficiaries with the option of receiving Part A and Part B services through a private health plan. Medicare Part D provides outpatient prescription drug benefits.

1.72. **Medicare Advantage —** The Medicare managed care options that are authorized under Title XVIII of the Social Security Act as specified at 42 C.F.R. Part 422.

1.73. **Medicare Appeal —** An Enrollee's request for formal review of an Adverse Benefit Determination of the Contractor in regards to a Medicare service in accordance with Section 2.15.

1.74. **Medicare-Medicaid Coordination Office —** Formally the Federal Coordinated Health Care Office, established by Section 2602 of the Affordable Care Act.

1.75. **Medicare-Medicaid Enrollee (or Enrollee) —** For the purposes of this Demonstration, an individual who is entitled to, or enrolled for, benefits under Part A of title XVIII of the Social Security Act, and enrolled for benefits under Part B of title XVIII of such Act, and is eligible for medical assistance under a State plan under title XIX of such Act or under a waiver of such plan.

1.76. **Medicare-Medicaid Plan (MMP)** -- A health plan contracted with DHCS and CMS to comprehensively manage the full continuum of Medicare and Medi-Cal benefits for Medicare-Medicaid Enrollees including Long Term Supports and Services as needed and desired by the Enrollee.

1.77. **Mental Health Plan (MHP):** Pursuant to California Code of Regulations, Title 9 section 1810.226, a MHP is an entity that enters into a contract with DHCS to provide directly, or arrange and pay, for Medi-Cal Specialty Mental Health Services. A MHP may be a county, counties acting jointly or another

governmental or non-governmental entity.

1.78. **Minimum Data Set (MDS) —** A clinical screening system, mandated by federal law for use in nursing facilities, that assesses the key domains of function, health, and service use. MDS assessment forms include the MDS-HC for home care and the MDS 2.0 for nursing facility residents.

1.79. **Multi-Purpose Senior Services Program (MSSP**) **—** A California-specific program, the 1915(c) Home and Community-Based Services Waiver that provides Home and Community-Based Services (HCBS) to Medi-Cal eligible individuals who are 65 years or older with disabilities as an alternative to nursing facility placement.

1.80. **Network Provider —** An appropriately credentialed and licensed individual, facility, agency, institution, organization, or other entity that has an agreement with the Contractor, or any First Tier, Downstream, or Related Entity, for the delivery of services covered under the Contract. A Network Provider must meet the requirements in Section 2.9.9.1.

1.81. **Notice of Action (NOA) –** A written notice of any action within the timeframes for each type of action as provided by 42 C.F.R. §§ 438.404 and 422.568.

1.82. **Passive Enrollment —** An enrollment process through which an eligible individual is enrolled by DHCS into a Contractor's plan following a minimum sixty (60) day advance notification that includes the opportunity for the Enrollee to choose another plan or opt out prior to the effective date.

1.83. **Post-Stabilization Care Services —** Services related to an emergency medical condition that are provided after an Enrollee is stabilized in order to maintain the stabilized condition, or are provided, to improve or resolve the condition.

1.84. **Primary Care Provider (PCP) --** A person responsible for supervising, coordinating, and providing initial and primary care to patients; for initiating referrals; and for maintaining the continuity of patient care. A PCP may be a physician or non-physician medical practitioner.

1.85. **Privacy —** Requirements established in the Privacy Act of 1974, the Health Insurance Portability and Accountability Act of 1996, and implementing regulations, as well as relevant California privacy laws.

1.86. **Program of All-Inclusive Care for the Elderly (PACE) —** As defined in 42 C.F.R. § 460.6, and authorized under California law at Welfare and

Institutions Code section 14591 et seq., PACE is a capitated program for individuals over the age of 55 certified by DHCS for nursing home level of care. PACE organizations cover all Medicare and Medicaid benefits, including medical services and long-term services and support, organizes a comprehensive service delivery system governed by federal regulations, and integrate Medicare and Medicaid financing. PACE is a three-way partnership between the federal Government, California, and the PACE Organizations.

1.87. **Provider Network —** A network of health care and social support providers, including but not limited to primary care physicians, nurses, nurse practitioners, physician assistants, Care Coordinators, specialty providers, Behavioral Health providers, community and institutional long-term care providers, pharmacy providers, and acute providers employed by or under subcontract with the Contractor. (See Appendix C of the Contract).

1.88. **Readiness Review —**Prior to being eligible to accept Demonstration enrollments, each prospective Contractor selected to participate in the Demonstration must undergo a Readiness Review. The Readiness Review evaluates each prospective Contractor's ability to comply with the Demonstration requirements, including but not limited to, the ability to quickly and accurately process claims and enrollment information, accept and transition new Enrollees, and provide adequate access to all Medicare and Medicaid-covered Covered Services that are Medically Necessary with Enrollee protections. Only Contractors passing the Readiness Review will participate in the Demonstration. At a minimum, each Readiness Review includes a desk review and a site visit to the prospective Contractor's headquarters.

1.89. **Recovery Model —** Framework for Behavioral Health that uses "recovery-oriented" services in recognition that systems of care should ensure culturally competent care for persons with severe mental illness and substance use disorders in the most appropriate, least restrictive level of care necessary to achieve meaningful outcomes such as health, home, purpose and community, consistent with the system of care as set forth in California Welfare and Institutions Code sections 5802 and 5806. Core practices within recovery-oriented systems include peer support, individual choice and person-driven approaches. The Recovery Model recognizes that Behavioral Health issues involve an individualized complex interaction between social, environmental and physiological components, and the need to incorporate all of these factors

within the care system in order to achieve health and wellness.

1.90. **Request for Solutions —** Document released in December 2011 by DHCS to assess if contractors have the requisite qualifications and resources suited to provide seamless access to the full continuum of medical care and social supports and services that Enrollees need to maintain good health and a high quality of life in the setting of their choice.

1.91. **Rural Health Clinic (RHC) –** An entity that meets all of the requirements for designation as a RHC under § 1861(aa)(1) of the Social Security Act and is approved for participation in the Medi-Cal program.

1.92. **Service Area —** The county or counties that the Contractor is approved to operate in under the terms of this Contract. A Service Area may have designated ZIP Codes (under the U.S. Postal Service) within a county that are approved by CMS and DHCS to operate under the terms of this Contract. See Appendix I for the Service Area for this contract.

1.93. **Skilled Nursing Facility (SNF) —** As defined in California Code of Regulations, Title 22 section 51121(a), any institution, place, building, or agency which is licensed as a SNF by the California Department of Public Health (CDPH) or is a distinct part or unit of a hospital, meets the standard specified in section 51215 of these regulations (except that the distinct part of a hospital does not need to be licensed as a SNF) and has been certified by DHCS for participation as a SNF in the Medi-Cal program. Section 51121(b) further defines the term "Skilled Nursing Facility" as including terms "skilled nursing home", "convalescent hospital", "nursing home", or "nursing facility".

1.94. **State Fair Hearing —** A "State Fair Hearing" is a quasi-judicial proceeding conducted by a judge, during which each hearing party may present arguments and evidence, including witness(es), and cross examine witness(es) against them, with respect to a decision regarding the availability or delivery of services or benefits, made by an agency. An "agency" is a government unit or managed care health plan involved in a hearing as a hearing party. Such agencies include all 58 California counties, the Los Angeles Department of Children and Family Services, the California Department of Aging, the CDSS Office of Services to the Blind, all 27 Medi-Cal Field Offices, and several CDHS units, including: Beneficiary Utilization Review Unit, Benefits Branch-Vision, In-Home Operations, Managed Care

Operations Branch, Recovery Section, and Office of Medi-Cal Dental Services.

1.95. **Streamlined Enrollment:** A process to permit Contractors operating in non-COHS counties to submit opt-in enrollments to DHCS on behalf of their members enrolled in the matching plan's Medi-Cal line of business.

1.96. **Threshold Languages —** As specified in annual guidance to Contractors on specific translation requirements for their service areas.

1.97. **Total Adjusted Expenditures –** The sum of the Adjusted Service Expenditures and the Adjusted Non-Service Expenditures.

1.98. **Total Capitation Rate Revenue –** The sum of the monthly capitation payments for the Demonstration Year (reflecting coverage of Medicare Parts A/B services, Medicare Part D services and Medi-Cal services, pursuant to Appendix A of this contract) including: 1) the application of risk adjustment methodologies, as described in Section 4.2; and 2) any payment adjustments as a result of the reconciliation described in Sections 4.13 and 4.14. Total Capitation Rate Revenue will be calculated as if all Contractors had received the full quality withhold payment.

1.99. **Two- Plan County —** A type of Medi-Cal managed care delivery model in which DHCS contracts two plans, offering beneficiaries a choice of health plan a with a "Local Initiative" (LI) and a "commercial plan" (CP). An LI is a non-profit, locally government health plan serving Medi-Cal beneficiaries.

1.100. **Urgent Care — S**ervices required to prevent serious deterioration of health following the onset of an unforeseen condition or injury (i.e., sore throats, fever, minor lacerations, and some broken bones). Medical services required promptly to prevent impairment of health due to symptoms that do not constitute an Emergency Medical Condition, but that are the result of an unforeseen illness, injury, or condition for which medical services are immediately required. Urgent Care is appropriately provided in a clinic, physician's office, or in a hospital emergency department if a clinic or physician's office is inaccessible. Urgent Care does not include primary care services or services provided to treat an Emergency Condition.

2. Contractor Responsibilities

Through the Capitated Financial Alignment Model Demonstration (the "Demonstration"), CMS and DHCS will work in partnership to offer Medicare-Medicaid Enrollees the option of enrolling in a Contractor's plan, which consists of a comprehensive network of health and social service providers. The Contractor will deliver and coordinate all components of Medicare and Medi-Cal Covered Services for Enrollees.

2.1. Compliance: The Contractor must, to the satisfaction of CMS and DHCS:

2.1.1. Comply with all provisions set forth in this Contract.

2.1.2. Comply with all applicable provisions of federal and State laws, the CFAM-MOU, regulations, guidance, waivers, Demonstration terms and conditions, including the implementation of a compliance plan. The Contractor must comply with the Medicare Advantage requirements in Part C of Title XVIII, and 42 C.F.R. Part 422, Part 423, and Part 438 except to the extent that variances from these requirements are provided in the CFAM-MOU.

2.1.3. Maintain appropriate licensure as a health care service plan in accordance with the Knox-Keene Health Care Service Plan Act of 1975 as amended and have no adverse actions with regard to enforcement or quality management. County-Organized Health System (COHS) plans are exempt from Knox-Keene licensure for their Medi-Cal business pursuant to WIC section 14087.95. Despite this exemption from licensure, this Contract obligates all Contractors, including COHS plans, to comply with all provisions of this Contract, including the contractual provisions relating to the Knox-Keene Act, unless otherwise expressly excluded.

2.1.4. The Contractor agrees that it will develop and implement an effective compliance program that applies to its operations, consistent with 42 C.F.R. § 420, et seq, 42 C.F.R. § 422.503, and 42 C.F.R. §§ 438.600-610, 42 C.F.R. § 455.

2.1.4.1. The Contractor must report all employees, providers, and Enrollees suspected of Fraud, waste, and/or Abuse that warrant investigation to DHCS – Office of Inspector General, the Medicaid Fraud Control Unit and CMS.

2.1.5. Comply with all current and applicable DPLs issued by DHCS. All current DPLs can be viewed at: http://www.dhcs.ca.gov/formsandpubs/Pages/MgdCareDualsPlanL

etters.aspx

2.1.5.1. All DPLs will be reviewed by CMS prior to issuance.

2.1.6. In the event an APL applies to an MMP, DHCS and CMS will jointly issue a memo to the plans via HPMS for the interim period between an APL issuance and a DPL issuance.

2.1.7. Maintain its contract with DHCS for the provision of Covered Services under the Medi-Cal program.

2.1.8. For Contractors that make or receive payments under the contract of at least $5,000,000, the Contractor must adopt and implement written policies for all employees of the Contractor, and of any contractor or agent of the Contractor, that provide detailed information about the False Claims Act and other Federal and State laws described in section 1902(a)(68) of the Social Security Act, including information about rights of employees to be protected as whistleblowers.

2.2. Contract Management and Readiness Review Requirements

2.2.1. Contract Readiness Review Requirements

2.2.1.1. CMS, or its designee, with participation by DHCS, will conduct a Readiness Review of each Contractor, which must be completed successfully prior to the Contract Operational Start Date.

2.2.1.2. CMS and DHCS Readiness Review Responsibilities

2.2.1.2.1. CMS and DHCS, or its designees, will conduct a Readiness Review of each Contactor that will include, at a minimum, one on-site review. This review shall be conducted prior to enrollment of beneficiaries into the Contractor's Plan. CMS and DHCS, or its designees, will conduct the Readiness Review to verify the Contractor's assurances that the Contractor is ready and able to meet its obligations under the Contract.

2.2.1.2.2. The scope of the Readiness Review will include, but is not limited to, a review of the following elements:

2.2.1.2.2.1. Network Provider composition and access, in accordance with Section 2.10;

2.2.1.2.2.2. Staffing, including Key Personnel and functions directly impacting on Enrollees (e.g., adequacy of Enrollee Services staffing), in accordance with Section 2.11;

2.2.1.2.2.3. Capabilities of First Tier, Downstream and Related Entities, in accordance with Appendix C;

2.2.1.2.2.4. Care Coordination capabilities, in accordance with Section 2.5.2;

2.2.1.2.2.5. Provider contracts templates, including any Provider Performance Incentives, in accordance with Sections 2.9 and 5.1.7;

2.2.1.2.2.6. Enrollee services capability (materials, processes and infrastructure, e.g., call center capabilities), in accordance with Section 2.12;

2.2.1.2.2.7. Comprehensiveness of quality management/quality improvement and utilization management strategies, in accordance with Section 2.11.6 and 2.16;

2.2.1.2.2.8. Internal Grievance and Appeal policies and procedures, in accordance with Section 2.14 and 2.15;

2.2.1.2.2.9. Fraud and abuse and program integrity, in accordance with Section 2.1.2;

2.2.1.2.2.10. Financial solvency, in accordance with Section 2.18;

2.2.1.2.2.11. Information systems, including claims payment system performance, interfacing and reporting capabilities and validity testing of Encounter Data, in accordance with Section 2.19, including IT testing and security assurances.

2.2.1.2.3. For Contractors that are COHS plans, the scope of the Readiness Review will extend to the enrollment functions that the Contractor will be conducting as described in Section 2.3.1.

2.2.1.2.4. No individual shall be enrolled into the Contractor's Cal MediConnect Plan unless and until CMS and the DHCS determine that the Contractor is ready and able to perform its obligations under the Contract as demonstrated during the Readiness Review.

2.2.1.2.5. CMS and DHCS or its designee will identify to the Contractor all areas where the Contractor is not ready and able to meet its obligations under the Contract and provide an opportunity for the Contractor to correct such areas to remedy all deficiencies prior to the start of marketing.

2.2.1.2.6. CMS or DHCS may, in its discretion, postpone the date the Contractor may start marketing or the Contract Operational Start Date for any Contractor that fails to satisfy all Readiness Review requirements. If, for any reason, the Contractor does not fully satisfy CMS or DHCS that it is ready and able to perform its obligations under the Contract prior to the start of marketing or the Contract Operational Start Date, and CMS or DHCS does not agree to postpone the Contract Operational Start Date, or extend the date for full compliance with the applicable Contract requirement, then CMS or DHCS may terminate the Contract pursuant to Section 5.5 of this Contract.

2.2.1.3. Contractor Readiness Review Responsibilities

2.2.1.3.1. The Contractor shall demonstrate to CMS and DHCS satisfaction that the Contractor is ready and able to meet all Contract requirements identified in the Readiness Review prior to the Contract Operational Start Date, and prior to the Contractor engaging in marketing of its Demonstration product;

2.2.1.3.2. Provide CMS and DHCS or its designee with the corrected materials requested by the Readiness Review.

2.2.2. Contract Management

2.2.2.1. The Contractor must employ a qualified individual to serve as the compliance officer of its Capitated Financial Alignment Model. The compliance officer must be primarily dedicated to the Contractor's program, hold a senior management position in the Contractor's organization, and be authorized and empowered to represent the Contractor in all matters pertaining to the Contractor's program. The compliance officer must act as liaison between the Contractor, CMS, and DHCS, and has responsibilities pursuant to this Contract, DPLs and other relevant guidance and authorities that include but, are not limited to, the following:

2.2.2.1.1. Ensure the Contractor's compliance with the terms of the Contract, including securing and coordinating resources necessary for such compliance;

2.2.2.1.2. Implement all action plans, strategies, and timelines, including but not limited to those described in the Contractor's response to the approved Request for Solutions (RFS);

2.2.2.1.3. Oversee all activities by the Contractor and its First Tier, Downstream and Related Entities.

2.2.2.1.4. Receive and respond to all inquiries and requests made by CMS and DHCS in timeframes and formats specified by CMS and DHCS;

2.2.2.1.5. Meet with representatives of CMS or DHCS, or both, on a periodic or as-needed basis and resolve issues that arise within specified timeframes;

2.2.2.1.6. Ensure the availability to CMS and DHCS upon their request, of those members of the Contractor's staff who have appropriate expertise in administration, operations, finance, management information systems, claims processing and payment, clinical service provision, quality management, Enrollee

services, utilization management, Provider Network management, and benefit coordination;

2.2.2.1.7. Coordinate requests and activities among the Contractor, all First Tier, Downstream and Related Entities CMS, and DHCS;

2.2.2.1.8. Make best efforts to promptly resolve any issues related to the Contract identified either by the Contractor, CMS, or DHCS; and

2.2.2.1.9. Meet with CMS and DHCS at the time and place requested by CMS and the State, determine that the Contractor is not in compliance with the requirements of the Contract.

2.2.3. Organizational Structure

2.2.3.1. Contractor shall maintain an organizational structure sufficient to conduct the proposed operations and ensure that its financial resources are sufficient for sound business operations in accordance with:

2.2.3.1.1. County Organized Health System, Geographic Managed Care, and Two- Plan County: Title 28 CCR Sections 1300.67.3, 1300.75.1, 1300. 76.3, 1300.77.1, 1300.77.2, 1300.77.3, 1300.77.4, and Health and Safety Code, Section 1375.1.

2.2.4. Delegation Oversight

2.2.4.1. Contractor shall provide ongoing delegation oversight of the structures, processes, and outcomes of First Tier, Downstream, and Related Entities operations.

2.2.4.2. Contractor shall continually assess its First Tier, Downstream, and Related Entities' ability to perform delegated activities through initial reviews, on-going monitoring, performance reviews, analysis of data, and utilization of available benchmarks, if available.

2.2.4.3. Contractor's Quality Improvement (QI) department shall maintain documentation of oversight activities.

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2.2.4.4. Contractor's delegation oversight and monitoring activities shall emphasize results. To that end, Contractor shall identify areas requiring improvement and shall monitor the performance of the First Tier, Downstream, and Related Entities to ensure that such improvement occurs.

2.2.4.5. Contractor delegates activities to its First Tier, Downstream, and Related Entities in accordance with terms and conditions, contracts, applicable regulations, and this contract.

2.2.4.6. Contractor shall provide delegation oversight of its First Tier, Downstream, and Related Entities that includes the following:

2.2.4.6.1. Desktop and annual on-site revises;

2.2.4.6.2. Monitoring; and

2.2.4.6.3. Continuous improvement activities.

2.3. Enrollment Activities

2.3.1. General Enrollment

2.3.1.1. Contractor shall accept all eligible beneficiaries as defined in Appendix J – Eligible Populations.

2.3.1.2. Eligible beneficiaries residing within the Contractor Service Area may be enrolled at any time up to six (6) months prior to the end of the Demonstration. Eligible beneficiaries shall be accepted by Contractor in the order in which they apply without regard to race, color, national origin, creed, ancestry, religion, language, age, gender, marital status, sexual orientation, health status, need for health care services or disability.

2.3.1.3. Enrollee coverage shall begin at 12:01 a.m. on the first day of the calendar month for which the eligible beneficiary's name is added to the approved list of Enrollees furnished by CMS and the DHCS Enrollment Broker. The term of enrollment shall continue unless this Contract expires, is terminated, or the Enrollee is disenrolled under the conditions described in Section 2.3.2, Disenrollment.

2.3.1.4. Enrollment will proceed unless restricted by CMS or the Sstate. Such restrictions will be defined in writing by CMS or the Sstate and the Contractor notified at least ten (10) calendar days prior to the start of the period of restriction. Release of restrictions will be in writing and transmitted to the Contractor at least ten (10) days calendar prior to the date of the release.

2.3.1.5. Intelligent Assignment. Enrollment activities specific to Two-Plan Counties and GMC Counties (Los Angeles, San Diego, San Bernardino, Santa Clara, Riverside):

2.3.1.5.1. On a quarterly basis, Contractor shall provide DHCS with a complete list of Network Providers and National Provider Identifier (NPI) numbers to assist in the assignment of eligible beneficiaries as part of the Passive Enrollment process. The Network Provider list will include all Network Providers for the Provider Network, where applicable.

2.3.1.5.2. Updates to the Network Provider list shall be sent to DHCS on a quarterly basis for the purposes of intelligent assignment, or as changes to the Provider Network are applied.

2.3.1.5.3. As part of the Enrollment process, DHCS will exclude individuals identified as at-risk or potentially at-risk for abuse or overuse of specified prescription drugs per 42 C.F.R. §§ 423.100 and 423.153(f).

2.3.1.5.4. As part of the Passive Enrollment process, DHCS will initially assign an Enrollee to a Cal MediConnect Plan based on a hierarchical logic in accordance with Section 2.3.1.5.1. Subject to 42 C.F.R. §§ 423.100 and 423.153(f), Enrollees shall have the ability to change Cal MediConnect Plans at any time.

2.3.1.5.4.1. DHCS shall utilize the following hierarchical logic to determine Primary Contractor Plan assignment:

2.3.1.5.4.1.1. If a beneficiary is in a Medi-Cal Managed Care Plan that is participating in the Cal MediConnect

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Program and is not enrolled in a Medicare Advantage product, DHCS will assign the beneficiary to the matching Cal MediConnect plan.

2.3.1.5.4.1.2. If the beneficiary is in a Medicare Advantage Dual Special Needs Plan owned by the parent organization of an MMP, DHCS will assign the beneficiary to the matching MMP.

2.3.1.5.4.1.3. If a beneficiary is in fee-for-service Medi-Cal and Medicare, DHCS will match the beneficiary's highest utilized and paid prescribing and/or rendering provider data [based on the most recent and available twelve (12) months of Medicare and Medi-Cal claim data] to the list of Network Providers supplied by the Contractor, in accordance with Section 2.3.1.5.1.

2.3.1.5.4.1.4. If only one (1) Cal MediConnect Plan is identified with the beneficiary's provider(s) in its network, DHCS will assign the beneficiary to that Cal MediConnect Plan.

2.3.1.5.4.1.5. If two (2) or more Cal MediConnect Plans are identified or if there is insufficient claim data to match to a Cal MediConnect Plan, the system will select a Cal MediConnect Plan based on an equal distribution ratio. For example, if there are two (2) Cal MediConnect Plans in the county, DHCS will assign based on a 50/50 split. In San Diego, the system will divide beneficiary assignments equally across the four (4) Cal MediConnect Plans.

2.3.1.5.4.1.6. This distribution is dependent on Contractor capacity and subject to be altered per the direction of the Contract Management Team (CMT).

2.3.1.5.5. DHCS will notify CMS and the Contractor of the beneficiary assignments via the enrollment transactions sent to CMS and the 834 Enrollment file.

2.3.1.5.6. DHCS will inform the Contractor of the provider NPIs used in the plan selection process.

2.3.1.5.7. CMS will notify the Contractor of the beneficiary assignments via the Daily Transaction Response Reply (DTRR) file distributed through the CMS Enrollment Broker.

2.3.1.5.8. Contractor is responsible for outreach to the Network Provider for enrollment related activities and for providing data to DHCS.

2.3.1.5.9. Contractor shall maintain systems to accept enrollment transactions from CMS' and the State's systems. Contractor shall process enrollment and disenrollment transactions according to the Medicare-Medicaid Plan Enrollment and Disenrollment Guidance, posted at http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/MMPFinalEnrollGuidance.pdf

2.3.1.6. Enrollment activities specific to County Organized Health Systems.

2.3.1.6.1. Contractor shall maintain systems to identify eligible beneficiaries as defined in Appendix J, and transmit enrollment transactions to CMS and the State's systems. Contractor shall process enrollment and disenrollment transactions according to the Medicare-Medicaid Plan Enrollment and Disenrollment Guidance Document.

2.3.1.7. Subject to CMT approval and Section 2.17.1.1.2, the Contractor may participate in Streamlined Enrollment.

2.3.1.7.1. Eligible Enrollees must be enrolled in the Contractor's Medi-Cal plan product.

2.3.1.8. CMS and DHCS may adjust the volume and spacing of Passive Enrollment periods, and will consider input from the Contractor in making any such adjustments.

2.3.1.9. The Contractor may, via the CMT, request a capacity limit pursuant to 42 C.F.R. § 422.60. For purposes of this Demonstration, CMS and DHCS will consider financial stability and network adequacy in the determination of a capacity limit.

2.3.2. Disenrollments

2.3.2.1. The Contractor shall have a mechanism for receiving timely information about all disenrollments from the Contractor's plan, including the effective date of disenrollment, from CMS and DHCS systems.

2.3.2.2. Contractor in Two-Plan and GMC Counties shall have processes and procedures in place to refer Enrollees that request disenrollment from the Plan to the DHCS Enrollment Broker.

2.3.2.3. Enrollees with a share of cost that do not meet the share of cost on the first of the month will be deemed eligible and remain enrolled for up to two (2) months at the Contractor's responsibility before being disenrolled per California's State-specific guidance to the Medicare-Medicaid Plan Enrollment and Disenrollment Guidance (Section 2.3.1.5.9.). Please see Appendix J for eligibility requirements for beneficiaries with a share of cost.

2.3.2.4. Subject to 42 C.F.R. §§ 423.38 and 423.100, Enrollees can elect to disenroll from the Cal MediConnect Plan or the Demonstration at any time and enroll in another Cal MediConnect Plan in a Two-Plan County or GMC county, a Medicare Advantage plan, PACE (as otherwise permissible); or elect to receive services through Medicare fee-for-service and a prescription drug plan and to receive Medicaid services in accordance with DHCS's Medi-Cal program and any waiver programs. (see Appendix L) Disenrollments received by DHCS or its contractor, or by CMS or its

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contractor, either orally or in writing, by the last calendar day of the month will be effective on the first calendar day of the following month.

2.3.2.4.1. The Contractor shall be responsible for ceasing the provision of Covered Services to an Enrollee upon the effective date of disenrollment.

2.3.2.4.2. DHCS and CMS shall terminate an Enrollee's coverage upon any of the occurrences specified in the Medicare-Medicaid Plan Enrollment and Disenrollment Guidance, including but not limited to the following:

2.3.2.4.2.1. The Enrollee's death. This disenrollment is effective the first day of the calendar month following the month of death. Termination may be retroactive to the month in which the Enrollee dies.

2.3.2.4.2.2. When an Enrollee elects to change Demonstration Plans. The effective date of disenrollment is the first day of the month after the month in which the disenrollment request was received.

2.3.2.4.2.3. When an Enrollee requests and is enrolled in a new Medicare Advantage plan through 1-800-Medicare. The effective date of disenrollment is the first day of the month after the month in which the disenrollment request was received.

2.3.2.4.2.4. When an Enrollee elects to receive his or her Medicare services through Medicare fee-for-service and a separate Medicare prescription drug plan.

2.3.2.4.2.5. The termination or expiration of this Contract terminates coverage for all Enrollees with the Contractor. Termination will take effect at 11:59 p.m. on the last day of the month in which this Contract terminates or expires, unless otherwise agreed to, in writing, by the parties.

2.3.2.4.3. The Contractor may not request the disenrollment of any Enrollee due to an adverse change in the Enrollee's health status or because of the Enrollee's utilization of medical services, diminished mental capacity, or uncooperative or disruptive behavior resulting from his or her special needs. The Contractor, however, may submit a written request, accompanied by supporting documentation to the CMT to disenroll an Enrollee, for cause, for the following reasons:

2.3.2.4.3.1. Enrollee remains out of the Service Area or cannot be located for more than six (6) consecutive months; or

2.3.2.4.4. The Contractor may not threaten, intimidate, pressure, or otherwise interfere with the Enrollee's right to disenroll.

2.3.2.5. Discretionary Involuntary Disenrollment: 42 C.F.R. § 422.74 and Sections 40.3 and 40.4 of the Medicare-Medicaid Plan Enrollment and Disenrollment Guidance provide instructions to Cal MediConnect Plans on discretionary involuntary disenrollment. This Contract and other guidance provide procedural and substantive requirements the Contractor, DHCS, and CMS must follow prior to involuntarily disenrolling an Enrollee. If all of the procedural requirements are met, DHCS and CMS will decide whether to approve or deny each request for involuntary disenrollment based on an assessment of whether the particular facts associated with each request satisfy the substantive evidentiary requirements.

2.3.2.5.1. Bases for Discretionary Involuntary Disenrollment:

2.3.2.5.1.1. Disruptive conduct: When the Enrollee engages in conduct or behavior that substantially impairs the Contractor's ability to furnish Covered Items and Services to either this Enrollee or other Enrollees and provided the Contractor made and documented reasonable efforts to resolve the problems presented by the Enrollee.

2.3.2.5.2. Procedural requirements:

2.3.2.5.2.1. The Contractor's request must be in writing and include all of the supporting documentation outlined under the evidentiary standards in Section 2.3.2.5.3.

2.3.2.5.2.2. The process requires three (3) written notices. The Contractor must include in the request, submitted to DHCS and CMS, evidence that the advance notice and notice of intent have already been sent to the Enrollee. The notices are:

2.3.2.5.2.2.1. Advance notice to inform the Enrollee that the consequences of continued disruptive behavior will be disenrollment. The advance notice must include a clear and thorough explanation of the disruptive conduct and its impact on the Contractor's ability to provide services, examples of the types of reasonable accommodations the Contractor has already offered, the Grievance procedures, and an explanation of the availability of other accommodations. If the disruptive behavior ceases after the Enrollee receives notice and then later resumes, the Contractor must begin the process again. This includes sending another advance notice.

2.3.2.5.2.2.2. Notice of intent to request the State and CMS' permission to disenroll the Enrollee; and

2.3.2.5.2.2.3. Planned action notice advising that CMS and the State have approved the Contractor's request. This planned action notice is not a procedural prerequisite for

approval and should not be sent under any circumstances prior to the receipt of express written approval and a disenrollment transaction from CMS and DHCS.

2.3.2.5.2.3. The Contractor must provide information about the Enrollee, including age, diagnosis, mental status, functional status, a description of his or her social support systems, and any other relevant information;

2.3.2.5.2.4. The submission must include statements from providers describing their experiences with the Enrollee (or refusal in writing, to provide such statements); and

2.3.2.5.2.5. Any information provided by the Enrollee. The Enrollee can provide any information he/she wishes.

2.3.2.5.2.6. If the Contractor is requesting the ability to decline future Enrollments for this individual, the Contractor must include this request explicitly in the submission.

2.3.2.5.2.7. Prior to approval, the complete request must be reviewed by DHCS and CMS including representatives from the Center for Medicare and must include staff with appropriate clinical or medical expertise.

2.3.2.5.3. Evidentiary standards: At a minimum, the supporting documentation must demonstrate the following to the satisfaction of both DHCS and CMS staff with appropriate clinical or medical expertise:

2.3.2.5.3.1. The Enrollee is presently engaging in a pattern of disruptive conduct that is seriously impairing the Contractor's ability to furnish Covered Items and Services to the Enrollee and/or other Enrollees.

2.3.2.5.3.2. The Contractor took reasonable efforts to address the disruptive conduct including at a minimum:

2.3.2.5.3.2.1. A documented effort to understand and address the Enrollee's underlying interests and needs reflected in his/her disruptive conduct and provide reasonable accommodations as defined by the Americans with Disabilities Act including those for individuals with mental and/or cognitive conditions. An accommodation is reasonable if it is efficacious in providing equal access to services and proportional to costs. DHCS and CMS will determine whether the reasonable accommodations offered are sufficient.

2.3.2.5.3.2.2. A documented provision of information to the individual of his or her right to use the Grievance procedures.

2.3.2.5.3.2.3. The Contractor provided the Enrollee with a reasonable opportunity to cure his/her disruptive conduct.

2.3.2.5.3.3. The Contractor must provide evidence that the Enrollee's behavior is not related to the use, or lack of use, of medical services.

2.3.2.5.3.4. The Contractor may also provide evidence of other extenuating circumstances that demonstrate the Enrollee's disruptive conduct;

2.3.2.5.4. Limitations: The Contractor shall not seek to terminate enrollment because of any of the following:

2.3.2.5.4.1. The Enrollee's uncooperative or disruptive behavior resulting from such Enrollee's special needs unless treating providers explicitly document their belief that there are no reasonable accommodations the Contractor could provide that would address the disruptive conduct.

2.3.2.5.4.2. The Enrollee exercises the option to make treatment decisions with which the Contractor or any health care professionals associated with the Contractor disagree, including the option of declining treatment and/or diagnostic testing.

2.3.2.5.4.3. An adverse change in an Enrollee's health status or because of the Enrollee's utilization of Covered Items and Services.

2.3.2.5.4.4. The Enrollee's mental capacity is, has, or may become diminished.

2.3.2.5.5. Fraud or abuse: When the Enrollee provides fraudulent information on an Enrollment form or the Enrollee willfully misuses or permits another person to misuse the Enrollee's ID card.

2.3.2.5.5.1. The Contractor may submit a request that an Enrollee be involuntarily disenrolled if an Enrollee knowingly provides, on the election form, fraudulent information that materially affects the individual's eligibility to enroll in the Contractor's plan; or if the Enrollee intentionally permits others to use his or her enrollment card to obtain services from the Contractor.

2.3.2.5.5.2. Prior to submission, the Contractor must have and provide to CMS/DHCS credible evidence substantiating the allegation that the Enrollee knowingly provided fraudulent information or intentionally permitted others to use his or her card.

2.3.2.5.5.3. The Contractor must immediately notify the CMT so that the Enrollment Broker and the HHS Office of the Inspector General may initiate an investigation of the alleged fraud and/or abuse.

2.3.2.5.6. The Contractor must provide notice to the Enrollee prior to submission of the request outlining the intent to request disenrollment with an explanation of the basis of the plan's decision and information on the Enrollee's access to Grievance procedures and a fair hearing.

2.4. Covered Services

2.4.1. The Contractor must authorize, arrange, integrate, and coordinate the provision of all Covered Services for its Enrollees. (See Covered Services in Appendix A.) Covered Services must be available to all Enrollees, as authorized by the Contractor. Covered Services include the Behavioral Health services that become Medi-Cal managed care benefits, pursuant to Welfare and Institutions Code section 14132.03.

2.4.2. The Contractor must provide the full range of Covered Services. If either Medicare or Medi-Cal provides more expansive services than the other program does for a particular condition, type of illness, or diagnosis, the Contractor must provide the most expansive set of services required by either program.

2.4.3. Care Plan Option (CPO) Services may be provided at the sole discretion of the Contractor and in accordance with the ICP.

2.4.3.1. The Grievance and Appeals process for CPO Services shall be the same process as used for others benefits authorized by the Contractor, as described in Sections 2.14 and 2.15, and shall comply with Welfare & Institutions Code section 14450 and Health & Safety Code sections 1368 and 1368.1.

2.4.3.2. CPO Services may include, but are not limited to:

2.4.3.2.1. Respite care: in home or out-of-home, which shall not supplant authorized IHSS hours;

2.4.3.2.2. Additional Personal Care and Chore Type Services beyond those authorized by IHSS; Contractor will

notify counties if additional personal care services are provided.

2.4.3.2.3. Nutritional assessment, supplements, and home delivered meals;

2.4.3.2.4. Home maintenance and minor home or environmental adaptation; and

2.4.3.2.5. Supplemental protective supervision.

2.4.3.3. Other services and requirements in accordance with the guidance provided in current and applicable DPL(s) as described in Section 2.1.5.

2.4.4. The Contractor may not contract with, or otherwise pay for any items or services (other than an emergency item or service, not including items or services furnished in an emergency room of a hospital):

2.4.4.1. Furnished by the Contractor by any individual or entity during any period when the individual or entity is excluded from participation under Titles V, XVIII, or XX, or under Title XIX pursuant to sections 1128, 1128A, 1156, or 1842(j)(2);

2.4.4.2. Furnished at the medical direction or on the prescription of a physician, during the period when such physician is excluded from participation under Titles V, XVIII, or XX, or under Title XIX pursuant to sections 1128, 1128A, 1156, or 1842(j)(2) and when the person furnishing such item or service knew, or had some reason to know, of the exclusion (after a reasonable time period and after reasonable notice has been furnished to the person;

2.4.4.3. Furnished by an individual or entity to whom the State has failed to suspend payments during any period when there is a pending investigation of a credible allegation of fraud against the individual or entity, unless the State determines there is good cause not to suspend such payments;

2.4.4.4. Furnished by an individual or entity that is included on the preclusion list, as defined in 42 C.F.R. § 422.222.

2.4.5. The Contractor may not pay for an item or service with respect to any amount expended for which funds may not be used under the Assisted Suicide Funding Restriction Act of 1997.

2.5. Care Delivery Model

2.5.1. Contractor shall abide by the care delivery model described within this Contract and is not required to submit a model of care to CMS or DHCS unless otherwise requested.

2.5.2. Care Coordination. The Contractor shall offer Care Coordination and case management services to all Enrollees, as described in Welfare and Institutions Code sections 14182.17(d)(4) and 14186(b).

2.5.2.1. Contractor will coordinate Enrollee care across the full continuum of service providers, including medical, Behavioral Health, and LTSS.

2.5.2.2. Contractor will focus on providing services in the least restrictive setting.

2.5.2.3. Care Coordination will be led by the Care Coordinator with participation by members of the ICT.

2.5.2.4. Contractor shall ensure effective linkages of clinical and management systems among Network Providers. Such linkages shall be established in plan policies and procedures.

2.5.2.4.1. Such linkages shall include communication protocols among First Tier, Downstream, and Related Entities.

2.5.2.5. Contractor's policies and procedures shall clarify all communications and reporting protocols related to coordination of services including but not limited to how Contractor shall oversee all such coordination activities.

2.5.2.6. Contractor will ensure that Care Coordination services:

2.5.2.6.1. Reflect a person-centered, outcome-based approach, consistent with the, CFAM-MOU, and DHCS' RFS;

2.5.2.6.2. Follow Enrollee's direction about the level of involvement of his or her caregivers or medical providers;

2.5.2.6.3. Span medical and LTSS systems, including coordination with IHSS, with a focus on transitions;

2.5.2.6.4. Reflect coordination with county agencies and direct contractors, if applicable, for Behavioral Health services;

2.5.2.6.5. Reflect coordination with county agencies, if applicable, for IHSS services;

2.5.2.6.6. Reflect coordination with Medi-Cal Dental and any MMP supplemental dental benefits, as applicable, for dental services;

2.5.2.6.7. Include development of Individual Care Plans (ICP) with Enrollees, as described in Section 2.8.3;

2.5.2.6.8. Are performed by nurses, social workers, Primary Care Providers, if appropriate, other medical, Behavioral Health, or LTSS professionals, and health plan Care Coordinators, as applicable; and

2.5.2.6.9. Reflect access to appropriate community resources, as defined in Welfare and Institution Code sections 14132.275(f)(7) and 14182.17(d) (4)(G) and (6)(B) and monitoring of skilled nursing utilization, with a focus on providing services in the least restrictive setting and transitions between the facilities and community.

2.5.2.7. Contractor will have a process for assigning a Care Coordinator to each Enrollee. Assignment will be made to a Care Coordinator with the appropriate experience and qualifications based on an Enrollee's assigned risk level and individual needs.

2.5.2.7.1. Contractor shall ensure an adequate ratio of Care Coordinators to Enrollees to provide Care Coordination as required through this Contract. The CMT shall monitor the ratio of Care Coordinators to Enrollees on a regular basis.

2.5.2.8. Interdisciplinary Care Team (ICT). The Contractor shall offer an ICT for each Enrollee, which will be developed around the Enrollee and ensure the integration of the Enrollee's medical and LTSS and the coordination of Behavioral Health

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Services delivered by a county Behavioral Health agency and IHSS services, when applicable. ICTs must be comprised of professionals appropriate for the needs, preferences, and abilities of the Enrollee.

2.5.2.8.1. Every Enrollee will have access to an ICT.

2.5.2.8.2. Enrollees may request the exclusion of any ICT member.

2.5.2.8.3. Contractor must include information about the ICT and ICP in their new member welcome packets.

2.5.2.8.4. ICT Functions. ICT will facilitate care management, including assessment, care planning, and authorization of services, transitional care issues and work closely with providers listed in Section 2.5.2.8.6.1to stabilize medical conditions, increase compliance with Care Plans, maintain functional status, and meet individual Enrollees Care Plan goals. ICT functions will include, at a minimum:

2.5.2.8.4.1. Develop and implement an ICP with Enrollee and/or caregiver participation as further described in Sections 2.5.2.11.7 and 2.8.3;

2.5.2.8.4.2. Conduct ICT meetings periodically, including at the Enrollee's discretion;

2.5.2.8.4.3. Manage communication and information flow regarding referrals, transitions, and care delivered outside the primary care site;

2.5.2.8.4.4. Maintain a call line or other mechanism for Enrollee inquiries and input , and a process for referring to other agencies, such as LTSS, IHSS, or Behavioral Health agencies, as appropriate;

2.5.2.8.4.5. Conduct conference calls among the Contractor, providers, and Enrollees;

2.5.2.8.4.6. Maintain a mechanism for monitoring Enrollee complaints and Grievances ; and

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2.5.2.8.4.7. Use secure email, fax, web portals or written correspondence to communicate. The ICT must take the Enrollee's individual needs (e.g., communication, cognitive, or other barriers) into account in communicating with the Enrollee.

2.5.2.8.5. Composition of ICT. ICT must be person-centered: built on the Enrollee's specific preferences and needs, delivering services with transparency, individualization, respect, linguistic and cultural competence, and dignity.

2.5.2.8.5.1. The ICT will be led by professionally knowledgeable personnel to address the Enrollee's medical, behavioral and LTSS care. If the ICT is led by a PCP, the PCP must be credentialed.ICT will include the Enrollee and/or authorized representative, family and/or caregiver if approved by the Enrollee, PCP (this may be a specialist, if a specialist is serving as the PCP), Care Coordinator, and may include the following persons, as needed and if applicable:

2.5.2.8.5.1.1. Hospital discharge planner;

2.5.2.8.5.1.2. Nursing facility representative;

2.5.2.8.5.1.3. Social Worker, including the IHSS social worker if IHSS services are provided;

2.5.2.8.5.1.4. Specialized providers, such as pharmacists and physical therapists;

2.5.2.8.5.1.5. If receiving IHSS, the IHSS provider, if authorized by Enrollee;

2.5.2.8.5.1.6. If enrolled in CBAS, the CBAS provider, if authorized by Enrollee;

2.5.2.8.5.1.7. MSSP care manager;

2.5.2.8.5.1.8. Behavioral Health specialist, which may include, but is not limited to, a specialty mental health provider or a substance use disorder counselor; and

2.5.2.8.5.1.9. Other professionals, as appropriate, and as delineated in applicable and current DPLs

2.5.2.8.6. Communication with ICT. Contractor will support multiple levels of interdisciplinary communication and coordination, such as individual consultations among providers, county agencies, and Enrollees. Contractor will have a documented process for coordinating the exchange of information amongst all ICT members, including when a change in ICT membership occurs.

2.5.2.8.7. Contractor will have procedures for notifying the ICT of emergency department use, hospital admission (psychiatric or acute) or SNF and coordinating a discharge plan.

2.5.2.8.8. Competencies of ICT. Contractor will provide training for ICT members, and potential ICT members, initially and on an annual basis. Required training topics include:

2.5.2.8.8.1. Person-centered planning processes;

2.5.2.8.8.2. Cultural competence;

2.5.2.8.8.3. Accessibility and accommodations;

2.5.2.8.8.4. Independent living and recovery and wellness principles; and

2.5.2.8.8.5. Information about LTSS programs, eligibility for these services, and program limitations.

2.5.2.8.8.6. Coordination with counties on IHSS.

2.5.2.8.9. Nothing in this contract shall be construed as requiring the Enrollee to participate on the ICT. The

Contractor shall allow the Enrollee to opt-out of the ICT at any time and the ICT shall be able to continue its operations. Enrollees may not be disenrolled for lack of participation on the ICT. Criteria for disenrollment are discussed in Section 2.3.2.

2.5.2.8.10. If an Enrollee refuses an ICT, at a minimum the Care Coordinator must provide his or her contact information to the Enrollee and re-visit the refusal at the time of reassessment, or if the Enrollee's PCP changes.

2.5.2.8.11. The administration of the ICT will also follow all applicable current DPLs.

2.5.2.9. Individual Care Plan (ICP). Contractor will develop an ICP for each Enrollee. Contractor will regularly engage Enrollees and/or their representatives in the design, reassessment and updates of the ICPs.

2.5.2.9.1. Enrollees or their authorized representative must have the opportunity to review and sign the ICP and any of its amendments. Contractor must provide Enrollees with copies of the ICP and any of its amendments. The ICP must be made available in alternative formats and in an Enrollee's preferred written or spoken language.

2.5.2.10. If an Enrollee refuses to be involved in ICP development, the Contractor must seek to re-visit the refusal at least at the time of reassessment, or if the Enrollee's PCP changes.

2.5.2.11. ICPs will include:

2.5.2.11.1. The name and contact information for the Enrollees current, assigned Care Coordinator. Enrollee service numbers may be used only if the number will transfer the Enrollee to her/his assigned Care Coordinator;

2.5.2.11.2. The name and contact information for the Enrollee's PCP and any specialists;

2.5.2.11.3. A complete, current list of the Enrollee's medications;

2.5.2.11.4. Enrollee goals, preferences, choices and abilities;

2.5.2.11.5. Measurable objectives and timetables to meet medical, Behavioral Health services, and LTSS needs as determined through the HRA, Multipurpose Senior Services Program (MSSP), and Community-Based Adult Services (CBAS) records, behavioral health utilization, other data, self and provider referrals, and input from members of the ICT, as appropriate;

2.5.2.11.6. Coordination of carved-out and linked services, and referral to appropriate community resources and other agencies, when appropriate;

2.5.2.11.7. Timeframes for reassessment and updating of Care Plan, to be done at least annually or if a significant change in condition occurs;

2.5.2.11.8. If the Enrollee is receiving Behavioral Health services, the ICP will also include:

2.5.2.11.8.1. The name and contact information of the primary county or county-contracted Behavioral Health provider;

2.5.2.11.8.2. Attestation that the county Behavioral Health provider and PCP have reviewed and approved the ICP; and

2.5.2.11.8.3. Record of at least one (1) case review meeting that included the county Behavioral Health provider and includes date of meeting, names of participants, and evidence of creation or adjustment of care goals.

2.5.2.11.9. If the Enrollee is receiving IHSS, the ICP should also include:

2.5.2.11.9.1. The name and contact information for the county social worker with the responsibility for authorizing and overseeing IHSS hours; and

2.5.2.11.9.2. The name and contact information for the IHSS worker.

2.5.2.11.10. Additional components discussed in current and applicable DPLs consistent with Section 2.1.5.

2.5.2.12. The Contractor will transfer, to another MMP, or its designated Contractor for Enrollees, information necessary to support continuity of care when an Enrollee transfers to another MMP. This information includes, but is not limited to, assessment, ICP, and other pertinent information.

2.5.2.12.1. The information shall be provided no later than thirty (30) calendar days from receipt of the notice of disenrollment to the Contractor and in theformat specified by DHCS and CMS.

2.5.2.12.2. This data sharing package and process will be subject to CMT approval following a joint planning process in the first half of 2018 with CMS, DHCS, and the Contractor.

2.5.2.12.2.1. Detail regarding data transfer methods, the content of the transfer package, look back periods, eligible beneficiaries, and other transfer specifics will be determined via this planning process

2.5.2.13. Basic Case Management. The PCP and/or Care Coordinator, in collaboration with the Contractor, will provide basic case management services.

2.5.2.13.1. Enrollees may choose to refuse any treatment, including case management.

2.5.2.13.2. Basic case management services include:

2.5.2.13.2.1. A review of clinical information from the provider;

2.5.2.13.2.2. Completion of the HRA. (see Section 2.8);

2.5.2.13.2.3. Creation of the ICP, in collaboration with the ICT (see Section 2.8.3);

2.5.2.13.2.4. Identification and referral to appropriate providers and facilities, such as medical, rehabilitation, support services, LTSS,

Behavioral Health, Care Plan Option Services, and for covered and non-covered services;

2.5.2.13.2.5. Direct communication with Enrollee, Enrollee providers, and family;

2.5.2.13.2.6. Enrollee and family education, including health lifestyle changes when warranted (see Section 2.9.11.8); and

2.5.2.13.2.7. Coordination of services outside of the Cal MediConnect Plan, such as referral to appropriate community social services, specialty mental health, Drug Medi-Cal services, IHSS service agencies or Medi-Cal Dental.

2.5.2.14. Complex Case Management. Contractor will develop methods to identify Enrollees who may benefit from complex case management services, using the risk stratification and HRA results (see sections 2.8.1 and 2.8.2) as well as utilization and clinical data and any other available information across medical, LTSS, and Behavioral Health domains, as well as self and provider referrals.

2.5.2.14.1. Complex case management services will include:

2.5.2.14.1.1. Basic case management services (see Section 2.5.2.13 et. seq.)

2.5.2.14.1.2. Management of acute or chronic illness

2.5.2.14.1.3. Intense coordination of resources to ensure Enrollee maintains optimal health or improved functionality, maintains current functioning, prevents or delays functional decline, and avoids institutionalization when appropriate and possible.

2.5.2.15. Coordination of Care Management. Contractor shall coordinate with external organization(s) for provision of Covered Services (described in Appendix A) as appropriate for the Enrollee (see Sections 2.6 and 2.7).

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2.5.2.15.1. Contractor shall develop and implement processes for coordination models that support appropriate referral of Enrollee to MSSP organization for services, assessment, eligibility determination, delineation of roles and responsibilities for care management.

2.5.2.15.2. Contractor shall develop and implement processes for coordination of care for nursing facility residents, including care transition plans and programs to move Enrollees back into the community to the extent possible, in accordance with WIC section 14182.17(d)(4)(H) and in accordance with the guidance provided in current and applicable DPL(s) as described in Section 2.1.5.

2.5.2.16. Coordination of Care Management with external organization for provision of IHSS as appropriate for the Enrollee.

2.5.2.16.1. Contractor shall develop and implement processes for coordination models that support appropriate referral of Enrollees to county IHSS agency for services, assessment, eligibility determination, delineation of roles and responsibilities for care management.

2.5.2.17. Care Plan Option Services. A CPO Service is optional under the Enrollee's ICP. See Section 2.4.3.

2.5.2.18. Annual Evaluation of Care Management Program. Contractor will conduct annual review, analysis, and evaluation of the effectiveness of the care management program processes and identify actions to be implemented to improve the quality of care and delivery of services.

2.5.2.18.1. Contractor will have a process for developing a corrective action plan, with specified timelines, for any out of compliance findings.

2.5.2.19. Discharge Planning and Care Coordination. Contractor shall ensure provision of discharge planning when Enrollee is admitted to a hospital or institution and continuation into the post discharge period. Discharge planning shall include ensuring that the necessary care, services, and supports are

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in place in the community for the Enrollee once he or she is discharged from a hospital or institution, including scheduling an outpatient appointment and/or conducting follow-up with the Enrollee and/or caregiver. Minimum criteria for discharge planning checklist must include:

2.5.2.19.1. Documentation of pre-admission status, including living arrangements, physical and mental function, social support, durable medical equipment (DME), and other services received. Documentation of pre-discharge factors, including an understanding of the medical condition or functional status by Enrollee or a representative of the Enrollee as applicable, physical and mental health status, financial resources, and social supports.

2.5.2.19.2. Per current and applicable DPLs regarding discharge planning, services needed after discharge, type of placement preferred by the Enrollee/representative of the Enrollee and hospital/institution, type of placement agreed to by the Enrollee/representative of Enrollee, specific agency/home recommended by the hospital, specific agency/home agreed to by the Enrollee/representative of the Enrollee, and pre-discharge counseling recommended.

2.5.2.19.3. Post-transition discharge policies and procedures will cover criteria to include, but not limited to, access to necessary medical care and follow up, medications, durable medical equipment and supplies, transportation, and integration of community based LTSS programs, as well as coordination with IHSS services authorized by the counties.

2.5.2.19.4. Coordination, as appropriate, with: 1) county agencies for IHSS and Behavioral Health services (through social worker and providers, as needed); 2) MSSP providers; 3) CBAS centers; 4) community organizations such as Area Agencies on Aging and DHCS Care Transition projects; 5) LTSS providers, including nursing facilities; 6) specialized providers (including, but not limited to specialists, pharmacists, physical/occupational therapists; 7) Medi-Cal Dental and, 8) others as deemed appropriate. For IHSS, the

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Contractor's coordination process must be developed jointly with county social service agencies and consider State requirements for counties regarding discharge planning.

2.5.2.19.5. Policies and procedures governing expedited MSSP assessment and eligibility determination as part of the Contractor's Care Coordination process for Enrollees who are being discharged from the hospital or at risk of immediate placement in a SNF.

2.5.2.19.6. Summary of the nature and outcome of Enrollee involvement in the discharge planning process, anticipated problems in implementing post-discharge plans, and further action contemplated by the hospital/institution.

2.5.2.19.7. For Enrollees receiving Behavior Health services, Contractor will have procedures developed jointly with the MHP for:

2.5.2.19.7.1. Notification of the ICT of hospital admission (psychiatric or acute) and coordinating a discharge plan, if applicable.

2.5.2.19.7.2. Direct transfers between psychiatric inpatient hospital services and inpatient hospital services required to address an Enrollee's medical problems based on changes in the Enrollee's mental health or medical condition.

2.5.2.20. In addition to the oversight of plan complaints, Grievances, and Cal MediConnect Ombuds Program activity via the CMT, the Contractor shall include ombudsman reports in quarterly updates to local advisory convenings and shall participate in all statewide stakeholder and oversight convenings as delineated in DPLs.

2.6. Long-Term Services and Supports (LTSS).

2.6.1. Contractor will ensure access to, provision of, and payment for: 1) CBAS for Enrollees who meet eligibility criteria for CBAS as defined in Section 2.6.1.1.1, and 2), MSSP for Enrollees who meet the eligibility

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criteria for MSSP pursuant to Welfare and Institutions Code section 9560.

2.6.1.1. Community Based Adult Services (CBAS): The Contractor shall contract for CBAS, which is an outpatient, facility-based program that delivers skilled nursing care, social services, therapies, personal care, family/caregiver training and support, nutrition services, and transportation to eligible Enrollees.

2.6.1.1.1. The Contractor shall make available the CBAS benefit to Enrollees who are age twenty-one (21) or older and derive their Medi-Cal eligibility from the State Plan, are Medicare beneficiaries, are either aged, blind, or disabled and who qualify based on the following criteria.

2.6.1.1.1.1. Meet medical necessity criteria as established by the State and meet "Nursing Facility Level of Care A" (NF-A) criteria, as set forth in the DHCS Code of Regulations, or above NF-A Level of Care; or

2.6.1.1.1.2. Have a moderate to severe cognitive disorder such as dementia, including dementia characterized by the descriptors of, or equivalent to, stages 5, 6, or 7 of the Alzheimer's Type; or

2.6.1.1.1.3. Have a mild cognitive disorder such as Dementia, including Dementia of the Alzheimer's Type, and needs assistance or supervision with two of the following: bathing, dressing, self-feeding, toileting, ambulation, transferring, medication management, or hygiene, or;

2.6.1.1.1.4. Have a Chronic Mental Disorder or acquired, organic, or traumatic brain injury. In addition to the presence of a Chronic Mental Disorder or acquired, organic, or traumatic brain injury, the Enrollee shall need assistance or supervision with either:

2.6.1.1.1.4.1. Two (2) of the following: bathing, dressing, self-feeding, toileting, ambulation, transferring, medication management, or hygiene; or

2.6.1.1.1.4.2. One (1) need from the above list and one (1) of the following: money management, accessing community and health resources, meal preparation, or transportation.

2.6.1.2. Multi-purpose Senior Services Program (MSSP): A program approved under the federal Medicaid Home and Community-Based, 1915(c) Waiver that provides HCBS to Medi-Cal eligible individuals who are 65 years or older with disabilities as an alternative to nursing facility placement.

2.6.1.2.1. Contractor shall inform its Enrollees about the MSSP and establish a mechanism to refer Enrollees who are enrolled in Cal MediConnect and are potentially eligible for the MSSP to MSSP providers for eligibility determination.

2.6.1.2.2. Care Coordination – Contractor shall coordinate and work collaboratively with MSSP providers on Care Coordination activities surrounding the MSSP Waiver Participant including, but not limited to: coordination of benefits between Contractor and MSSP provider to avoid duplication of services and coordinate Care Management activities particularly at the point of discharge from the MSSP.

2.6.1.2.3. For Enrollees that may qualify for MSSP, but are on the waiting list, the Contractor may provide alternate services as identified through the development of the ICP as described in Sections 2.5.2.11.7 and 2.8.3.

2.6.2. The Contractor will ensure referral to IHSS for Enrollees who meet the eligibility criteria for IHSS pursuant to Welfare and Institutions Code section 12305.6.

2.6.2.1. In-Home Supportive Services (IHSS): A program that serves aged, blind, or disabled persons who are unable to perform activities of daily living and cannot remain safely in their

own homes without help pursuant to the California Welfare and Institutions Code (commencing with section 12300) of Chapter 3, and sections 14132.95, 14132.952, and 14132.956.).

2.6.2.1.1. Contractor will coordinate with county agencies to facilitate IHSS participation on the ICT. Contractor will ensure Network Providers coordination with IHSS.

2.6.2.1.2. Contractor will coordinate with county agencies to develop and implement detailed processes for coordination and integration of IHSS which shall include, but not be limited to:

2.6.2.1.2.1. Provision of intake activities and redeterminations by IHSS social workers and allocation of IHSS hours according to WIC section 12301.1 and how that information is coordinated and shared with the ICT.

2.6.2.1.2.2. Framework for referrals to IHSS county agencies, coordination for change of condition, discharge planning, reassessments, and the ICT.

2.6.2.1.3. DHCS and CDSS will continue to provide the Contractor with IHSS assessment data.

2.6.3. Nursing Facilities

2.6.3.1. Contractor shall contract with SNFs, as defined in California Code of Regulations Title 22 section 51121(a), in its Service Area that are licensed by California Department of Public Health (CDPH) and certified by DHCS for participation as a SNF in the Medi-Cal Program and additional Contractor credentialing standards, if any. See Section 2.10.2.3.

2.6.3.2. If SNFs beds are not available in the Contractor's Service Area, Contractor shall contract with qualified SNFs in areas outside of the Contractor's Service Area, in correspondence to the Contractor's projected need for SNF beds of its Enrollees.

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2.7. Coordinated Primary Care and Behavioral Health.

2.7.1. Contractor shall provide Enrollee access to Behavioral Health services covered by Medicare and Medi-Cal with a focus on the Recovery Model (See Covered Services in Appendix A). Coordination of Behavioral Health services financed and administered by county agencies shall include at a minimum the following:

2.7.1.1. Contractor will develop and implement a plan to ensure seamless access, coordination and delivery of Covered Services that are Medically Necessary to Enrollees who meet the medical necessity criteria.

2.7.1.1.1. To determine responsibility for covering Medi-Cal Specialty Mental Health Services, the Contractor and county will follow the medical necessity criteria for specialty mental health 1915(b) waiver services described in the California Code of Regulations Title 9 sections 1820.205, 1830.205, and 1830.210. The outpatient criteria can be summarized as the following three criteria: 1) diagnosis – one or more of the specified diagnoses; 2) impairment – significant impairment or probability of deterioration of an important area of life functioning; or; 3) intervention: services must address the impairment, be expected to significantly improve the condition, and the condition is not responsive to a physical health care based treatment.

2.7.1.1.2. To determine medical necessity for Drug Medi-Cal Benefits, Contractor and counties will follow California Code of Regulations Title 22 sections 51303 and 54301. Services shall be prescribed by a physician, and are subject to utilization controls, as set forth in California Code of Regulations Title 22 section 51159.

2.7.1.1.3. To determine medical necessity for the authorization of Covered Services that become Medi-Cal managed care Behavioral Health Services on January 1, 2014, pursuant to Welfare and Institutions Code section 14132.03, the Contractor shall use medical necessity criteria set forth current and applicable DPL(s) as described in Section 2.1.5.

2.7.1.2. Contractor will have a Memorandum of Understanding (MOU) with county agencies that finance and administer Behavioral Health services. The MOU must be approved by CMS and DHCS. It will include:

2.7.1.2.1. Service Coordination: Contractor will include comprehensive screening for Behavioral Health as part of the HRA (see Section 2.8.2.2) and ICP (see Section 2.8.3). The local MOU will describe:

2.7.1.2.1.1. Delineation of clinical responsibilities and provider contracting responsibilities;

2.7.1.2.1.2. Point of contact within the Cal MediConnect Plan and county entity(ies) and the various communications processes to address issues related to clinical coordination, including pharmaceutical coordination;

2.7.1.2.1.3. A process for resolving disagreements related to clinical decision making, administrative, and policy issues;

2.7.1.2.1.4. Standardized approaches to screening, referral, and linkages and coordination for mental health and substance use services with timelines specified; and

2.7.1.2.1.5. Processes for clinical consultation and coordination of ICPs.

2.7.1.2.2. Administrative coordination: Contractor will clearly delineate administrative responsibilities and provider contracting responsibilities, including:

2.7.1.2.2.1. Point of contacts and communication processes to address administrative coordination;

2.7.1.2.2.2. Process for annual review and evaluation of administrative management programs; and

2.7.1.2.2.3. Process for demonstrating how administrative problem identification and resolution occurs.

2.7.1.2.3. Information exchange: Contractor will develop data sharing mechanisms with the county Behavioral Health agencies, to the greatest extent practicable under State and federal Privacy laws, to share accurate and timely information to inform care delivery. It will describe:

2.7.1.2.3.1. Information flow between Contractor and county agencies; and

2.7.1.2.3.2. Processes for exchange of health information.

2.7.1.2.4. Performance measures: Contractor is required to report on measures related to Behavioral Health services for which they have direct contracts with providers including Medicare Behavioral Health benefits.

2.7.1.2.4.1. Contractor is required to show evidence of data sharing agreement with county agencies that provide Medi-Cal Behavioral Health services. The data sharing agreements shall provide for the exchange of data in compliance with all applicable State and federal laws.

2.7.1.2.4.2. Shared financial accountability is discussed in Section 4.7.4.

2.8. Health Risk Assessments, ICP, and Care Coordination

2.8.1. Risk Stratification. Contractor will use an approved health risk stratification mechanism or algorithm to identify new Enrollees with high risk and more complex health care needs. The health risk stratification shall be conducted in accordance applicable DPL(s) as indicated in Section 2.1.5

2.8.1.1. Contractor shall use the following data sources to identify an Enrollees' risk level.

2.8.1.1.1. Medicare utilization data, including Medicare Parts A, B, and D.

2.8.1.1.2. Medi-Cal utilization data, including IHSS, MSSP, SNF, and Behavioral Health pharmacy data.

2.8.1.1.3. Results of previously administered assessments.

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2.8.1.1.4. Other population- and individual-based tools.

2.8.2. Health Risk Assessment (HRA). In accordance with all applicable federal and State laws WIC section 14182.17(d)(2), and in accordance with applicable DPL(s) as indicated in Section 2.1.5. Contractor will complete HRAs for all Enrollees.

2.8.2.1. The HRA will serve as the starting point for the development of the ICP.

2.8.2.2. For all Enrollees, the assessment process will, at a minimum, identify:

2.8.2.2.1. Referrals to appropriate LTSS and home- and community-based services;

2.8.2.2.2. Caregivers, Enrollees, and authorized representatives participation;

2.8.2.2.3. Facilitation of timely access to primary care, specialty care, DME, medications, and other health services needed by the Enrollee, including referrals to resolve physical or cognitive barriers to access;

2.8.2.2.4. Facilitation of communication among the Enrollee's providers, including Behavioral Health providers as appropriate;

2.8.2.2.5. Identification of the need for providing other activities or services needed to assist Enrollees in optimizing health or functional status, including assisting with self-management skills or techniques, health education, and other modalities improve health or functional status; and

2.8.2.2.5.1. Support for Enrollees who need more complex case management, as described in Sections 2.5.2.14 and 2.5.2.15.

2.8.2.2.5.2. Other elements in accordance with applicable DPL(s) as indicated in Section 2.1.5.

2.8.2.3. For Enrollees identified by the risk stratification mechanism described in Section 2.8.1 as higher-risk, the Contractor will complete the HRA within forty-five (45) calendar days of

enrollment in accordance with applicable DPL(s) as indicated in Section 2.1.5.

2.8.2.4. For Enrollees identified by the risk stratification mechanism described in Section 2.8.1 as lower-risk, the Contractor will complete the HRA within ninety (90) calendar days of enrollment in accordance with applicable DPL(s) as indicated in Section 2.1.5

2.8.2.5. Contractor shall notify PCPs of enrollment of any new Enrollee who has not completed a HRA within the time period set forth above and whom Contractor has been unable to contact. Contractor shall encourage PCPs to conduct outreach to their Enrollees and to schedule visits.

2.8.2.6. Reassessments will be conducted at least annually, within twelve (12) months of last assessment, or as often as the health and/or functional status of the Enrollee requires.

2.8.2.6.1. When determining the mode for completing reassessment, the Contractor will consider the reason the assessment needs to be updated, the Enrollee's needs and health or functional status, and the preference of the Enrollee.

2.8.2.7. Contractor will regularly use electronic health records and claims data to inform reassessments and to identify Enrollees at high risk, with newly diagnosed acute and chronic conditions, or high frequency emergency department or hospital use, or IHSS or Behavioral Health referral.

2.8.3. Individualized Care Plan (ICP). A comprehensive, person-centered ICP will be developed for each Enrollee that includes Enrollee goals and preferences, measurable objectives and timetables to meet medical needs, Behavioral Health and LTSS needs. It must include timeframes for reassessment. See Section 2.5.2.11.7.

2.8.3.1. The Contractor must complete the ICP within ninety (90) calendar days of enrollment.

2.8.3.2. The Contractor will provide the ICP to the Enrollee no less than annually.

2.8.4. Continuity of Care. Contractor shall ensure Enrollees continue to have access to medically necessary items, services, and medical and LTSS providers as described below and in accordance with applicable DPL(s) as indicated in Section 2.1.5.

2.8.4.1. Contractor must allow Enrollees to maintain their current providers and service authorizations at the time of enrollment for:

2.8.4.1.1. A period up to twelve (12) months for Medicare services if all of the following criteria are met under WIC section 14132.275(l)(2)(A):

2.8.4.1.1.1. Contractor will verify the Enrollee has an existing relationship with the provider prior to enrollment by identifying whether the Enrollee has seen the requested out-of-network PCP or specialist at least once within the previous twelve (12) months from the date of enrollment The link between the new Enrollee and the out-of-network provider may be established by the Contractor using Medicare data provided by DHCS or by documentation by the provider or Enrollee;

2.8.4.1.1.2. Provider is willing to accept payment from the Contractor based on the current Medicare fee schedule; and

2.8.4.1.1.3. Contractor would not otherwise exclude the provider from its Provider Network due to documented quality of care concerns or State or federal exclusion requirements.

2.8.4.1.2. A period of up to twelve (12) months for Medi-Cal services if all of the following criteria are met under Welfare and Institutions Code section 14182.17(d)(5)(G).

2.8.4.1.2.1. Contractor will verify the Enrollee has an existing relationship with the provider prior to enrollment by identifying whether the Enrollee has seen the requested out-of-network provider at least once within the previous

twelve (12) months from the date of enrollment. The link between the new Enrollee and the out-of-network provider may be established by the Contractor using Medi-Cal FFS claims, treatment authorization request data or Medi-Cal managed care Encounter Data provided by the State or by documentation from the provider or Enrollee.

2.8.4.1.2.2. Provider is willing to accept payment from the Contractor based on the Contractor's rate for the service offered or applicable Medi-Cal rate, whichever is higher; and

2.8.4.1.2.3. Contractor would not otherwise exclude the provider from their Provider Network due to documented quality of care concerns or State or federal exclusion requirements.

2.8.4.1.3. Enrollees will not be required to change nursing facilities during the duration of the Demonstration if they resided in the nursing facility prior to enrollment in MediConnect, the facility is licensed by CDPH, meets acceptable quality standards, and the facility and Contractor agree to rates in accordance with Section 2.8.4.1.2.2.

2.8.4.1.4. Sections 2.8.4.1.1 and 2.8.4.1.2 do not apply to providers of the following: durable medical equipment, medical supplies, transportation, other ancillary services, or carved-out services.

2.8.4.1.5. Contractor must inform Enrollees of its new Network Providers.

2.8.4.1.6. If an Enrollee receives care from an out-of-network provider, Contractor must advise the Enrollee and provider that they have received care from an out-of-network provider that would not otherwise be covered at an in-network level.

2.8.4.1.7. Part D transition rules and rights will continue as provided for in current law and regulation for the

entire integrated formulary associated with the Cal MediConnect Plan.

2.8.4.1.8. The DHCS will distribute an enrollment choice packet that will provide descriptions of continuity of care rights, developed in all Threshold Languages, and distributed to Enrollees in their enrollment choice packet, distributed sixty (60) days before they are enrolled in a Cal MediConnect Plan.

2.8.4.1.8.1. Contractors in COHS will distribute an enrollment package that will provide descriptions of continuity of care rights, developed in all Threshold Languages, and distributed to Enrollees in their enrollment packet, distributed sixty (60) days before they are enrolled in a Cal MediConnect Plan.

2.8.4.1.9. Out of Network Reimbursement Rules – For reimbursement of out-of-network Emergency Services or Urgent Care services, as defined by 42 C.F.R. § 424.101 and 42 C.F.R. § 405.400 respectively, the Health Care Professional is required to accept as payment in full by the Contractor the amounts that the Health Care Professional could collect for that service if the beneficiary were enrolled in original Medicare or Medi-Cal FFS. However, the Contractor is not required to reimburse the Health Care Professional more than the Health Care Professional's charge for that service. The original Medicare reimbursement amounts for providers of services (as defined by section 1861(u) of the Act) do not include payments under 42 C.F.R. §§ 412.105(g) and 413.76. A section 1861(u) provider of services may be paid an amount that is less than the amount it could receive if the beneficiary were enrolled in original Medicare or Medicaid FFS if the provider expressly notifies the Contractor in writing that it is billing an amount less than such amount. For Emergency Services and postabilization care services, as defined by 42 C.F.R. § 438.114(a), for which Medi Cal is the primary payor, the Contractor must comply with 42 C.F.R. § 438.114 and an out-of-network provider is required to accept the applicable Medi-Cal fee-for-service payment

amount as payment in full by the Contractor consistent with 42 U.S.C. § 1396u-2(b)(2)(D). Enrollees maintain balance billing protections as provided in Section 5.1.12.

2.8.4.1.9.1. Contractors may authorize other out-of-network services to promote access to and continuity of care. For services that are part of the traditional Medicare benefit package, prevailing Medicare Advantage policy will apply, under which the Contractor shall pay non-contracted Health Care Professionals and section 1861(u) providers of services the amount the provider could collect for that service if the beneficiary were enrolled in original Medicare (less any payments under 42 C.F.R. §§ 412.105(g) and 413.76 for section 1861(u) providers) regardless of setting and type of care for authorized out-of-network services.

2.8.4.1.10. If an Enrollee is receiving any service that would not otherwise be authorized by the Contractor after the continuity of care period, the Contractor must notify the Enrollee prior to the end of the continuity of care period that the service will no longer be authorized, according to the requirements at 42 C.F.R. § 438.404 and 42 C.F.R. § 422.568 and in accordance with applicable DPL(s) as indicated in Section 2.1.5.

2.8.4.1.11. The Contractor must provide an appropriate transition process for Enrollees who are prescribed Part D drugs that are not on its formulary (including drugs that are on the Contractor's formulary but require prior authorization or step therapy under the Contractor's utilization management rules). This transition process must be consistent with the requirements at 42 C.F.R. § 423.120(b)(3).

2.8.4.1.12. If Contractor's Provider Network is unable to provide necessary services covered under the Contract to a particular Enrollee, Contractor must adequately and timely cover these services out of network for the

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Enrollee, for as long as the Contractor is otherwise unable to provide them, as required by 42 C.F.R § 438.206(b)(4).

2.9. Provider Network

2.9.1. The Contractor must demonstrate annually that it has an adequate network as approved by CMS and the State to ensure adequate access to medical, Behavioral Health, pharmacy, and LTSS, excluding IHSS, providers that are appropriate for and proficient in addressing the needs of the enrolled population, including physical, communication, and geographic access.

2.9.2. The Contractor must maintain a Provider Network sufficient to provide all Enrollees with access to the full range of Covered Services, including Behavioral Health services, other specialty services, and all other services required in 42 C.F.R. §§ 422.112, 423.120, and 438.206 and under this Contract (see Covered Services in Appendix A).

2.9.2.1. Contractor will be required to comply with 42 C.F.R. § 438.56(d)(2).

2.9.3. The Contractor must notify the CMT of any significant Provider Network changes immediately, but no later than five (5) days, following a change in Contractor's Provider Network that renders Contractor unable to provide one (1) or more Covered Services within the access to care standards set forth in Section 2.10.2, with the goal of providing notice to the CMT at least sixty (60) days prior to the effective date of any such change.

2.9.4. The Contractor must comply with the requirements specified in 42 C.F.R. §§ 422.504, 423.505, 438.214, which includes selection and retention of providers, credentialing and recredentialing requirements, and nondiscrimination.

2.9.5. The Contractor shall assure that all network providers that provide Medicare Covered Services do not appear on the CMS preclusion list in order to receive reimbursement for claims or otherwise participate in the Medicare program. Pursuant to 42 C.F.R. § 438.602(b), the Contractor shall ensure that all such providers are enrolled with DHCS as Medicaid providers consistent with the provider screening, disclosure, and enrollment requirements of 42 C.F.R. 455, subparts B and E. Payment of a portion of a Medicare Covered Service is not considered a Medicaid Covered Service for the purpose of this section.

2.9.6. The Contractor may not employ or contract with providers excluded from participation in federal health care programs under either Section 1128 or Section 1128A of the Social Security Act; this does not include IHSS providers.

2.9.7. The Contractor may also offer single-case out-of-network agreements to providers who are: 1) not willing to enroll in the Contractor's Provider Network, 2) currently serving Enrollees, 3) willing to continue serving them at the Contractor in-network rate of payment, under the following circumstances:

2.9.7.1. The Contractor's Provider Network does not have an otherwise qualified Network Provider to provide the services within its Provider Network, or transitioning the care in-house would require the Enrollee to receive services from multiple providers/facilities in an uncoordinated manner which would significantly impact the Enrollee's condition;

2.9.7.2. Transitioning the Enrollee to another provider could endanger life, cause suffering or pain, cause physical deformity or malfunction, or significantly disrupt the current course of treatment; or

2.9.7.3. Transitioning the Enrollee to another provider would require the Enrollee to undertake a substantial change in recommended treatment for Medically Necessary Covered Services.

2.9.8. The Provider Network shall be responsive to the linguistic, cultural, and other unique needs of any minority, person who is homeless, Enrollees with disabilities, or other special population served by the Contractor, including the capacity to communicate with Enrollees in languages other than English, when necessary, as well as those who are deaf, hard-of-hearing or deaf and blind.

2.9.8.1. Contractor shall have a cultural and linguistic services program that incorporates the requirements of California Code of Regulations Title 22 section 53876 regardless of whether it operates in a Two-Plan County. Contractor shall monitor, evaluate, and take effective action to address any needed improvement in the delivery of culturally and linguistically appropriate services. Contractor shall review and update its cultural and linguistic services consistent

with the group needs assessment requirements as specified by DHCS.

2.9.8.2. Contractor shall implement and maintain a written description of its cultural and linguistic services program, which shall include at minimum the following:

2.9.8.2.1. An organizational commitment to deliver culturally and linguistically appropriate health care services;

2.9.8.2.2. Goals and objectives;

2.9.8.2.3. A timetable for implementation and accomplishment of the goals and objectives;

2.9.8.2.4. An organizational chart showing the key staff persons with overall responsibility for cultural and linguistic services and activities. A narrative shall explain the chart and describe the oversight and direction to the community advisory committee, provisions for support staff, and reporting relationships. Qualifications of staff, including appropriate education, experience and training shall also be described; and

2.9.8.2.5. Standards and performance requirements for the delivery of culturally and linguistically appropriate health care services.

2.9.8.3. Linguistic Capability of Employees: Contractor shall assess, identify and track the linguistic capability of interpreters or bilingual employees and contracted staff (clinical and non-clinical).

2.9.8.4. The Contractor shall educate Network Providers through a variety of means including, but not limited to, provider alerts or similar written issuances, about their legal obligations under State and federal law to communicate with Enrollees with limited English proficiency, including the provision of interpreter services, and the resources available to help providers comply with those obligations.

2.9.8.5. The Contractor shall ensure that multilingual Network Providers and, to the extent that such capacity exists within the Contractor's Service Area, all Network Providers,

understand and comply with their obligations under Sate or federal law to assist Enrollees with skilled medical interpreters and the resources that are available to assist Network Providers to meet these obligations.

2.9.8.6. The Contractor shall ensure that Network Providers have interpreters/translators that are available for those who are deaf or hearing-impaired within the Contractor's Service Area.

2.9.8.7. The Contractor shall ensure that its Network Providers are responsive to the unique linguistic, cultural, ethnic, racial, religious, age, gender or other unique needs of Enrollees, including Enrollees who are homeless, disabled (both congenital and acquired disabilities) and other special populations served under the Contract.

2.9.8.8. The Contractor shall ensure that its Network Providers have an understanding of disability-competent care.

2.9.8.9. Contractor shall comply with all applicable federal requirements in Section 504 of the Rehabilitation Act of 1973 and the Americans with Disabilities Act (ADA) of 1990 (42 U.S.C. Section 12101 et seq.), 45 C.F.R. Part 84 and 28 C.F.R. Part 36. Title IX of the Education Amendments of 1972 (regarding education programs and activities), and the Age Discrimination Act of 1975.

2.9.9. Provider Qualifications and Performance

2.9.9.1. All Network Providers of Covered Services must be qualified in accordance with current applicable legal, professional, and technical standards and appropriately licensed, certified or registered. All providers must have good standing in the Medicare and Medi-Cal programs and a valid NPI number, as applicable. Providers that have been terminated from or suspended either Medicare or Medi-Cal cannot participate in Contractor's Provider Network.

2.9.9.1.1. Contractor is responsible for the oversight of all Network Providers delivering non-Covered Services (e.g., CPO Services).

2.9.10. Subcontracting Requirements

2.9.10.1. The Contractor remains fully responsible for meeting all of the terms and requirements of the Contract regardless of whether the Contractor subcontracts for performance of any Contract responsibility. No subcontract will operate to relieve the Contractor of its legal responsibilities under the Contract.

2.9.10.2. Contractor may enter into subcontracts with other entities in order to fulfill the obligations of the Contract. Contractor shall evaluate the prospective First Tier, Downstream or Related Entity's ability to perform the subcontracted services, shall oversee and remain accountable for any functions and responsibilities delegated and shall meet the subcontracting requirements per this Contract and 42 C.F.R. §§ 422.504(i), 423.505(i), 438.230(b)(3), (4) and California Code of Regulations Title 22 section 53867.

2.9.10.3. All contracts entered into with First Tier, Downstream and Related Entities shall be in writing and in accordance with the requirements of the 42 C.F.R. § 438.230(b)(2), Knox-Keene Health Care Services Plan Act of 1975, Health and Safety Code section 1340 et seq.; Title 28, CCR Section 1300 et seq.; WIC Section 14200 et seq.; Title 22, CCR Section 53800 et seq.; and other applicable federal and State laws and regulations, including the required contract provisions between the Contractor and First Tier, Downstream and Related Entities in Appendix C.

2.9.10.4. The Contractor remains fully responsible for functions delegated and for ensuring adherence to the legal responsibilities under the Contract, as described in Appendix C, except that the Contractor's legal responsibilities under this Contract for the provision of LTSS shall be limited as set forth in WIC sections 14186 through 14186.4.

2.9.10.5. The Contractor is responsible for the satisfactory performance and adequate oversight of its First Tier, Downstream and Related Entities. First Tier, Downstream and Related Entities are required to meet the same federal and State financial and program reporting requirements as the Contractor. Additional required contract provisions between the Contractor and First Tier, Downstream and Related Entities is contained in Appendix C.

2.9.10.6. The Contractor must:

2.9.10.6.1. Establish contracts and other written agreements between the Contractor and First Tier, Downstream and Related Entities for Covered Services not delivered directly by the Contractor or its employees;

2.9.10.6.2. Contract only with qualified or licensed providers who continually meet federal and State requirements, as applicable, and the qualifications contained in Appendix C.

2.9.10.6.3. This section does not apply to the California Department of Social Services or any other State department contracting with the Contractor for the provision of services under the Demonstration.

2.9.11. Provider Education and Training

2.9.11.1. Provider Education. Prior to any enrollment of Enrollees under this Contract and thereafter, Contractor shall conduct Network Provider education regarding Contractor policies and procedures as well as the Cal MediConnect program and the Contractor model of care.

2.9.11.2. Provider Training. Contractor shall ensure that all Network Providers receive training regarding the Cal MediConnect Program in order to operate in full compliance with the Contract and all applicable federal and State statutes and regulations, including rights and responsibilities pertaining to Grievance and Appeals procedures and timelines under this contract. Contractor shall ensure that Network Provider training relates to Cal MediConnect services-including but not limited to the care coordination benefit, policies, procedures and any modifications to existing services, policies or procedures. Training shall include methods for sharing information among Contractor, Network Provider, Enrollee and/or other healthcare professionals. Contractor shall conduct training for all Network Providers within thirty (30) working days after the Contractor places a newly contracted provider on active status. Contractor shall ensure that Network Provider training includes information on all Enrollee rights including the right to full disclosure of health care information and the right to actively participate in

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health care decisions. The Contractor will maintain policies and procedures on Advance Directives pursuant to 42 C.F.R. §§ 422.128, 438.3(j), and 489.102, and will educate its Network Providers concerning its policies and procedures on Advance Directives. Contractor shall ensure that ongoing training is conducted when deemed necessary by either the Contractor, CMS, or DHCS.

2.9.11.2.1. Contractor shall develop and implement a process to provide information to Network Providers and to train Network Providers on a continuing basis regarding clinical protocols, evidenced-based practice guidelines and DHCS-developed cultural awareness and sensitivity instruction. This process shall include an educational program for Network Providers regarding health needs specific to this population that utilizes a variety of educational strategies, including but not limited to, posting information on websites as well as other methods of educational outreach to Network Providers.

2.9.11.3. Provider Orientation. Contractor shall conduct orientation sessions for Network Providers and their office staff.

2.9.11.4. Cultural Competency Training. Contractor shall provide cultural competency, sensitivity, or diversity training for staff, Network Providers and First Tier, Downstream and Related Entities with direct Enrollee interaction. The training shall cover information about the identified cultural groups in the Contractor's Service Areas, such as the groups' beliefs about illness and health; methods of interacting with providers and the health care structure; and, language and literacy needs including limited English proficiency; and diverse cultural and ethnic backgrounds.

2.9.11.5. Provider Manual. The Provider Manual shall be a comprehensive online reference tool for the Provider and staff regarding, but not limited to, administrative, prior authorization, and referral processes, claims and encounter submission processes, continuity of care requirements, and plan benefits. The Provider Manual shall also address topics such as clinical practice guidelines, availability and access standards, care management programs and Enrollee rights.

2.9.11.5.1. Except as otherwise required or authorized by CMS, DHCS or by operation of law, ensure that Network Providers receive thirty (30) days advance notice in writing of policy and procedure changes, and maintain a process to provide education and training for Network Providers regarding any changes that may be implemented, prior to the policy and procedure changes taking effect.

2.9.11.6. Provider Directory. Contractor shall make its Provider Directory available to Providers via Contractor's web-portal and as described in Section 2.17.5.10.

2.9.11.7. Provider-based Health Education for Enrollees. Contractor shall encourage Network Providers to provide health education to Enrollees as described in Section 2.9.11.8. Contractor shall ensure that Network Providers have the preventive care, disease-specific and plan services information necessary to support Enrollee education in an effort to promote compliance with treatment directives and to encourage self-directed care.

2.9.11.8. Health Education. Contractor shall implement and maintain a health education program that includes programs, services, functions, and resources necessary to provide health education, health promotion and patient education for all Enrollees. This includes helping the Enrollee understand their health plan and the benefits the plan provides.

2.9.11.8.1. Contractor shall ensure administrative oversight of the health education program by a qualified full-time health educator.

2.9.11.8.2. Contractor shall provide health education programs and services at no charge to Enrollees directly and/or through subcontracts or other formal agreements with providers that have expertise in delivering health education services to the Enrollee population.

2.9.11.8.3. Contractor shall ensure the organized delivery of health education programs using educational strategies and methods that are appropriate for

Enrollees and effective in achieving behavioral change for improved health.

2.9.11.8.4. Contractor shall ensure that health education materials are written at the sixth grade reading level and are culturally and linguistically appropriate for the intended audience.

2.9.11.8.5. Contractor shall maintain a health education program that provides educational interventions addressing the following health categories and topics:

2.9.11.8.5.1. Appropriate use of health care services – e.g., managed health care; preventive and primary health care; obstetrical care; health education services; and, complementary and alternative care.

2.9.11.8.5.2. Risk-reduction and healthy lifestyles – e.g., tobacco use and cessation; alcohol and drug use; injury prevention; prevention of sexually transmitted diseases; HIV and unintended pregnancy; nutrition, weight control, and physical activity.

2.9.11.8.5.3. Self-care and management of health conditions – e. g., pregnancy; asthma; diabetes; and, hypertension.

2.9.11.8.6. Contractor shall ensure that Enrollees receive point of service education as part of preventive and primary health care visits. Contractor shall provide education, training, and program resources to assist Network Providers in the delivery of health education services for Enrollees.

2.9.11.8.7. Contractor shall maintain health education policies and procedures, and standards and guidelines; conduct appropriate levels of program evaluation; and, monitor performance of providers that are contracted to deliver health education services to ensure effectiveness, as approved by the Contractor's quality improvement committee.

2.9.11.8.8. Contractor shall periodically review the health education program to ensure appropriate allocation of health education resources, and maintain documentation that demonstrates effective implementation of the health education requirements.

2.9.11.9. Health, Safety and Welfare Education. As part of its Provider education, Contractor shall include information related to identifying, preventing and reporting abuse, neglect, exploitation, and critical incidents.

2.9.11.10. Disability Sensitivity Training. As part of its Provider education, Contractor shall provide disability sensitivity training for its medical, Behavioral Health, MSSP and CBAS providers. (see Section 2.9.8.8).

2.10. Network Management

2.10.1. General requirements. The Contractor shall establish, maintain, and monitor a network that is sufficient to provide adequate access to all Covered Services in the Contract. Section 2.9.1 discusses the annual network review and approval requirement.

2.10.1.1. Taking into consideration:

2.10.1.1.1. The anticipated number of Enrollees;

2.10.1.1.2. The expected utilization of services, in light of the characteristics and health care needs of Contractor's Enrollees;

2.10.1.1.3. The number and types of providers required to furnish the Covered Services;

2.10.1.1.4. The number of Network Providers who are not accepting new patients; and

2.10.1.1.5. The geographic location of Network Providers and Enrollees, taking into account distance, travel time, the means of transportation and whether the location provides physical access for Enrollees with disabilities.

2.10.1.2. The Contractor will work in collaboration with Network Providers to actively improve the quality of care provided to

Enrollees, consistent with the quality improvement goals and all other requirements of this Contract.

2.10.1.3. The Contractor shall operate a toll-free pharmacy technical help call center or make available call support to respond to inquiries from pharmacies and providers regarding the Enrollee's prescription drug benefit; inquiries may pertain to operational areas such as claims processing, benefit coverage, claims submission, and claims payment. This requirement can be accommodated through the use of on-call staff pharmacists or by contracting with the Contractor's pharmacy benefit manager during non-business hours as long as the individual answering the call is able to address the call at that time. The call center must operate or be available during the entire period in which the Contractor's network pharmacies in its Service Area are open, (e.g., Contractors whose pharmacy networks include twenty-four (24) hour pharmacies must operate their pharmacy technical help call centers twenty-four (24) hours a day as well). The pharmacy technical help call center must meet the following operating standards:

2.10.1.3.1. Average hold time must not exceed two (2) minutes, with the average hold time defined as the time spent on hold by the caller following the interactive voice response (IVR) system, touch tone response system, or recorded greeting and before reaching a live person.

2.10.1.3.2. Eighty (80) percent of incoming calls answered within thirty (30) seconds.

2.10.1.3.3. Disconnect rate of all incoming calls not to exceed five (5) percent.

2.10.2. Access to Care Standards. The Contractor must demonstrate annually that its Provider Network meets the stricter of the following standards:

2.10.2.1. For Medicare medical providers and facilities, time, distance and minimum number standards updated annually on the CMS website (https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-

Office/FinancialAlignmentInitiative/MMPInformationandGuidance/MMPApplicationandAnnualRequirements.html);

2.10.2.2. For Medicare pharmacy providers, time, distance and minimum number as required in Appendix E, Article II, Section I and 42 C.F.R. § 423.120; or

2.10.2.3. For Medi-Cal providers and facilities, the Contractor contract with a sufficient number of LTSS providers, including but not limited to SNFs (distinct part and free-standing), MSSP, CBAS and County Social Services Agencies located in the Contractor's Service Area.

2.10.2.3.1. If the LTSS provider within the Service Area cannot meet the Enrollee's medical needs, the Contractor must contract with the nearest LTSS provider outside of the covered Service Area. Contractor is responsible for all Covered Services, pursuant to WIC section 14186.3(c).

2.10.2.3.2. Contractor shall ensure the provision of acceptable accessibility standards in accordance with 42 C.F.R. §§ 438.206(c) and 438.68 and Title 28 CCR Section 1300.67.2.2 and as specified below.

2.10.2.4. Ensure that Network Providers offer hours of operation that are no less than the hours of operation offered to commercial Enrollees or comparable to Medi-Cal fee-for-service, if the provider serves only Medi-Cal Enrollees.

2.10.3. Appropriate Clinical Timeframes. Except for LTSS, Contractor shall communicate, enforce, and monitor providers' compliance with these standards:

2.10.3.1. Contractor shall ensure that Enrollees are offered appointments for covered health care services within a time period appropriate for their condition.

2.10.3.2. Enrollees must be offered appointments within the following timeframes:

2.10.3.2.1. Urgent Care appointment for services that do not require prior authorization – within forty-eight (48) hours after request;

2.10.3.2.2. Urgent appointment for services that do require prior authorization within ninety-six (96) hours after request;

2.10.3.2.3. Non-urgent primary care appointments – within ten (10) business days after request;

2.10.3.2.4. Appointment with a specialist – within fifteen (15) business days after request;

2.10.3.2.5. Non-urgent appointment for ancillary services for the diagnosis or treatment of injury, illness, or other health condition – within fifteen (15) business days after request.

2.10.3.3. Shortening or Expanding Timeframes: Timeframes may be shortened or extended as clinically appropriate by a qualified health care professional acting within the scope of his or her practice consistent with professionally recognized standards of practice. If the timeframe is extended, it must be documented within the Enrollee's medical record that a longer timeframe will not have a detrimental impact on the Enrollee's health.

2.10.3.4. Contractor will monitor providers regularly to determine compliance with the timely access requirements

2.10.3.5. Contractor will take corrective action if it, or its providers, fail to comply with timely access requirements.

2.10.4. PCP Assignment

2.10.4.1. The Contractor will allow each Enrollee to choose his or her PCP to the extent possible and appropriate. If the Enrollee does not select a PCP within thirty (30) calendar days of the effective coverage date, Contractor shall assign that Enrollee to a PCP and notify the Enrollee and the assigned PCP in writing no later than forty (40) calendar days after the Enrollee's coverage date.

2.10.4.2. If an Enrollee does not select a PCP within thirty (30) calendar days of the effective date of coverage date, Contractor shall use FFS utilization data or other data sources, including electronic data, to:

2.10.4.2.1. Establish existing provider relationships for the purpose of PCP assignment, including a specialist or clinic, if an Enrollee indicates a preference for either. Contractor shall comply with all federal and State Privacy laws in the provision and use of this data.

2.10.4.3. Contractor shall notify the PCP that an Enrollee has selected or been assigned to the PCP within ten (10) calendar days from when selection or assignment is completed by the Enrollee or the Contractor, respectively.

2.10.4.4. Contractor shall maintain procedures that proportionately include contracting traditional and safety-net providers in the assignment process for Enrollees who do not choose a PCP.

2.10.4.5. If, at any time, an Enrollee notifies the Contractor of a PCP choice, such choice shall override Enrollee assignment to a PCP in accordance with applicable DPL(s) as indicated in Section 2.1.5.

2.10.5. Provider Credentialing, Recredentialing, and Board Certification

2.10.5.1. Credentialing and Recredentialing: Contractor shall develop and maintain written policies and procedures that include initial credentialing, recredentialing, recertification, and reappointment of physicians including PCPs and specialists in accordance with the DHCS Policy Letter 02-03, check to see if a provider is suspended or excluded suspended, excluded, or otherwise ineligible because of a sanction to receive, directly or indirectly, reimbursement from the Medi-Cal program pursuant to WIC section 14043.61 and 42 C.F.R. § 455.436;, and adhere to managed care standards at 42 C.F.R. § 422.204. 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.

2.10.5.1.1. Contractor shall ensure those policies and procedures are reviewed and approved by the plan governing body, or designee.

2.10.5.1.2. Contractor shall ensure that the responsibility for recommendations regarding credentialing decisions will rest with a credentialing committee or other peer review body.

2.10.5.2. 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 provider credentialing or recredentialing and in accordance with applicable DPL(s) as indicated in Section 2.1.5.

2.10.5.3. Credentialing and Practitioner Licensure Authorities and Application within Approved Contracts: Contractor will use procedures consistent with DHCS policy for all of Medi-Cal. DHCS can modify these rules at any time and is required to notify CMS ninety (90) days prior of any such changes.

2.10.6. Federally Qualified Health Centers (FQHC) and Rural Health Clinics (RHC): Contractor shall meet federal requirements for access to FQHC services, including those in 42 U.S.C. § 1396 b(m). Contractor shall reimburse FQHCs and RHCs in accordance with current federal and State laws and regulations. If FQHC and RHCs services are not available in the Provider Network, Contractor shall authorize out-of-network services subject to the prevailing Medicare Advantage payment requirements for out-of-network services.

2.10.6.1. FQHC and RHCs Reimbursements: The Contractor shall ensure that its payments to FQHCs and RHCs for services to Enrollees are no less than the sum of:

2.10.6.1.1. The level and amount of payment that the plan would make for such services if the services had been furnished by an entity providing similar services that was not a FQHC and RHCs, and

2.10.6.1.2. The amount of cost-sharing that would have been paid to the FQHC for serving the Enrollee if the Enrollee were in Medicare fee-for-service, consistent with how such amounts are included in the Medi-Cal component of the Capitation Rates.

2.10.6.1.3. The intent of these provisions is to ensure that Contractors pay FQHCs and RHCs amounts consistent with Medicare and Medi-Cal managed care policies while preserving the opportunity for FQHCs to separately claim supplemental payments under such policies.

2.10.7. IHSS Network. Contractor shall develop and execute an MOU with County Social Services Agency responsible for IHSS that reflects an agreement between the Contractor and County Social Services Agency regarding roles and responsibilities for Cal MediConnect and IHSS. This MOU will specify the role of the county in:

2.10.7.1. Assessing, approving, and authorizing each current and new Enrollee's initial and continuing need for services, in addition to sharing those assessments with the Enrollee's ICT.

2.10.7.2. Sharing confidential data regarding IHSS authorized hours and services as necessary and as permissible under applicable State and federal law.

2.10.7.3. Determining whether the Enrollees' desires to have his or her IHSS providers involved in care planning or coordination, and if so, obtain express consent from the Enrollee or his or her authorized representative.

2.10.7.4. Support an Enrollee who is at risk for out-of-home placement in obtaining IHSS services.

2.10.7.5. Report documentation that Contractor has developed and will conduct a benefit orientation and training program specific to IHSS for First Tier, Downstream and Related Entities. The Contractor also provides documentation that it has trained personnel of IHSS organizations regarding the Contractor's Covered Services and policies and procedures to access services and coordinate care.

2.10.8. Emergency Services Programs (ESPs)

2.10.8.1. Contractor shall have, as a minimum, a designated emergency service facility, providing care on a twenty-four (24) hour-a-day, seven (7) day-a-week basis. This designated emergency service facility will have one or more physicians and one nurse on duty in the facility at all times.

2.10.9. Emergency Care

2.10.9.1. Contractor shall cover Emergency Services without prior authorization pursuant to Title 28 CCR Section 1300.67(g), Title 22 CCR Section 53216, and Section 1932(b)(2) of the Social Security Act. Contractor shall coordinate access to emergency care services in accordance with 42 C.F.R. § 438.114 and the Contractor's DHCS-approved emergency department protocol.

2.10.9.2. Contractor shall ensure adequate follow-up care for those Enrollees who have been screened in the emergency room and require non-emergency care.

2.10.9.3. Contractor shall ensure that a contracting physician is available twenty-four (24) hours a day to authorize Medically Necessary post-stabilization care and coordinate the transfer of stabilized Enrollees in an emergency department, if necessary.

2.10.9.4. Contractor may not specify what constitutes an Emergency Medical Condition on the basis of lists of diagnoses or symptoms.

2.10.9.5. Contractor may not refuse to cover Emergency Services based on the emergency room provider, hospital, or fiscal agent not notifying the Enrollee's PCP, MCO, PIHP, PAHP or applicable State entity of the Enrollee's screening and treatment within ten (10) calendar days of presentation for Emergency Services.

2.10.9.6. An Enrollee who has an Emergency Medical Condition may not be held liable for payment of subsequent screening and treatment needed to diagnose the specific condition or stabilize the Enrollee.

2.10.9.7. May not deny payment for treatment obtained under either of the following circumstances:

2.10.9.7.1. An Enrollee had an Emergency Medical Condition, including cases in which the absence of immediate medical attention would not have had the outcomes specified in the definition of an Emergency Medical Condition.

2.10.9.7.2. The Contractor's representative instructs the Enrollee to seek Emergency Services.

2.10.9.8. The attending emergency physician, or the provider actually treating the Enrollee, is responsible for determining when the Enrollee is sufficiently stabilized for transfer or discharge, and that determination is binding on the entities as responsible for coverage and payment.

2.10.10. Post-Stabilization Care Services

2.10.10.1. The Contractor must cover and pay for Post-Stabilization Care Services.

2.10.10.2. The Contractor is financially responsible for Post-Stabilization Care Services obtained within or outside the organization that are pre-approved by a Contractor's provider or other Contractor representative.

2.10.10.3. The Contractor is financially responsible for Post-Stabilization Care Services obtained within or outside the Contractor's organization that are not pre-approved by a Network Provider or other Contractor representative, but are administered to maintain the Enrollee's stabilized condition within one (1) hour of a request to the Contractor for pre-approval of further Post-Stabilization Care Services.

2.10.10.4. The Contractor is financially responsible for Post-Stabilization Care Services obtained from within or outside the Contractor that are not pre-approved by a Network Provider or other Contractor representative, but administered to maintain, improve, or resolve the Enrollee's stabilized condition if the Contractor:

2.10.10.4.1. Does not respond to a request for pre-approval within one (1) hour;

2.10.10.4.2. Cannot be contacted; or

2.10.10.4.3. Or the Contractor's representative and the treating physician cannot reach an agreement concerning the Enrollee's care and a Network Provider is not available for consultation.

2.10.10.4.4. In this situation, the Contractor must give the treating physician the opportunity to consult with a Network Provider and the treating physician may continue with care of the Enrollee until a Network Provider is reached or one of the criteria in 42 C.F.R. § 113(c)(3) is met.

2.10.10.5. The Contractor must limit charges to Enrollees for Post-Stabilization Care Services to an amount no greater than what the Contractor would charge the Enrollee if he or she had obtained the services through the Contractor.

2.10.10.6. End of Contractor's financial responsibility. The Contractor's financial responsibility for Post-Stabilization Care Services it has not pre-approved ends when:

2.10.10.6.1. A Network Provider with privileges at the treating hospital assumes responsibility for the Enrollee's care;

2.10.10.6.2. A Network Provider assumes responsibility for the Enrollee's care through transfer;

2.10.10.6.3. Contractor's representative and the treating physician reach an agreement concerning the Enrollee's care; or

2.10.10.6.4. The Enrollee is discharged

2.10.11. Long Term Services and Supports Providers Network

2.10.11.1. Contractor shall develop policies and procedures to train:

2.10.11.1.1. All Contractor staff involved in Care Coordination:

2.10.11.1.1.1. Person-centered planning processes;

2.10.11.1.1.2. Linguistic, cultural, and cognitive competence;

2.10.11.1.1.3. Core concepts of the Olmstead Decision, i.e. serving Enrollees in the least restrictive settings as appropriate;

2.10.11.1.1.4. Accessibility and accommodations; independent living;

2.10.11.1.1.5. Wellness principles;

2.10.11.1.1.6. Criteria for safe transitions, transition planning, Care Plans after transitioning; and,

2.10.11.1.1.7. Along with other required training as specified by DHCS—both initially and on an annual basis.

2.10.11.1.2. Specially designated Care Coordination staff in dementia care management including but not limited to:

2.10.11.1.2.1. Understanding dementia;

2.10.11.1.2.2. Symptoms and progression;

2.10.11.1.2.3. Understanding and managing behaviors and communication problems caused by dementia; caregiver stress and its management; and,

2.10.11.1.2.4. Community resources for Enrollees and caregivers.

2.10.11.1.3. Specially designated Care Coordination staff in MSSP including but not limited to:

2.10.11.1.3.1. An overview of the characteristics and needs of MSSP's target population;

2.10.11.1.3.2. MSSP's eligibility criteria;

2.10.11.1.3.3. Assessment and reassessment processes, services, and service authorization process; and,

2.10.11.1.3.4. How to refer Enrollees to MSSP for assessment and eligibility determination.

2.10.11.1.4. All Contractor staff generally on the addition of LTSS and social services to Contractor

operations. For all trainings, Contractor shall meet specifications set by DHCS, document completion of training, and have specific policies to address non completion.

2.10.12. Women's Health Services: Contractor shall ensure female Enrollees have direct access to a women's health specialist within the network to provide women's routine and preventive health care services. Such access may be in addition to the Enrollee's PCP.

2.10.13. Family Planning Provider Network

2.10.13.1. Contractor shall cover family planning services for all Enrollees whether the family planning services are provided by contracted provider or an out-of-network provider.

2.10.13.2. Contractor agrees to abide by 42 C.F.R. § 438.206.

2.10.14. Indian Health Network: The Contractor shall permit Indian Enrollees eligible to receive services from an Indian Health Care Provider to choose an Indian Health Care Provider as a PCP if the Indian Health Care Provider has capacity to provide such services regardless of whether the Indian Health Care Provider is in or out of network;

2.10.14.1. The Contractor shall demonstrate that there are sufficient Indian Health Care Providers in the Provider Network to ensure timely access to Covered Services for Indian Enrollees who are eligible to receive services;

2.10.14.2. For services provided prior to January 1, 2018, the Contractor shall pay both network and non-network Indian Health Care Providers who provide Covered Services to Indian Enrollees a negotiated rate which shall be no lower than the DHCS fee for service rate for the same service or, in the absence of a negotiated rate, an amount not less than the amount that the Contractor would pay for the Covered Service provided by a non-Indian health care provider;

2.10.14.3. For services provided on or after January 1, 2018, the Contractor shall reimburse Indian Health Care Providers who provide Covered Services to Indian Enrollees, who are eligible to receive services, at the most current and applicable outpatient per-visit rate published in the Federal Register by the Indian Health Service, and Contractor shall ensure any retroactive outpatient per visit rates are

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appropriately reimbursed to the Indian Health Care Provider;

2.10.14.4. The Contractor shall pay non-network Indian Health Care Providers that are FQHCs for the provision of services to an Indian Enrollee at a rate equal to the rate that the Contractor would pay to a network FQHC that is not an Indian health care provider, including any supplemental payment from the State to make up the difference between the contract amount and what the Indian Health Care Provider would have received FFS.

2.10.14.5. When the amount the in-network Indian Health Care Provider receives from the contractor is less than the amount the IHCP would receive FFS, the State must make a supplemental payment to the Indian Health Care Provider that the Indian Health Care Provider would receive FFS or the applicable encounter rate.

2.10.14.6. The Contractor shall not impose enrollment fees, premiums, or similar charges on Indians regardless of payer. The Contractor must exempt from all cost sharing any Indian who is currently receiving or has ever received an item or service furnished by an Indian Health Care Provider or through referral under contract health services.

2.10.14.7. The Contractor must permit an out of network Indian Health Care Provider to refer an Indian Enrollee to a Network Provider.

2.11. Enrollee Access to Services

2.11.1. General. The Contractor must provide services to Enrollees as follows:

2.11.1.1. Authorize, arrange, coordinate and provide to Enrollees all Covered Services that are Medically Necessary;

2.11.1.2. Reasonably accommodate Enrollees and ensure that the programs and services are as accessible (including physical and geographic access) to an Enrollee with disabilities as they are to an Enrollee without disabilities, and shall have written policies and procedures to assure compliance, including ensuring that physical, communication, and programmatic barriers do not inhibit Enrollees with

disabilities from obtaining all Covered Services from the Contractor by:

2.11.1.2.1. Providing flexibility in scheduling to accommodate the needs of the Enrollees;

2.11.1.2.2. Providing interpreters or translators for Enrollees who are deaf and hard of hearing and those with limited English proficiency;

2.11.1.2.3. Ensuring that Enrollees with disabilities are provided with reasonable accommodations to ensure effective communication, including auxiliary aids and services. Reasonable accommodations will depend on the particular needs of the Enrollee and include but are not limited to:

2.11.1.2.3.1. Providing large print (at least 16-point font) versions of all written materials to Enrollees with visual impairments;

2.11.1.2.3.2. Ensuring that all written materials are available in formats compatible with optical recognition software;

2.11.1.2.3.3. Reading notices and other written materials to Enrollees upon request;

2.11.1.2.3.4. Assisting Enrollees in filling out forms over the telephone;

2.11.1.2.3.5. Ensuring effective communication to and from Enrollees with disabilities through email, telephone, and other electronic means;

2.11.1.2.3.6. TTY, computer-aided transcription services, telephone handset amplifiers, assistive listening systems, closed caption decoders, videotext displays and qualified interpreters for the deaf; and

2.11.1.2.3.7. Individualized assistance.

2.11.1.3. The Contractor must identify to DHCS the individual in its organization who is responsible for ADA compliance related to this Demonstration and his/her job title. The Contractor must also establish and execute a work plan to achieve and maintain ADA compliance; and

2.11.1.4. If the Contractor's Provider Network is unable to provide necessary medical services covered under the Contract to a particular Enrollee, the Contractor must adequately and timely cover these services out of network for the Enrollee, for as long as the Contractor is unable to provide them.

2.11.1.5. When a PCP or medical, Behavioral Health or LTSS provider is terminated from the Contractor's plan or leaves the Provider Network for any reason, the Contractor must make a good faith effort to give written notification of termination of such provider, within fifteen (15) days after receipt or issuance of the termination notice, or no later than thirty (30) calendar days before the termination date, to each Enrollee who received his or her care from, or was seen on a regular basis by, the terminated PCP or any other medical, behavioral or LTSS provider. For terminations of PCPs, the Contractor must also report the termination to DHCS and provide assistance to the Enrollee in selecting a new PCP within fifteen (15) calendar days. For Enrollees who are receiving treatment for a chronic or ongoing medical condition or LTSS, the Contractor shall ensure that there is no disruption in services provided to the Enrollee.

2.11.1.6. Contractor shall ensure that each Enrollee has a PCP who is available and physically present at the service site for sufficient time to ensure access for the assigned Enrollee when medically required. This requirement does not preclude an appropriately licensed professional from being a substitute for the PCP in the event of vacation, illness, or other unforeseen circumstances.

2.11.2. Contractor shall ensure Enrollee access to specialists for Covered Services that are Medically Necessary. Contractor shall ensure adequate staff within the Service Area, including physicians, administrative and other support staff directly and/or through subcontracts, sufficient to assure that health services will be provided in accordance with Section 2.10.2 and consistent with all specified requirements.

2.11.2.1. Contractor shall establish acceptable accessibility requirements in accordance with Title 28 CCR Section 1300.67.2.1 and as specified below. DHCS will review and approve requirements for reasonableness. Contractor shall communicate, enforce, and monitor Network Providers' compliance with these requirements.

2.11.2.1.1. Appointments: Contractor shall implement and maintain procedures for Enrollees to obtain appointments for routine care, Urgent Care, routine specialty referral appointments, prenatal care, and adult initial health assessments. Contractor shall also include procedures for follow-up on missed appointments.

2.11.2.1.2. First Prenatal Visit: Contractor shall ensure that the first prenatal visit for a pregnant Enrollee will be available within two (2) weeks upon request.

2.11.2.1.3. Waiting Times: Contractor shall develop, implement, and maintain a procedure to monitor waiting times in the Network Providers' offices, telephone calls (to answer and return), and time to obtain various types of appointments indicated in 2.11.2.1.1 appointments, above.

2.11.2.1.4. Telephone Procedures: Contractor shall require Network Providers to maintain a procedure for triaging Enrollees' telephone calls, providing telephone medical advice (if it is made available) and accessing telephone interpreters.

2.11.2.1.5. After Hours Calls: At a minimum, Contractor shall ensure that all Enrollees have access to appropriate licensed professional for after-hours calls.

2.11.2.1.6. Unusual Specialty Services: Contractor shall arrange for the provision of seldom used or unusual specialty services from specialists outside the network if unavailable within Contractor's network, when determined medically necessary.

2.11.3. Services Not Subject to Prior Approval

2.11.3.1. The Contractor will assure coverage of Emergency Medical Conditions and Urgent Care services. The Contractor must not require prior approval for the following services:

2.11.3.1.1. Any services for Emergency Medical Conditions (which includes emergency Behavioral Health care);

2.11.3.1.2. Urgent Care sought outside of the Service Area;

2.11.3.1.3. Urgent Care under unusual or extraordinary circumstances provided in the Service Area when the contracted medical provider is unavailable or inaccessible;

2.11.3.1.4. Preventative services;

2.11.3.1.5. Family planning services;

2.11.3.1.6. Out-of-area renal dialysis services;

2.11.3.1.7. Basic prenatal care;

2.11.3.1.8. Sexually transmitted disease services; and

2.11.3.1.9. HIV testing.

2.11.4. The Contractor must have a mechanism in place to allow Enrollees with special health care needs to have direct access to a specialist as appropriate for the Enrollee's condition and identified needs, such as a standing referral to a specialty Provider.

2.11.5. Authorization of Services. In accordance with 42 C.F.R. § 438.210, the Contractor shall authorize services as follows:

2.11.5.1. For the processing of requests for initial and continuing authorizations of Covered Services, the Contractor shall:

2.11.5.1.1. Have in place and follow written policies and procedures;

2.11.5.1.2. Have in effect mechanisms to ensure the consistent application of review criteria for authorization decisions;

2.11.5.1.3. Have in place procedures to allow Enrollees to initiate requests for provision of services; and

2.11.5.1.4. Consult with the requesting Network Provider when appropriate.

2.11.5.2. The Contractor shall ensure that an authorized Care Coordinator is available twenty-four (24) hours a day for timely authorization of Covered Services that are Medically Necessary and to coordinate transfer of stabilized Enrollees in the emergency department, if necessary. The Contractor's guidelines for medical necessity must, at a minimum, be consistent with Medicare standards for acute services and prescription drugs and Medi-Cal standards for LTSS.

2.11.5.3. Any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested must be made by a health care professional who has appropriate clinical expertise in treating the Enrollee's medical condition, performing the procedure, or providing the treatment. Behavioral Health services denials must be rendered by board-certified or board-eligible psychiatrists or by a licensed clinician, acting within their scope of practice, with the same or similar specialty as the Behavioral Health services being denied, except in cases of denials of service for psychological testing, which shall be rendered by a qualified psychologist.

2.11.5.4. The Contractor shall assure that all Behavioral Health authorization and utilization management activities are in compliance with 42 U.S.C. § 1396u-2(b)(8). Contractor must comply with the requirements for demonstrating parity for quantitative treatment limitations between Behavioral Health and medical/surgical inpatient, outpatient and pharmacy benefits.

2.11.5.5. The Contractor must notify the requesting Network Provider, either orally or in writing, and give the Enrollee written notice of any decision by the Contractor to deny a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested. The notice must meet the requirements of 42 C.F.R. § 438.404 and Title 22 CCR § 53261, and must:

2.11.5.5.1. Be produced in a manner, format, and language that can be easily understood;

2.11.5.5.2. Be made available in Threshold Languages, upon request;

2.11.5.5.3. Include information, in Threshold Languages about how to request translation services and alternative formats. Alternative formats shall include materials which can be understood by persons with limited English proficiency: and

2.11.5.5.4. In any written communication to a physician or other health care provider of a denial, delay or modification of a request, include the name and telephone number of the health care professional responsible for the denial, delay or modification.

2.11.5.6. The Contractor must make authorization decisions in the following timeframes:

2.11.5.6.1. For standard authorization decisions, provide notice as expeditiously as the Enrollee's health condition requires, within five (5) working days from receipt of the information reasonably necessary to render a decision, and in all circumstances no later than fourteen (14) calendar days after receipt of the request for service, with a possible extension not to exceed fourteen (14) additional calendar days. Such extension shall only be allowed if:

2.11.5.6.1.1. The Enrollee or the Provider requests an extension, or

2.11.5.6.1.2. The Contractor can justify (to the satisfaction of DHCS and/or CMS upon request) that:

2.11.5.6.1.2.1. The extension is in the Enrollee's interest; and

2.11.5.6.1.2.2. There is a need for additional information where:

2.11.5.6.1.2.2.1. There is a reasonable likelihood that receipt of such information would

lead to approval of the request, if received; and

2.11.5.6.1.2.2.2. Such outstanding information is reasonably expected to be received within fourteen (14) calendar days.

2.11.5.6.2. For expedited service authorization decisions, where the provider indicates or the Contractor determines that following the standard timeframe in Section 2.11.5.6.1 could seriously jeopardize the Enrollee's life or health or ability to attain, maintain, or regain maximum function, the Contractor must make a decision and provide notice as expeditiously as the Enrollee's health condition requires and no later than seventy-two (72) hours after receipt of the request for service, with a possible extension not to exceed fourteen (14) additional calendar days. Such extension shall only be allowed if:

2.11.5.6.2.1. The Enrollee or the provider requests an extension; or

2.11.5.6.2.2. The Contractor can justify (to DHCS and/or CMS upon request) that:

2.11.5.6.2.2.1. The extension is in the Enrollee's interest; and

2.11.5.6.2.2.2. There is a need for additional information where:

2.11.5.6.2.2.2.1. There is a reasonable likelihood that receipt of such information would lead to approval of the request, if received; and

2.11.5.6.2.2.2.2. Such outstanding information is reasonably expected to be received within fourteen (14) calendar days.

2.11.5.6.3. In accordance with 42 C.F.R. §§ 438.3(i), 438.210(e), and 422.208, compensation to individuals or entities that conduct utilization management activities for the Contractor must not be structured so as to provide incentives for the individual or entity to deny, limit, or discontinue Medically Necessary Covered Services to any Enrollee.

2.11.6. Utilization Management

2.11.6.1. Utilization management program: Contractor shall develop, implement, and continuously update and improve, a utilization management program that ensures appropriate processes are used to review and approve the provision of medically necessary Covered Services, excluding Part D benefits. Contractor is responsible to ensure that the utilization management program includes:

2.11.6.1.1. Qualified staff responsible for the utilization management program.

2.11.6.1.2. The separation of medical decisions from fiscal and administrative management to assure medical decisions will not be unduly influenced by fiscal and administrative management.

2.11.6.1.3. Allowances for a second opinion from a qualified health professional at no cost to the Enrollee.

2.11.6.1.4. 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 providers are involved in the development and or adoption of specific criteria used by the Contractor.

2.11.6.1.5. Communications to Network Providers of the procedures and services that require prior authorization and ensure that all contracting Network Providers are aware of the procedures and timeframes necessary to obtain prior authorization for these services.

2.11.6.1.6. An established specialty referral system to track and monitor referrals requiring prior authorization through the Contractor. The system shall include authorized, denied, deferred, or modified referrals, and the timeliness of the referrals. Contractor shall ensure that all contracted Network Providers and non-contracting specialty providers are informed of the prior authorization and referral process at the time of referral.

2.11.6.1.7. The quarterly reporting of utilization management activities into the DHCS, including a process to electronically report on the number and types of Appeals, denials, deferrals, and modifications to the appropriate DHCS and CMT staff.

2.11.6.1.8. Procedures for continuously reviewing the performance of health care personnel, the utilization of services and facilities, and cost.

2.11.6.1.9. Procedures to identify, communicate, and implement actions to correct potential over and under-utilization issues that are identified.

2.11.6.2. These activities shall be done in accordance with Health and Safety Code Section 1363.5 and 28 CCR 1300.70(b)(2)(H) and (G) and 42 C.F.R. §§ 422.112, 422.152, 422.202, and 422.4.

2.11.6.3. Pre-Authorizations and Review Procedures Contractor shall ensure that its pre-authorization, concurrent review and retrospective review procedures meet the following minimum requirements:

2.11.6.3.1. Decisions to deny or to authorize an amount, duration, or scope that is less than requested shall be made by a qualified health care professional with appropriate clinical expertise in treating the condition and disease.

2.11.6.3.2. Qualified health care professionals supervise review decisions, including service reductions, and a qualified physician will review all denials that are made, whole or in part, on the basis of

medical necessity. For purposes of this provision, a qualified physician or Contractor's pharmacist may approve, defer, modify, or deny prior authorizations for pharmaceutical services, provided that such determinations are made under the auspices of and pursuant to criteria established by the Contractor's medical director, in collaboration with the Contractor's pharmacy and therapeutics committee or its equivalent.

2.11.6.3.3. There is a set of written criteria or guidelines for utilization review that is based on sound medical evidence, is consistently applied, regularly reviewed, and updated.

2.11.6.3.4. Reasons for decisions are clearly documented.

2.11.6.3.5. Notification to Enrollees regarding denied, deferred or modified referrals is made.

2.11.6.3.6. Decisions and Appeals are made in a timely manner and are not unduly delayed for medical conditions requiring time sensitive services.

2.11.6.3.7. Prior Authorization requirements shall not be applied to Emergency Services, urgently needed services, family planning services, preventive services, basic prenatal care, sexually transmitted disease services, and HIV testing.

2.11.6.3.8. Records, including any NOA, shall meet the retention requirements described in Section 5.4 Records Retention, Inspection, and Audit.

2.11.6.3.9. Contractor must notify the requesting provider or Enrollee of any decision to deny, approve, modify, or delay a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested. The notice to the provider may be orally or in writing.

2.11.7. Timeframes for Authorization

2.11.7.1. Emergency and Urgently Needed Care: No prior authorization required, following the reasonable person

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standard to determine that the presenting complaint might be an emergency.

2.11.7.2. Concurrent review of authorization for treatment regimen already in place: Within five (5) business days or less, consistent with urgency of the Enrollee's medical condition and in accordance with Health and Safety Code Section 1367.01, or any future amendments thereto.

2.11.7.3. Retrospective review: Within thirty (30) calendar days in accordance with Health and Safety Code Section 1367.01, or any future amendments thereto. Retrospective review applies only to Medi-Cal services, but Contractor may at its discretion apply retrospective review to Medicare services.

2.11.7.4. Non Part D covered pharmaceuticals: Twenty-four (24) hours on all drugs that require prior authorization in accordance with WIC section 14185 or any future amendments thereto.

2.11.7.5. Routine authorizations: Five (5) working days from receipt of the information reasonably necessary to render a decision (these are requests for specialty service, cost control purposes, out-of-network not otherwise exempt from prior authorization) in accordance with Health and Safety Code Section 1367.01, or any future amendments thereto, but, no longer than fourteen (14) calendar days from the receipt of the request. The decision may be deferred and the time limit extended an additional fourteen (14) calendar days only where the Enrollee or the Enrollee's provider requests an extension, or the Contractor can provide justification upon request by the State for the need for additional information and how it is in the Enrollee's interest. Any decision delayed beyond the time limits is considered a denial and must be immediately processed as such.

2.11.7.6. Expedited Authorizations: For requests in which a provider indicates, or the Contractor determines that, following the standard timeframe could seriously jeopardize the Enrollee'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 Enrollee's health condition requires and not later than seventy-two (72) hours after receipt of the request for

services. The Contractor may extend this period by up to fourteen (14) calendar days if the Enrollee requests an extension, or if the Contractor justifies, to the DHCS upon request, a need for additional information and how the extension is in the Enrollee's interest. Any decision delayed beyond the time limits is considered a denial and must be immediately processed as such.

2.11.7.7. LTSS Authorization as follows:

2.11.7.7.1. Must include the PCP or case manager signature on any nursing facility authorization or reauthorization request.

2.11.7.7.2. Must include the PCP or case manager signature on any CBAS authorization or reauthorization request.

2.11.7.7.3. Through the HRA and ICT discussions, the Contractor shall refer Enrollees who are potentially eligible for MSSP to MSSP providers for authorization into the MSSP. MSSP providers and the Contractor shall collaborate and coordinate MSSP care management services (see Section 2.6.1.2).

2.11.7.7.4. Through the HRA and ICT discussions, the Contractor shall refer Enrollees who are potentially eligible for IHSS to County Social Services Agency responsible for IHSS service authorization. County IHSS eligibility worker may participate on the ICT whenever IHSS services are involved in the care of the Enrollees.

2.11.8. Review of Utilization Data

2.11.8.1. Contractor shall include within the utilization management program mechanisms to detect both under- and over-utilization of health care services. Contractor's internal reporting mechanisms used to detect Enrollee utilization patterns shall be reported to DHCS upon request.

2.11.9. Delegating Utilization Management Activities

2.11.9.1. Contractor may delegate utilization management activities. If Contractor delegates these activities, Contractor shall comply with Section 2.11.5.

2.11.10. Availability of Services

2.11.10.1. Access to Services for Emergency Conditions and Urgent Care. The Contractor must ensure access to twenty-four (24) hour Emergency Services for all Enrollees, whether they reside in institutions or in the community.

2.11.10.1.1. The Contractor must cover and pay for any services obtained for Emergency Conditions in accordance with 42 C.F.R. § 438.114(c).

2.11.10.1.2. Emergency Medical Treatment and Labor Act (EMTALA): The Contractor and Network Providers must comply with EMTALA, including the requirements for qualified hospital medical personnel to provide appropriate medical screening examinations to any Enrollee who "comes to the emergency department," as defined in 42 C.F.R. § 489.24(b); and, as applicable, to provide Enrollees stabilizing treatment or, if the hospital lacks the capability or capacity to provide stabilizing treatment, appropriate transfers.

2.11.10.1.3. An Enrollee who has an Emergency Condition may not be held liable for payment of subsequent screening and treatment needed to diagnose the specific condition or stabilize the Enrollee.

2.11.10.1.4. The attending emergency physician, or the provider actually treating the Enrollee, is responsible for determining when the Enrollee is sufficiently stabilized for transfer or discharge, and that determination is binding on the Contractor as responsible for coverage and payment.

2.11.10.1.5. The Contractor may not refuse to cover Emergency Services based on the emergency room provider, hospital, or fiscal agent not notifying the Enrollee's Primary Care Provider, the Contractor

or applicable State entity of the Enrollee's screening and treatment within ten (10) calendar days of presentation for Emergency Services.

2.12. Enrollee Services

2.12.1. Enrollee service representatives (ESRs). The Contractor must employ ESRs trained to answer Enrollee inquiries and concerns from Enrollees and potential Enrollees, consistent with the requirements of 42 C.F.R. §§ 422.111(h) and 423.128(d) as well as the following requirements:

2.12.1.1. Be trained to answer Enrollee inquiries and concerns from Enrollees and potential Enrollees regarding medical, behavioral, and LTSS services provided;

2.12.1.2. Be trained in the use of TTY, video relay services, remote interpreting services, how to provide accessible PDF materials, and other alternative formats;

2.12.1.3. Be capable of speaking directly with, or arranging for an interpreter to speak with, Enrollees in their primary language, including American Sign Language (ASL), or through an alternative language device or telephone translation service;

2.12.1.4. Inform callers that interpreter services are free;

2.12.1.5. Be knowledgeable about Medi-Cal, Medicare, the CFAM-MOU, and the terms of the Contract;

2.12.1.6. Be available to Enrollees to discuss and provide assistance with Enrollee Grievances and complaints;

2.12.1.7. Make oral interpretation services available free-of-charge to Enrollees in all non-English languages spoken by Enrollees, including ASL and how to access those services;

2.12.1.8. Maintain the availability of services, such as TTY services, computer-aided transcription services, telephone handset amplifiers, assistive listening systems, closed caption decoders, videotext displays and qualified interpreters and other services for Deaf and hard of hearing Enrollees;

2.12.1.9. Demonstrate sensitivity to culture, including disability competent care and the independent living philosophy;

2.12.1.10. Provide assistance to Enrollees with cognitive impairments; for example, provide written materials in simple, clear language at a reading level of sixth grade and below, and individualized guidance from ESRs to ensure materials are understood;

2.12.1.11. Provide reasonable accommodations needed to assure effective communication and provide Enrollees with a means to identify their disability to the Contractor;

2.12.1.12. Maintain employment standards and requirements (e.g., education, training, and experience) for Enrollee services department staff and provide a sufficient number of staff to meet defined performance objectives; and

2.12.1.13. Ensure that ESRs make available to Enrollees and potential Enrollees, upon request, information concerning the following:

2.12.1.13.1. Enrollees' rights and responsibilities;

2.12.1.13.2. The procedures for an Enrollee to change plans or to opt out of Cal MediConnect;

2.12.1.13.3. How to access oral interpretation services and written materials in Threshold Languages and alternative formats;

2.12.1.13.4. The identity, locations, qualifications, and availability of Network Providers;

2.12.1.13.5. Information on all Covered Services and other available services or resources (e.g., State agency services) either directly or through referral or authorization;

2.12.1.13.6. Be able to direct Enrollees to the Medi-Cal Dental program for any fee-for-service dental benefits available from Medi-Cal;

2.12.1.13.7. The procedures available to an Enrollee and Network Provider(s) to challenge or Appeal the failure of the Contractor to provide a Covered Service and to Appeal any Adverse Benefit Determinations (denials); and

2.12.1.13.8. Additional information that may be required by Enrollees and potential Enrollees to understand the requirements and benefits of the Cal MediConnect.

2.12.2. Enrollee Service Telephone Responsiveness

2.12.2.1. The Contractor must operate a call center during normal business hours seven (7) days a week, consistent with the required Medicare Communications and Marketing Guidelines and the Marketing Guidance for California Medicare-Medicaid Plans. The Enrollee must be able to speak with a live ESR, Monday through Friday, during normal business hours, consistent with the required Medicare Communications and Marketing Guidelines and the Marketing Guidance for California Medicare-Medicaid Plans. The Contractor may use alternative technologies on Saturdays, Sundays, and State and federal holidays (except New Year's Day). The Contractor's ESR's must answer eighty percent (80%) of all Enrollee telephone calls within thirty (30) seconds or less. The Contractor must limit average hold time to two (2) minutes, with the average hold time defined as the time spent on hold by the caller following the interactive voice response (IVR) system, touch tone response system, or recorded greeting and before reaching a live person. The Contractor must limit the disconnect rate of all incoming calls to five percent (5%). The Contractor must have a process to measure the time from which the telephone is answered to the point at which an Enrollee reaches an ESR capable of responding to the Enrollee's question in a manner that is sensitive to the Enrollee's language and cultural needs.

2.12.3. Coverage Determinations and Appeals Call Center Requirements

2.12.3.1. The Contractor must operate a toll-free call center with live ESRs available to respond to Network Providers or Enrollees for information related to requests for coverage under Medicare or Medi-Cal, and Medicare and Medi-Cal Appeals (including requests for Medicare exceptions and prior authorizations). The Contractor is required to provide immediate access to requests for Medicare and Medi-Cal covered benefits and services, including Medicare coverage determinations and redeterminations, via its toll-free call

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centers. The call centers must operate during normal business hours, as specified in the Medicare Communications and Marketing Guidelines and the Marketing Guidance for California Medicare-Medicaid Plans. The Contractor must accept requests for Medicare or Medi-Cal coverage, including Medicare coverage determinations /redeterminations, outside of normal business hours, but is not required to have live Enrollee service representatives available to accept such requests outside normal business hours. Voicemail may be used outside of normal business hours provided the message:

2.12.3.1.1. Indicates that the mailbox is secure;

2.12.3.1.2. Lists the information that must be provided so the case can be worked (e.g., provider identification, beneficiary identification, type of request (coverage determination or Appeal), physician support for an exception request, and whether the Enrollee is making an expedited or standard request);

2.12.3.1.3. For coverage determination calls (including exceptions requests), articulates and follows a process for resolution within twenty-four (24) hours of call for expedited requests and seventy-two (72) hours for standard requests; and

2.12.3.1.4. For Appeals calls, articulates the process, information needed and provide for a resolution within seventy-two (72) hours for expedited Appeal requests and seven (7) calendar days for standard Part D Appeal requests and thirty (30) days for other standard Appeal requests.

2.12.4. Enrollee Advisory Committee

2.12.4.1. The Contractor shall establish an Enrollee advisory committee that will provide regular feedback to the Contractor's governing board on issues of Demonstration management and Enrollee care. The Contractor shall ensure that the Enrollee advisory committee:

2.12.4.1.1. Meets at least quarterly throughout the Demonstration.

2.12.4.1.2. Is comprised of Enrollees, family members and other caregivers that reflect the diversity of the Demonstration population, including individuals with disabilities. CMS and DHCS reserve the right to review and approve Enrollee membership.

2.12.4.2. The Contractor shall also include Ombudsman reports in quarterly updates to the Enrollee advisory committee and shall participate in all statewide stakeholder and oversight convenings as requested by DHCS and/or CMS.

2.13. IHSS Related Complaints, Grievances and Appeals

2.13.1. For Enrollee complaints, Grievances, or Appeals related to IHSS, Contractor must comply with the established Grievance and Appeal process established by CDSS and by the county agencies responsible for IHSS, in compliance with WIC section 10950.

2.14. Enrollee Grievances

2.14.1. Grievance Filing -- The Contractor shall inform Enrollees that they may file a Grievance through either the Contractor or Cal Medi-Connect Ombuds Program for complaints relating to Medicare and Medi-Cal covered benefits and services. Medicare beneficiaries may also file a Grievance through 1-800 Medicare. The Contractor must display a link to the electronic Grievance form on the Medicare.gov Internet Web site on the Contractor's main web page pursuant to 42 C.F.R. § 422.504 (a)(15)(ii). The Contractor must inform Enrollees of the email address, postal address or toll-free telephone number where an Enrollee Grievance regarding Medicare and Medi-Cal covered benefits and services may be filed. Authorized representatives may file Grievances on behalf of Enrollees to the extent allowed under applicable federal or State law.

2.14.2. Internal (plan level) Grievance: An Enrollee may file an Internal Enrollee Grievance regarding Medicare and Medi-Cal covered benefits and services at any time with the Contractor or its providers by calling or writing to the Contractor or provider. The Contractor must have a system in place for addressing Enrollee Grievances, including Grievances regarding reasonable accommodations and access to services under the ADA.

2.14.2.1. Reporting of plan level Grievances: Contractor shall track and report to DHCS the number and types of inquiries, complaints, Grievances, Appeals, and resolutions related to Cal MediConnect, in compliance with 42 C.F.R. § 438.416 and as described in WIC section 14182.17(e)(4)(E), in the format specified by DHCS in accordance applicable DPL(s) as indicated in Section 2.1.5. DHCS will then make the required information publicly available on DHCS' internet web site.

2.14.2.1.1. Internal Grievance: Contractor shall establish and maintain a Grievance process consistent with 42 C.F.R. Part 438 Subpart F, under which Enrollees may submit their Grievance regarding all Covered Services and benefits to the Contractor. Contractor shall establish and maintain a Grievance process approved by DHCS under which Enrollees may submit their Grievances regarding all benefits and services, consistent with the Knox-Keene Act, and the regulations promulgated thereunder, Welfare and Institutions Code section 14450 and CCR, Title 22, Section 53260.

2.14.2.1.2. The Contractor must maintain written records of all Grievance activities, and notify CMS and DHCS of all internal Grievances. The Grievance record must include the name of the covered person for whom the Grievance was filed; the name of the Contractor's representative recording the grievance; a general description of the reason for the Grievance; the date received; the date of each review or, if applicable, review meeting; and resolution information including date of resolution. The Grievance record must be accessible to CMS and DHCS upon request.

2.14.2.1.3. The system must meet the following standards:

2.14.2.1.3.1. Timely acknowledgement of receipt of each Enrollee Grievance;

2.14.2.1.3.2. Timely review of each Enrollee Grievance;

2.14.2.1.3.3. Response, electronically, orally or in writing, to each Enrollee Grievance within a reasonable time, but no later than thirty (30) days after the Contractor receives the Grievance;

2.14.2.1.3.4. Expedited response, orally or in writing, within twenty-four (24) hours after the Contractor receives the Grievance to each Enrollee Grievance whenever Contractor extends the Appeals timeframe or Contractor refuses to grant a request for an expedited Appeal; and

2.14.2.1.3.5. Notice to the Enrollee of the disposition of the grievance. The Notice must meet the requirements of 42 C.F.R. § 438.408(d)(1), and must:

2.14.2.1.3.5.1. Be produced in a manner, format, and language that can be easily understood;

2.14.2.1.3.5.2. Be made available in Threshold Languages, upon request;

2.14.2.1.3.5.3. Include information, in the most commonly used languages about how to request translation services and alternative formats; and

2.14.2.1.3.5.4. Include information about availability to Enrollees of information about Enrollee Appeals, as described in Section 2.15, including reasonable assistance with Enrollee Grievances and Appeals in completing any forms or other procedural steps, which shall include interpreter services and toll-

free numbers with TTY/TDD and interpreter capability.

2.14.2.1.3.6. In compliance with 42 C.F.R. § 438.406(b), procedures to ensure that decision makers on Grievances were not involved in previous levels of review or decision-making nor were a subordinate of any such individual, and who are health care professionals with clinical expertise in treating the Enrollee's condition or disease if any of the following apply:

2.14.2.1.3.6.1. A Grievance regarding denial of expedited resolutions of an Appeal.

2.14.2.1.3.6.2. Any Grievance or Appeal involving clinical issues.

2.14.2.1.3.7. In addition to Grievance logs required by Medicare and Medi-Cal rules and 42 C.F.R. § 438.416, per CA Health and Safety Code section 1368(a)(4)(B) and Title 28 CCR 1300.68(d)(8), the Contractor shall maintain a log of all Exempt Grievances. The log shall be periodically reviewed by the plan and shall include the following information for each Exempt Grievance:

2.14.2.1.3.7.1. The date of the call

2.14.2.1.3.7.2. The name of the complainant

2.14.2.1.3.7.3. The complainant's member identification number

2.14.2.1.3.7.4. The nature of the Grievance

2.14.2.1.3.7.5. The nature of the resolution

2.14.2.1.3.7.6. The name of the plan representative who took the call and resolved the Grievance

2.14.2.1.3.8. Notice to the Enrollee of the disposition of the Grievance.

2.14.3. External Grievance: The Contractor shall inform Enrollees that they may file an external Grievance for Medicare only covered benefits and services through 1-800-Medicare or for Medicare and Medi-Cal covered benefits and services through the Cal MediConnect Ombudsman program. The Contractor must display a link to the electronic Grievance form on the Medicare.gov Internet Web site on the Contractor's main web page per 42 C.F.R. § 422.504(a)(15)(ii).

2.14.3.1. The Contractor must inform Enrollees of the email address, postal address or toll-free telephone number where an Enrollee Grievance may be filed.

2.14.3.2. Consistent with Health & Safety Code Section 1368(b), Contractor, except for non-Knox Keene Act Licensed COHS plans, shall inform Enrollees that they may file an External Grievance for Medi-Cal only covered benefits and services through DMHC's consumer complaint process. Contractor shall inform Enrollees of the DMHC's toll-free telephone number, DMHC's TDD line for the hearing and speech impaired, and DMHC's website address pursuant to Health & Safety Code Section 1368.02

2.15. Enrollee Appeals

2.15.1. Integrated Notice of Action— In accordance with 42 C.F.R. §§ 431.206, 438.404 and 42 C.F.R. §§ 422.568-572, the Contractor must give the Enrollee written notice of any Adverse Benefit Determination. Enrollees will be notified of all applicable Cal MediConnect, Medicare and Medi-Cal Appeal rights through a single notice. The form and content of the notice must be approved by CMS and DHCS. The Contractor shall notify the Enrollee of its decision at least ten (10) days in advance of the date of its action.

2.15.1.1. The notice must explain:

2.15.1.1.1. The action the Contractor has taken or intends to take;

2.15.1.1.2. The reasons for the action, including the right of the Enrollee to be provided upon request and free of charge, reasonable access to and copies of all documents, records, and other information

relevant to the Enrollee's Adverse Benefit Determination. Such information includes medical necessity criteria, and any processes, strategies, or evidentiary standards used in setting coverage limits;

2.15.1.1.3. The citation to the regulations supporting such action

2.15.1.1.4. The Enrollee's, provider's, or authorized representative's right to file an Appeal with the Contractor and whether exhaustion of the Contractor's internal Appeal process is a prerequisite to additional external review from by Medicare, Independent Medical Review by DMHC (if applicable), or a State Fair Hearing;

2.15.1.1.5. Procedures for exercising Enrollee's rights to Appeal;

2.15.1.1.6. Circumstances under which expedited resolution is available and how to request it; and

2.15.1.1.7. If applicable, the Enrollee's rights to have benefits continue pending the resolution of the plan level Appeal.

2.15.1.2. Contractor must provide a member notice of resolution, as expeditiously as the Enrollee's health condition requires, not exceeding thirty (30) calendar days from the day Contractor receives the Appeal, or in the case of an expedited Appeal within seventy-two (72) hours as described in section 2.15.3.5. An Enrollee notice, at a minimum, must include the result and date of the Appeal resolution. For decisions not wholly in the Enrollee's favor, Contractor, at a minimum must include:

2.15.1.2.1. Enrollee's right to request a State Fair Hearing;

2.15.1.2.2. How to request a State Fair Hearing;

2.15.1.2.3. Right to continue to receive benefits pending a State Fair Hearing;

2.15.1.2.4. How to request the continuation of benefits;

2.15.1.2.5. That Enrollee may be liable for cost of any continued benefits if the Contractor's action is upheld on Appeal;

2.15.1.2.6. Enrollee's right to file an external Grievance through DMHC's consumer complaint process or request an Independent Medical Review from DMHC with respect to any and all disputes concerning Medi-Cal based services that are medical in nature and that relate to health care service plan obligations set forth under the Knox-Keene Act and the regulations promulgated thereunder.; and

2.15.1.2.7. How to file an external Grievance through DMHC's consumer complaint process or request an Independent Medical Review from DMHC.

2.15.1.2.8. COHS plans that have not obtained a Knox-Keene license are not required to comply with 2.15.1.2.6 and 2.15.1.2.7 of this Contract.

2.15.1.3. Contractors without a Knox-Keene license may extend the timeframe to resolve an Appeal by up to fourteen (14) days if the Enrollee requests the extension, or Contractor shows that there is a need for additional information and how the delay is in the Enrollee's interest. Contractor must provide the Enrollee with written notice within two (2) calendar days of the reason for the extension and inform the Enrollee of the right to file a Grievance if they disagree with the delay; and the Contractor must make reasonable efforts to provide prompt oral notice of the delay. Effective January 1, 2020, Contractors with a Knox-Keene license may not allow extensions to resolve Appeals.

2.15.1.4. Written material must use easily understood language and format, be available in alternative formats, and in an appropriate manner that takes into consideration those with special needs. The Contractor must inform Enrollees that information is available in alternative formats and how to access those formats.

2.15.2. Appeals relating to Medi-Cal covered benefits and services shall proceed pursuant to the laws and regulations governing Medi-Cal Appeals. Appeals relating to Medicare covered benefits and services

shall proceed pursuant to the laws and regulations governing Medicare Appeals.

2.15.2.1. Written notice must be translated for Enrollees who speak Threshold Languages.

2.15.2.2. Written notices must include language clarifying that oral interpretation is available for all languages and how to access it.

2.15.2.3. The Contractor must maintain written records of all Appeals activities. The Appeal record must include the name of the covered person for whom the Appeal was filed; the name of the Contractor's representative recording the Appeal; a general description of the reason for the Appeal; the date received; the date of each review or, if applicable, review meeting; and resolution information for each level of Appeal including date of resolution. The Appeal record must be accessible to CMS and DHCS upon request.

2.15.3. Medi-Cal Appeals and beneficiary protections will be maintained for Appeals regarding Medi-Cal services.

2.15.3.1. Enrollee or provider may file an Appeal with the Contractor either orally or in writing. The Contractor shall assist the Enrollee in confirming an oral Appeal in writing.

2.15.3.2. Enrollee, the Enrollee's authorized representative, or a Provider with the Enrollee's written consent, may file the oral or written Enrollee Appeal with the Contractor within sixty (60) calendar days after date of the Integrated Notice of Action.

2.15.3.3. Contractor must:

2.15.3.3.1. Timely acknowledge receipt of each Enrollee Appeal, including provide a written acknowledgemnent to the Enrollee within 5 calendar days of receipt.

2.15.3.3.2. Ensure that oral inquiries seeking to Appeal an action are treated as Appeals and confirm those

inquiries in writing unless the Enrollee or provider requests expedited resolution.

2.15.3.3.3. Provide a reasonable opportunity to present evidence and allegation of fact or law, in person, as well as in writing.

2.15.3.3.4. Provide the Enrollee and representative the Enrollee's case file, including medical records, and any other documents and records free of charge. The Enrollee's case file must be provided sufficiently in advance of the resolution timeframes.

2.15.3.3.5. Consider the Enrollee, representative, or estate representative of a deceased Enrollee as parties to the Appeal.

2.15.3.3.6. In compliance with 42 C.F.R. § 438.406(b), ensure that decision makers on Appeals were not involved in previous levels of review or decision-making nor a subordinate of any such individual and are health care professionals with clinical expertise in treating the Enrollee's condition or disease if any of the following apply:

2.15.3.3.6.1. A denial of an Appeal based on lack of medical necessity;

2.15.3.3.6.2. A Grievance regarding denial of expedited resolution of an Appeal; or

2.15.3.3.6.3. Any Appeal involving clinical issues.

2.15.3.4. Contractor shall implement and maintain an Enrollee internal Appeals system, which includes oversight of any First Tier, Downstream or Related Entity, in accordance with all applicable federal and State laws and regulations, including but not limited to the following:

2.15.3.4.1. Federal Medicaid regulations governing Medi-Cal Managed Care Appeals and Medi-Cal Appeals in general, at 42 C.F.R. 431 Subpart E and 42 C.F.R. 438 Subpart F.

2.15.3.4.2. Standards for expedited review of Grievances involving an imminent and serious threat to the health of the Enrollee: Title 28, CCR, Sections 1300.68 and 1300.68.01;

2.15.3.4.3. Internal Contractor Appeal processes, in accordance with the Knox-Keene Act and the regulations promulgated thereunder, and external Appeal processes in accordance with DMHC's Independent Medical Review System set forth in Article 5.55 of the Knox-Keene Act (commencing with Health & Safety Code Section 1374.30) and the regulations promulgated thereunder; and the fair hearing standards for Medi-Cal managed care, Title 22, CCR, Sections 51014.1, 51014.2, 53894, and 53858, as well as 42 C.F.R. § 431.244 related to standard and expedited fair hearings decisions;

2.15.3.4.4. Twelve (12) month continuity of care under certain circumstances. WIC section14182.17 (d)(7)(A)(ii).

2.15.3.5. Expedited internal Medi-Cal Appeals**.** Contractor shall comply with all State law and regulations pertaining to expedited Appeals, as well as the following requirements:

2.15.3.5.1. Contractor shall implement and maintain procedures as described below to resolve expedited internal Appeals for Medi-Cal services. These procedures shall be followed whenever Contractor determines or the provider indicates that taking the time for a standard resolution could seriously jeopardize the Enrollee's life, health, or ability to attain, maintain, or regain maximum function.

2.15.3.5.2. Enrollee or provider may file an expedited Appeal either orally or in writing, and no additional Enrollee follow-up is required.

2.15.3.5.3. Contractor must inform the Enrollee of the limited time available for the Enrollee to present evidence and allegations of fact or law, in person and in writing.

2.15.3.5.4. Contractor must provide an Enrollee notice as quickly as the Enrollee's health condition requires, not exceeding 72 hours from the Contractor's receipt of the Appeal.

2.15.3.5.5. Contractor without a Knox-Keene license may extend the timeframe to resolve an Appeal by up to fourteen (14) days if the Enrollee requests the extension, or Contractor shows that there is a need for additional information and how the delay is in the Enrollee's interest. Contractor must make reasonable efforts to provide the Enrollee prompt oral notice, and provide the Enrollee with written notice of the reason for the extension within 2 calendar days and inform the Enrollee of the right to file a Grievance if they disagree with the delay. Contractor must issue and carry out its determination as expeditiously as the Enrollee's health condition requires and no later than the date the extension expires. Effective January 1, 2020, Contractors with a Knox-Keene license may not allow extensions to resolve Appeals.

2.15.3.5.6. Contractor must provide written notice and must make a reasonable effort to provide oral notice of expedited Appeal decision.

2.15.3.5.7. Contractor must ensure that punitive action is not taken against a provider who either requests an expedited resolution or supports an Enrollee's Appeal.

2.15.3.5.8. If Contractor denies a request for expedited resolution of an Appeal, it must:

2.15.3.5.8.1. Transfer the Appeal to the standard timeframe of no longer than thirty (30) calendar days from the day the Contractor receives the Appeal with a possible fourteen (14) day extension for Contractactors without a Knox-Keene licsense, and

2.15.3.5.8.2. Give the Enrollee prompt oral notice of the denial of a request for expedited resolution and a written notice within two (2) calendar days.

2.15.3.6. Responsibilities in State Fair Hearings Related to Medi-Cal Benefits and Services**.** Contractor shall comply with all regulations and procedures regarding State Fair Hearings, set forth in the Manual of Policies and Procedures issued by the California Department of Social Services, pursuant to Title 22, CCR, Section 50953. Contractor shall have the following responsibilities with respect to State Fair Hearings that are expedited, in compliance with CDSS All County Letter 13-40.

2.15.3.6.1. An Enrollee, or an Enrollee's authorized representative, may request a State Fair Hearing either orally or in writing, consistent with 42 C.F.R. § 431.221.

2.15.3.7. Parties to an internal Medi-Cal Appeal or State Fair Hearing.

2.15.3.7.1. The parties to an internal plan Appeal or the State Fair Hearing related to a Medi-Cal benefit or service include the Contractor as well as the Enrollee and his or her representative or the representative of a deceased Enrollee's estate.

2.15.3.8. Responsibilities in Independent Medical Reviews (IMR) Related to Medi-Cal Benefits and Services. Contractor, except for non-Knox Keene Act licensed COHS plans, shall comply with all statutes, regulations and procedures regarding DMHC's Independent Medical Review System, as set forth in the Knox-Keene Act and the regulations promulgated thereunder, including but not limited to the following requirements:

2.15.3.8.1. Enrollees may request an IMR regarding Medi-Cal services from DMHC within six (6) months of a denial, modification or delay of a Medi-Cal service based on Contractor's determination, in whole or in part, that the service is not medically necessary. Health & Safety Code Section 1374.30.

2.15.3.8.2. Enrollees shall not be required to participate in Contractor's internal Appeal process for more than thirty (30) days before applying for an IMR. Health & Safety Code Section 1368(b)(1)(A).

2.15.3.8.3. Enrollees whose Appeal requires expedited review pursuant to Health & Safety Code Section 1368.01 shall not be required to participate in the Contractor's Internal Grievance process for more than three (3) days before applying for an IMR. Health & Safety Code Section 1374.30(j)(3).

2.15.3.8.4. Enrollees may apply for an IMR without first participating in Contractor's Internal Appeal process in extraordinary and compelling cases, as determined by DMHC, and in cases where Enrollee's request for an experimental treatment was denied. Health & Safety Code Section 1368.03 and 1374.31(a); Title 28, CCR Section 1300.70.4(b)(2).

2.15.3.8.5. Contractor must notify Enrollee in writing of the opportunity to request an IMR of a decision denying an experimental therapy within five (5) business days of the decision to deny coverage. Title 28, CCR Section 1300.70.4(b); Health & Safety Code Section 1370.4(c)(1).

2.15.3.8.6. Enrollees may not request an IMR if a State Fair Hearing has already been held on the issue. Title 28, CCR Section 1300.74.30(f)(3).

2.15.3.8.7. If DMHC determines that Enrollee is not eligible for an IMR, the Enrollee's case will be reviewed through DMHC's consumer complaint process. Health & Safety Code Section 1368(b).

2.15.4. Medicare Appeals rights and protections will be maintained and enhanced for Medicare services only.

2.15.4.1. Federal Regulations and law will continue to govern all Medicare Appeals regarding Medicare services. As outlined in the MOU, Enrollees will continue to have access to the existing Medicare Part C and Part D Appeals processes. The

Medicare Part C process is set forth at 42 C.F.R. Part 422, Subpart M and in Chapter 13 of the Medicare Managed Care Manual. The Medicare Part D process is set forth at 42 C.F.R. Part 423, Subparts M and U and in Chapter 18 of the Medicare Prescription Drug Benefit Manual.

2.15.4.2. Hospital Discharge and other Discharge Appeals

2.15.4.2.1. The Contractor must comply with the hospital discharge Appeal requirements at 42 C.F.R. §§ 422.620-422.622.

2.15.4.2.2. The Contractor must comply with the termination of services Appeal requirements for individuals receiving services from a comprehensive outpatient rehabilitation facility, SNF, or home health agency at 42 C.F.R. §§ 422.624 and 422.626.

2.15.5. Continuation of Benefits Pending an Appeal

2.15.5.1. Medicare Benefits and Services

2.15.5.1.1. The Contractor must continue providing benefits for all prior approved non-Part D Medicare benefits for which a Contractor has issued a NOA for termination or modification pending completion of the internal Contractor Appeal. This means that such benefits will continue to be provided to Enrollees and that the Contractor must continue to pay providers for providing such services or benefits pending an internal Appeal.

2.15.5.1.2. Payments will not be recouped based on the outcome of the Appeal for services covered during all pending Appeals.

2.15.5.2. Medi-Cal Benefits and Services

2.15.5.2.1. The Contractor must continue providing all prior approved Medi-Cal benefits for which a Contractor has issued a NOA for termination or modification pending completion of the internal Contractor Appeal or per timeframes in 42 C.F.R. § 438.420, whichever comes first. This means that such benefits will continue to be provided to

Enrollees and that the Contractor must continue to pay providers for providing such services or benefits until the completion of the hearing process, or until the Enrollee withdraws the Appeal request or fails to file timely per the timeframes in 42 C.F.R. § 438.420, whichever comes first.

2.15.5.2.2. Payments will not be recouped based on the outcome of the Appeal for services covered during all pending Appeals.

2.15.6. In the event that the Enrollee pursues the Appeal in multiple forums (for example, if the Enrollee files for a State Fair Hearing while the IRE decision is pending) and receives conflicting decisions, the Contractor is bound by, and must act in accordance with, the decision favorable to the Enrollee or the decision closest to the Enrollee's relief requested on Appeal.

2.16. Quality Improvement Program

2.16.1. Quality Improvement (QI) Program. The Contractor shall:

2.16.1.1. Deliver quality care that enables Enrollees to stay healthy, get better, manage chronic illnesses and/or disabilities, and maintain/improve their quality of life. Quality care refers to:

2.16.1.1.1. Quality of physical health care, including primary and specialty care;

2.16.1.1.2. Quality of Behavioral Health services focused on recovery, resiliency and rehabilitation;

2.16.1.1.3. Quality of LTSS;

2.16.1.1.4. Adequate access and availability to primary, Behavioral Health services, specialty health care, and LTSS providers and services;

2.16.1.1.5. Continuity and coordination of care across all care and services settings, and for transitions in care; and

2.16.1.1.6. Enrollee experience and access to high quality, coordinated and culturally competent clinical care

and services, inclusive of LTSS across the care continuum.

2.16.2. Apply the principles of Continuous Quality Improvement (CQI) to all aspects of the Contractor's service delivery system through ongoing analysis, evaluation and systematic enhancements based on:

2.16.2.1. Quantitative and qualitative data collection and data-driven decision-making;

2.16.2.2. Up-to-date evidence-based practice guidelines and explicit criteria developed by recognized sources or appropriately certified professionals or, where evidence-based practice guidelines do not exist, consensus of professionals in the field;

2.16.2.3. Feedback provided by Enrollees and providers in the design, planning, and implementation of its CQI activities;

2.16.2.4. Rapid Cycle Quality Improvement, when appropriate, as determined by DHCS;

2.16.2.5. Issues identified by the Contractor, DHCS and/or CMS; and

2.16.2.6. Ensure that the QI requirements of this Contract are applied to the delivery of primary and specialty health care services, Behavioral Health services and LTSS.

2.16.3. QI Program Structure

2.16.3.1. The Contractor shall maintain a well-defined QI organizational and program structure that supports the application of the principles of CQI to all aspects of the Contractor's service delivery system. The QI program must be communicated in a manner that is accessible and understandable to internal and external individuals and entities, as appropriate. The Contractor's QI organizational and program structure shall comply with all applicable provisions of 42 C.F.R. § 438, including Subpart E, Quality Assessment and Performance Improvement, 42 C.F.R. § 422, Subpart D Quality Improvement, and shall meet the quality management and improvement criteria described in the most current NCQA health plan accreditation requirements in 28 CCR Section 1300.70.

2.16.3.2. The Contractor shall:

2.16.3.2.1. Establish a mechanism to detect both underutilization and overutilization of services and assess the quality and appropriateness of care furnished to Enrollees with special health care needs.

2.16.3.2.2. Establish a set of QI functions and responsibilities that are clearly defined and that are proportionate to, and adequate for, the planned number and types of QI initiatives and for the completion of QI initiatives in a competent and timely manner;

2.16.3.2.3. Ensure that such QI functions and responsibilities are assigned to individuals with the appropriate skill set to oversee and implement an organization-wide, cross-functional commitment to, and application of, CQI to all clinical and non-clinical aspects of the Contractor's service delivery system;

2.16.3.2.4. Establish internal processes to ensure that the quality management activities for primary, specialty, Behavioral Health services, and LTSS reflect utilization across the Provider Network and include all of the activities in this Section 2.16 of this Contract and, in addition, the following elements:

2.16.3.2.4.1. A process to utilize Healthcare Plan Effectiveness Data and Information Set (HEDIS), Consumer Assessment of Healthcare Providers and Services (CAHPS), the Health Outcomes Survey (HOS) and other measurement results in designing QI activities;

2.16.3.2.4.2. A medical record review process for monitoring Provider Network compliance with policies and procedures, specifications and appropriateness of care. Such process shall include the sampling method used which shall be proportionate to

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utilization by service type. The Contractor shall submit its process for medical record reviews and the results of its medical record reviews to DHCS;

2.16.3.2.4.3. A process to measure Provider Network and Enrollees, at least annually, regarding their satisfaction with the Contractor's plan. The Contractor shall submit a survey plan to DHCS for approval and shall submit the results of the survey to DHCS and CMS;

2.16.3.2.4.4. A process to measure clinical reviewer consistency in applying clinical criteria to utilization management activities, using inter-rater reliability measures;

2.16.3.2.4.5. A process for including Enrollees and their families in quality management activities, as evidenced by participation in consumer advisory boards; and

2.16.3.2.4.6. In collaboration with and as further directed by DHCS, develop a customized medical record review process to monitor the assessment for and provision of LTSS.

2.16.3.2.5. Have in place a written description of the QI Program that delineates the structure, goals, and objectives of the Contractor's QI initiatives. Such description shall include the following:

2.16.3.2.5.1. Organizational commitment to the delivery of quality health care services as evidenced by goals and objectives which are approved by Contractor's governing body and periodically evaluated and updated.

2.16.3.2.5.2. Organizational chart showing the key staff and the committees and bodies

responsible for quality improvement activities including reporting relationships of QI committee(s) and staff within the Contractor's organization.

2.16.3.2.5.3. Qualifications of staff responsible for quality improvement studies and activities, including education, experience and training.

2.16.3.2.5.4. The role, structure, and function of the Quality Improvement Committee.

2.16.3.2.5.5. The processes and procedures designed to ensure that all Covered Services that are Medically Necessary are available and accessible to all Enrollees regardless of race, color, national origin, creed, ancestry, religion, language, age, gender, marital status, sexual orientation, health status, or disability, and that all Covered Services that are Medically Necessary are provided in a culturally and linguistically appropriate manner.

2.16.3.2.5.6. 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 Enrollees are able to obtain appointments within established standards.

2.16.3.2.5.7. Description of the quality of clinical care services provided, including, but not limited to, preventive services for children and adults, perinatal care, primary care, specialty, emergency, inpatient, and ancillary care services.

2.16.3.2.5.8. Description of the activities, including activities used by persons with chronic

conditions, designed to assure the provision of case management, coordination and continuity of care services. Such activities shall include, but are not limited to, those designed to assure availability and access to care, clinical services and care management.

2.16.3.2.5.9. A description of the mechanisms used to provide feedback to staff and providers regarding QI outcomes.

2.16.3.2.6. Address all aspects of health care, including specific reference to Behavioral Health services and to LTSS, with respect to monitoring and improvement efforts, and integration with physical health care. Behavioral Health and LTSS aspects of the QI program may be included in the QI description, or in a separate QI Plan referenced in the QI description as follows:

2.16.3.2.6.1. Address the roles of the designated physician(s), Behavioral Health clinician(s), and LTSS providers with respect to QI program;

2.16.3.2.6.2. Identify the resources dedicated to the QI program, including staff, or data sources, and analytic programs or IT systems; and

2.16.3.2.6.3. Include organization-wide policies and procedures that document processes through which the Contractor ensures clinical quality, access and availability of health care and services, and continuity and coordination of care. Such processes shall include, but not be limited to, Appeals and Grievances and utilization management.

2.16.3.2.7. Plans in Los Angeles and Orange counties must initiate QI activities for Enrollees in Medicare LTI status per Section 4.2.2.2.6.4.

2.16.3.2.7.1. QI activities under this initiative are subject to CMT approval.

2.16.3.3. Delegation of Quality Improvement Activities

2.16.3.3.1. Contractor is accountable for all QI functions and responsibilities (e.g. utilization management, credentialing and site review) that are delegated to First Tier, Downstream, and Related Entities.

2.16.3.3.2. Contractor shall maintain a system to ensure accountability for delegated QI activities, that at a minimum:

2.16.3.3.2.1. Evaluates First Tier, Downstream and Related Entity's ability to perform the delegated activities including an initial review to assure that the First Tier, Downstream, and Related Entity has the administrative capacity, task experience, and budgetary resources to fulfill its responsibilities;

2.16.3.3.2.2. Ensures First Tier, Downstream, and Related Entity meets standards set forth by the Contractor and DHCS; and

2.16.3.3.2.3. Includes the continuous monitoring, evaluation and approval of the delegated functions.

2.16.3.3.3. Submit to DHCS and CMS an annual QI Work Plan that shall include the following components or other components as directed by DHCS and CMS:

2.16.3.3.3.1. Planned clinical and non-clinical initiatives;

2.16.3.3.3.2. The objectives for planned clinical and non-clinical initiatives;

2.16.3.3.3.3. The short and long term time frames within which each clinical and non-clinical initiative's objectives are to be achieved;

2.16.3.3.3.4. The individual(s) responsible for each clinical and non-clinical initiative;

2.16.3.3.3.5. Any issues identified by the Contractor, DHCS, Enrollees, and providers, and how those issues are tracked and resolved over time;

2.16.3.3.3.6. Program review process for formal evaluations that address the impact and effectiveness of clinical and non-clinical initiatives at least annually; and

2.16.3.3.3.7. Process for correcting deficiencies.

2.16.3.3.4. Evaluate the results of QI initiatives at least annually, and submit the results of the evaluation to DHCS and CMS. The evaluation of the QI program initiatives shall include, but not be limited to, the results of activities that demonstrate the Contractor's assessment of the quality of physical and Behavioral Health services rendered, the effectiveness of LTSS, and accomplishments and compliance and/or deficiencies in meeting the previous year's QI Strategic Work Plan; and

2.16.3.3.5. Contractor shall develop a QI report for submission to DHCS and CMS on an annual basis. The annual report shall include:

2.16.3.3.5.1. An Assessment of the QI activities undertaken and an evaluation of areas of success and needed improvements in services rendered within the QI program, including but not limited to:

2.16.3.3.5.1.1. The collection of aggregate data on utilization;

2.16.3.3.5.1.2. The review of quality of services rendered; and

2.16.3.3.5.1.3. Outcomes/findings from Quality Improvement Projects (QIPs),

consumer satisfaction surveys and collaborative initiatives.

2.16.3.3.5.2. Consistent with 42 C.F.R. § 438.332(b), copies of all final reports of non-governmental accrediting agencies (e.g. JCAHO, NCQA) relevant to the Contractor's Medi-Cal line of business, including accreditation status, any deficiencies noted, and expiration date of the accreditation. Include the corrective action plan developed to address noted deficiencies.

2.16.3.3.5.3. An assessment of First Tier, Downstream and Related Entity's performance of delegated QI activities.

2.16.3.3.6. Maintain sufficient and qualified staff employed by the Contractor to manage the QI activities required under the Contract, and establish minimum employment standards and requirements (e.g. education, training, and experience) for employees who will be responsible for quality management. QI staff shall include:

2.16.3.3.6.1. At least one designated physician, who shall be a medical director or associate medical director, at least one designated Behavioral Health provider, and a professional with expertise in the assessment and delivery of LTSS with substantial involvement in the QI program; and

2.16.3.3.6.2. A qualified individual to serve as the Cal MediConnect QI Director.

2.16.4. QI Activities

2.16.4.1. Performance Measurement

2.16.4.1.1. The Contractor shall engage in performance measurement and performance improvement projects, designed to achieve, through ongoing

measurement and intervention, significant improvements, sustained over time, in clinical care and non-clinical care processes, outcomes and Enrollee experience. The Contractor's QI program must include a health information system to collect, analyze, and report quality performance data as described in 42 C.F.R. §§ 422.516(a), 422.152, 423.514, 438.242(a) and (b), and 330.

2.16.4.1.2. Performance improvement projects must involve:

2.16.4.1.2.1. Measurement of performance using objective quality indicators

2.16.4.1.2.2. Implementation of systems interventions to achieve improvement in quality

2.16.4.1.2.3. Evaluation of the effectiveness of the interventions

2.16.4.1.2.4. Planning and initiation of activities for increasing and sustaining improvement

2.16.4.1.3. Measurement and improvement projects shall be conducted in accordance with requirements in the CFAM-MOU, Figure 7-1 core quality measures, and as specified in this Contract, and shall include, but are not limited to:

2.16.4.1.3.1. All HEDIS, HOS and CAHPS data, as well as all other measures specified in Figure 7-1 core quality measures of the MOU referenced above (Figure 7-1). HEDIS, HOS and CAHPS must be reported consistent with Medicare requirements. All existing Part D metrics will be collected as well. Additional details, including technical specifications, will be provided in annual guidance for the upcoming reporting year.

2.16.4.1.3.2. The Contractor shall collect annual data and contribute to all Demonstration QI-related processes, as directed by DHCS and CMS, as follows:

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2.16.4.1.3.2.1. Collect and submit to DHCS, CMS and/or CMS' contractors, in a timely manner, data for the measures;

2.16.4.1.3.2.2. Contribute to all applicable DHCS and CMS data quality assurance processes, shall include, but not be limited to, responding, in a timely manner, to data quality inadequacies identified by DHCS and rectifying those inadequacies, as directed by DHCS

2.16.4.1.3.2.3. The Contractor shall demonstrate how to utilize results of the measures specified in any CMS and DHCS reporting requirements documents in designing QI initiatives.

2.16.4.2. Consumer Satisfaction Survey:

2.16.4.2.1. At intervals as determined by DHCS, DHCS' contracted EQRO will conduct a consumer satisfaction survey of a representative sample of Enrollees in each county, as determined by the technical specifications of the survey instrument chosen by DHCS. If requested, Contractor shall provide appropriate data to the EQRO to facilitate this survey.

2.16.4.3. Quality Improvement Project (QIP)Requirements

2.16.4.3.1. The Contractor shall implement and adhere to all processes relating to the QIP requirements, as directed by DHCS and CMS, and as follows:

2.16.4.3.1.1. In accordance with 42 C.F.R. § 438.330 (b) and (d) collect information and data in accordance with QIP requirement specifications for its Enrollees; using the format and submission guidelines specified

by DHCS and CMS in annual guidance provided for the upcoming Contract year;

2.16.4.3.1.2. The Contractor is required to conduct or participate in two (2) QIPS approved by DHCS. If Contractor holds multiple managed care contracts with DHCS, Contractor is required to conduct or participate in no more than two (2) QIPS for each Contract.

2.16.4.3.1.2.1. One (1) QIP must be an internal quality improvement project (IQIP), the requirements of which may be met by the completion of the Medicare QIP process.

2.16.4.3.1.2.2. One (1) QIP must be a DHCS facilitated statewide collaborative in accordance with applicable DPL(s) as indicated in Section 2.1.5.

2.16.4.4. Implement the QIP requirements, in a culturally competent manner;

2.16.4.5. Evaluate the effectiveness of QIP interventions, completed in a reasonable time period as to generally allow information on the success of performance improvement projects in the aggregate to produce new information on quality of care every year;

2.16.4.6. Plan and initiate processes to sustain achievements and continue improvements;

2.16.4.7. Submit to DHCS and CMS, if requested by CMS or DHCS, comprehensive written reports, using the format, submission guidelines and frequency specified by DHCS and CMS. Such reports shall include information regarding progress on QIP requirements, barriers encountered and new knowledge gained. As directed by DHCS and CMS, the Contractor shall present this information to DHCS and CMS, if requested, at the end of the QI requirement project cycle as determined by DHCS and CMS; and

2.16.4.8. In accordance with 42 C.F.R. § 422.152 (c), develop a Chronic Care Improvement Program (CCIP) and establish criteria for participation in the program. The CCIP must be relevant to and target the Contractor's plan population. Although the Contractor has the flexibility to choose the design of their CCIPs, DHCS and CMS may require them to address specific topic areas.

2.16.5. External Quality Review (EQR) Activities

2.16.5.1. The Contractor shall take all steps necessary to support the EQRO contracted by DHCS and the QIO to conduct EQR activities, in accordance with 42 C.F.R. § 438.358 and 42 C.F.R. § 422.153. Contractor shall address the findings of the external review through its QI program. Contractor shall develop and implement performance improvement goals, objectives, and activities in response to the EQR findings as part of Contractor's QI program. A description of the performance improvement goals, objectives, and activities developed and implemented in response to the EQRO findings will be included in Contractor's QI program. DHCS may also require separate submission of an improvement plan specific to the findings of the EQRO. EQR activities shall include, but are not limited to the following:

2.16.5.1.1. Annual validation of performance measures reported to DHCS, as directed or calculated by DHCS;

2.16.5.1.2. Annual validation of QI projects required by DHCS and CMS; and

2.16.5.1.3. At least once every three (3) years, review of compliance with standards mandated by 42 C.F.R. Part 438, Subpart D, 42 C.F.R. Part 422, Subpart D, and 42 C.F.R. Part 423, Subpart D, and at the direction of DHCS, regarding access, structure and operations, and quality of care and services furnished to DHCS. The Contractor shall take all steps necessary to support the EQRO and QIO in conducting EQR activities including, but not limited to:

2.16.5.1.3.1. Designating a qualified individual to serve as project director for each EQR activity who shall, at a minimum perform the following activities:

2.16.5.1.3.1.1. Oversee and be accountable for compliance with all aspects of the EQR activity;

2.16.5.1.3.1.2. Coordinate with staff responsible for aspects of the EQRO activity and ensure that staff respond to requests by the EQRO, QIO, DHCS and CMS staff in a timely manner;

2.16.5.1.3.1.3. Serve as the liaison to the EQRO, QIO, DHCS and CMS and answer questions or coordinate responses to questions from the EQRO, QIO, CMS and DHCS in a timely manner; and

2.16.5.1.3.1.4. Ensure timely access to information systems, data, and other resources, as necessary for the EQRO and/or QIO to perform the EQR activity and as requested by the EQRO, QIO, CMS or DHCS.

2.16.5.1.3.2. Maintaining data and other documentation necessary for completion of EQR activities specified above. The contractor shall maintain such documentation for a minimum of ten (10) years;

2.16.5.1.3.3. Reviewing the EQRO's draft EQR report and offering comments and documentation to support the correction of any factual errors or omissions, in a timely manner, to the EQRO or

2.16.5.1.4. Participating in meetings relating to the EQR process, EQR findings, and/or EQR trainings with the EQRO and DHCS;

2.16.5.1.5. Implementing actions, as directed by DHCS and/or CMS, to address recommendations for QI made by the EQRO or QIO, and sharing outcomes and results of such activities with the EQRO or QIO, and CMS in subsequent years; and

2.16.5.1.6. Participating in any other activities deemed necessary by the EQRO and/or QIO and approved by DHCS and CMS.

2.16.6. CMS-Specified Performance Measurement and Performance Improvement Projects

2.16.6.1. The Contractor shall conduct additional performance measurement or performance improvement projects if mandated by CMS pursuant to 42 C.F.R. § 438.330.

2.16.7. Clinical Practice Guidelines

2.16.7.1. The Contractor shall adopt, disseminate, and monitor the use of clinical practice guidelines relevant to Enrollees that are:

2.16.7.1.1. Based on valid and reliable clinical evidence or a consensus of health care professionals;

2.16.7.1.2. Consider the needs of Enrollees;

2.16.7.1.3. Developed in consultation with contracting health care professionals;

2.16.7.2. Contractor will review and update practice guidelines periodically as appropriate

2.16.7.3. Contractor will disseminate the practice guidelines to all affected providers and upon request, to Enrollees and potential Enrollees.

2.16.7.4. Delegated Credentialing: Contractor may delegate credentialing and recredentialing activities. If Contractor delegates these activities, Contractor shall comply with:

2.16.7.4.1. Credentialing Provider Organization Certification: Contractor and their Network Providers (e.g. a medical group or independent physician organization) may obtain credentialing provider organization certification (POC) from the NCQA.

2.16.7.5. Contractor shall ensure that all contracted laboratory testing sites have either a Clinical Laboratory Improvement Act (CLIA) certificate or waiver of a certificate of registration along with a CLIA identification number.

2.16.7.6. Disciplinary Actions: Contractor shall implement and maintain a system for the reporting of serious quality deficiencies that result in suspension or termination of a practitioner to the appropriate authorities. Contractor shall implement and maintain policies and procedures for disciplinary actions including, reducing, suspending, or terminating a practitioner's privileges. Contractor shall implement and maintain a provider Appeal process.

2.16.7.7. Health Plan Accreditation: If Contractor has received a rating of "Excellent," Commendable" or "Accredited" from NCQA, the Contractor shall be "deemed" to meet the DHCS requirements for credentialing and will be exempt from the DHCS medical review audit of credentialing.

2.16.7.8. Deeming of credentialing certification from other private credentialing organizations will be reviewed on an individual basis.

2.16.7.9. Credentialing of Other Non-Physician Medical Practitioners: Contractor shall develop and maintain policies and procedures that ensure that the credentials of nurse practitioners, certified nurse midwives, clinical nurse specialists and physician assistants have been verified in accordance with State requirements applicable to the provider category.

2.16.8. The Contractor's decisions regarding UM, Enrollee education, coverage of services, and other areas included in the practice guidelines must be consistent with the Contractor's clinical practice guidelines.

2.16.9. Quality Improvement Committee: 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 Enrollees and Network Providers, who are representative of the composition of the contracted Provider Network, actively participate on the committee or medical sub-committee that reports to the QIC.

2.16.9.1. The committee shall meet at least quarterly but as frequently as necessary to demonstrate follow-up on all findings and required actions. The activities, findings, recommendations, and actions of the committee shall be reported to the governing body in writing on a scheduled basis.

2.16.9.2. Contractor shall maintain minutes of committee meetings and minutes shall be submitted to DHCS quarterly. Contractor shall maintain a process to ensure rules of confidentiality are maintained in quality improvement discussions as well as avoidance of conflict of interest on the part of committee members.

2.17. Marketing, Outreach, and Enrollee Communications Standards

2.17.1. General Marketing, Outreach, and Enrollee Communications Requirements

2.17.1.1. The Contractor is subject to rules governing marketing and Enrollee Communications as specified under Section 1851(h) of the Social Security Act; 42 C.F.R. §§ 422.111, 422.2260 et. seq., 423.120(b) and (c), 423.128, 423.2260, 438.10; and the Medicare Communications and Marketing Guidelines, with the following exceptions or modifications:

2.17.1.1.1. Contractor may complete an application for enrollment from a potential Cal MediConnect Enrollee and submit it to the State Enrollment Broker;

2.17.1.1.2. If approved to participate in Streamlined Enrollment, the Contractor may collect enrollment information from a potential eligible Enrollee and submit that request to the State per Section 2.3.1.7.

2.17.1.1.3. The Contractor may refer Enrollees and potential Enrollees who inquire about Capitated Financial

Alignment model eligibility or enrollment to the Enrollment Broker, although the Contractor may provide Enrollees and potential Enrollees with information about the Contractor's plan and its benefits prior to referring a request regarding eligibility or enrollment to the Enrollment Broker;

2.17.1.1.4. The Contractor must make available to CMS and DHCS, upon request, current schedules of all educational events conducted by the Contractor to provide information to Enrollees or potential Enrollees;

2.17.1.1.5. The Contractor must convene all educational and marketing/sales events at sites within the Contractor's Service Area that are physically accessible to all Enrollees or potential Enrollees, including persons with disabilities and persons using public transportation.

2.17.1.1.6. The Contractor may not directly or indirectly conduct door-to-door, telephone, or other unsolicited contacts;

2.17.1.1.7. The Contractor does not seek to influence enrollment in conjunction with the sale or offering of any private insurance; and

2.17.1.1.8. The Contractor may not use any Marketing, Outreach, or Enrollee Communications materials that contain any assertion or statement (whether written or oral) that:

2.17.1.1.8.1. The recipient must enroll with the Contractor in order to obtain benefits or in order not to lose benefits;

2.17.1.1.8.2. The Contractor is endorsed by CMS, Medicare, Medi-Cal, the federal government, DHCS, or similar entity.

2.17.2. The Contractor's Marketing, Outreach, and Enrollee Communications materials must be:

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2.17.2.1. Made available in alternative formats, upon request and as needed to assure effective communication for blind and vision-impaired Enrollees;

2.17.2.2. Provided in a manner, format and language that may be easily understood by persons with limited English proficiency, or for those with developmental disabilities or cognitive impairments; and

2.17.2.3. Translated into Threshold Languages for all required vital materials, as specified in the Marketing Guidance for California Medicare-Medicaid Plans and annual guidance to Contractors on specific translation requirements for their Service Areas; and

2.17.2.4. Mailed with a multi-language insert or alternate language taglines that indicate that the Enrollee can access free interpreter services to answer questions about the plan. This message shall be written in the languages required in the Medicare Communications and Marketing Guidelines and Marketing Guidance for California Medicare-Medicaid Plans provisions on the multi-language insert and alternate language taglines.

2.17.2.5. Distributed to the Contractor's entire Service Area, as specified in Appendix I of this Contract.

2.17.3. Submission, Review, and Approval of Marketing, Outreach, and Enrollee Communications Materials

2.17.3.1. The Contractor must receive prior approval of all Marketing, Outreach, and Enrollee Communications in categories of materials that CMS and DHCS require to be prospectively reviewed. Contractor materials may be designated as eligible for the File & Use process, as described in 42 C.F.R. §§ 422.2262(b) and 423.2262(b), and will therefore be exempt from prospective review and approval by both CMS and DHCS. CMS and DHCS may agree to defer to one or the other party for review of certain types of marketing and Enrollee Communications, as agreed in advance by both parties. Contractors must submit all materials that are consistent with the definition of communications materials and marketing materials at 42 C.F.R. § 422.2260, whether prospectively reviewed or not, via the CMS HPMS

Marketing Module. The Contractor that is a non-Knox-Keene licensed COHS plan shall ensure that Marketing, Outreach, and Enrollee Communications involving Medi-Cal based services are consistent with the requirements of the Knox-Keene Act and the regulations promulgated thereunder. The Contractor, unless it is a non-Knox-Keene licensed COHS plan, shall submit to DMHC any Marketing, Outreach, and Enrollee Communications required to be reviewed by DMHC pursuant to the Knox-Keene Act.

2.17.3.2. CMS and DHCS may conduct additional types of review of Contractor's Marketing, Outreach, and Enrollee Communications activities, including, but not limited to:

2.17.3.2.1. Review of on-site marketing facilities, products, and activities during regularly scheduled Contract compliance monitoring visits.

2.17.3.2.2. Random review of actual Marketing, Outreach, and Enrollee Communications pieces as they are used in the marketplace.

2.17.3.2.3. "For cause" review of materials and activities when complaints are made by any source, and CMS or DHCS determine it is appropriate to investigate.

2.17.3.2.4. "Secret shopper" activities where CMS or DHCS request Contractor materials, such as enrollment packets.

2.17.4. Beginning of Marketing, Outreach and Enrollee Communications Activity

2.17.4.1. The Contractor may not begin Marketing, Outreach, and Enrollee Communications activities to Enrollees or potential new Enrollees more than ninety (90) days prior to the effective date of coverage for the following Contract year.

2.17.5. Requirements for Dissemination of Marketing, Outreach, and Enrollee Communications Materials

2.17.5.1. Consistent with the timelines specified in the Marketing Guidance for California Medicare-Medicaid Plans, the Contractor must provide new Enrollees with the following

materials which, with the exception of the materials specified in 2.17.5.4, must also be provided annually thereafter:

2.17.5.1.1. An Evidence of Coverage (EOC)/Member Handbook document, or a distinct and separate notice on how to access the Member Handbook online and how to request a hard copy, that is consistent with the requirements at 42 C.F.R. § 438.10, 42 C.F.R. § 422.111, and 42 C.F.R. § 423.128; includes information about all Covered Services, as outlined below, and that uses the model document developed by CMS and DHCS.

2.17.5.1.1.1. Enrollee rights (see Appendix B);

2.17.5.1.1.2. An explanation of the process by which clinical information, including diagnostic and medication information, will be available to key caregivers;

2.17.5.1.1.3. How to request and obtain a copy of the Enrollee's medical records, and to request that they be amended or corrected;

2.17.5.1.1.4. How to obtain access to services, including specialty, Behavioral Health, pharmacy and LTSS providers;

2.17.5.1.1.5. How to obtain services and prescription drugs for Emergency Conditions and Urgent Care in and out of the Provider Network and in and out of the Service Area; including:

2.17.5.1.1.5.1. What constitutes Emergency Medical Condition, Emergency Services, and Post-Stabilization Care Services, with reference to the definitions in 42 C.F.R. § 438.114(a);

2.17.5.1.1.5.2. The fact that prior authorization is not required for Emergency Services;

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2.17.5.1.1.5.3. The process and procedures for obtaining Emergency Services, including the use of the 911 telephone system or its local equivalent;

2.17.5.1.1.5.4. The locations of any emergency settings and other locations at which providers and hospitals furnish Emergency Services and Post-Stabilization Care Services covered under the Contract;

2.17.5.1.1.5.5. That the Enrollee has a right to use any hospital or other setting for emergency care; and

2.17.5.1.1.5.6. The Post-Stabilization Care Services rules as outlined under 42 C.F.R. § 422.113(c).

2.17.5.1.2. Information about Advance Directives (at a minimum those required in 42 C.F.R. § 489.102 and 42 C.F.R. § 422.128), including Enrollee rights under the law of California; the Contractor's policies respecting the implementation of those rights, including a statement of any limitation regarding the implementation of Advance Directives as a matter of conscience; that complaints concerning noncompliance with the Advance Directive requirements may be filed with DHCS; designating a health care proxy, and other mechanisms for ensuring that future medical decisions are made according to the desire of the Enrollee; and that information provided must reflect changes in State law as soon as possible, but no later than ninety (90) days after the effective date of the change;

2.17.5.1.3. How to obtain assistance from ESRs;

2.17.5.1.4. How to file Grievances and internal and external Appeals, including:

2.17.5.1.4.1. Grievance, Appeal and fair hearing procedures and timeframes;

2.17.5.1.4.2. Toll free numbers that the Enrollee can use to file a Grievance or an Appeal by phone;

2.17.5.1.4.3. A statement that when requested by the Enrollee, benefits will continue at the Contractor level for all benefits during the Contractor Appeal process, and the Enrollee may be required to pay to DHCS the cost of services furnished while the Appeal is pending if the final decision is adverse to the Enrollee; and, how the Enrollee can identify who the Enrollee wants to receive written notices of denials, terminations, and reductions;

2.17.5.1.4.4. How to obtain assistance with the Appeals processes through the ESR and other assistance mechanisms as DHCS or CMS may identify, including an Ombudsperson;

2.17.5.1.5. The extent to which, and how Enrollees may obtain benefits, including family planning services, from out-of-network providers;

2.17.5.1.6. How and where to access any benefits that are available under the State plan but are not covered under the Contract, including any cost sharing, and how transportation is provided;

2.17.5.1.7. How to change providers;

2.17.5.1.8. How to disenroll from Cal Medi-Connect voluntarily;

2.17.5.1.9. How to receive counseling and referral services that are not covered under the Contract because of moral or religious objections;

2.17.5.1.10. The structure and operation of the Contractor; and

2.17.5.1.11. The structure and operation of any physician incentive plans the Contractor may have in place.

2.17.5.2. A Summary of Benefits (SB) that contains a concise description of the important aspects of enrolling in the Contractor's plan, as well as the benefits offered under the Contractor's plan, including any cost sharing, applicable conditions and limitations, and any other conditions associated with receipt or use of benefits, and is consistent with the model document developed by CMS and DHCS. The SB should provide sufficient detail to ensure that Enrollees understand the benefits to which they are entitled. For new Enrollees, the SB is required only for Enrollees enrolled through Passive Enrollment.

2.17.5.3. A combined provider and pharmacy directory that includes all providers of Medicare, Medi Cal, and Flexible Benefits and is consistent with the requirements in Section 2.17.5.10, or a distinct and separate notice on how to access this information online and how to request a hard copy.

2.17.5.4. A single identification (ID) card for accessing all Covered Services under the plan that uses the model document developed by CMS and DHCS.

2.17.5.5. A comprehensive, integrated formulary that includes prescription drugs and over-the-counter products required to be covered by Medicare Part D and DHCS's outpatient prescription drug benefit and that uses the model document developed by CMS and DHCS.

2.17.5.6. The procedures for an Enrollee to change Cal MediConnect Plans or to opt out of Cal MediConnect.

2.17.5.7. The Contractor must provide the following materials to current Enrollees on an ongoing basis:

2.17.5.7.1. An ANOC that summarizes all major changes to the Contractor's covered benefits from one Contract year to the next, and that uses the model document developed by CMS and DHCS.

2.17.5.7.2. As needed to replace old versions or upon an Enrollee's request, a single ID card for accessing all Covered Services under the Contractor;

2.17.5.7.3. The Contractor must provide all Medicare Part D required notices, with the exception of the creditable coverage and late enrollment penalty notices required under Chapter 4 of the Prescription Drug Benefit Manual, and the LIS Rider required under Chapter 13 of the Prescription Drug Benefit Manual.

2.17.5.8. Consistent with the requirement at 42 C.F.R. § 423.120(b)(5), the Contractor must provide Enrollees with at least thirty (30) calendar days advance notice regarding certain changes to the comprehensive, integrated formulary.

2.17.5.9. The Contractor must ensure that all information provided to Enrollees and potential Enrollees (and families when appropriate) is provided in a manner and format that is easily understood and that is:

2.17.5.9.1. Made available in large print (at least 16 point font) to Enrollees as an alternative format, upon request;

2.17.5.9.2. For materials specified in the Medicare-Medicaid marketing guidance, available in Threshold Languages, as provided for in the Marketing Guidance for California Medicare-Medicaid Plans;

2.17.5.9.3. Written with cultural sensitivity and at a sixth grade reading level; and

2.17.5.9.4. Available in alternative formats, according to the needs of Enrollees and potential Enrollees, including Braille, oral interpretation services in non-English languages, as specified in Section 2.3.1.4 of this Contract; audiotape; ASL video clips, and other alternative media, as requested.

2.17.5.10. Provider/Pharmacy Network Directory

2.17.5.10.1. The Contractor must comply with the following maintenance and distribution requirements:

2.17.5.10.1.1. Maintain a combined Provider/Pharmacy Network directory

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that uses the model document developed by CMS and DHCS;

2.17.5.10.1.2. Provide either a print copy or a distinct and separate notice about how to access this information online or request a hard copy, as specified in the Medicare Communications and Marketing Guidelines and the Marketing Guidance for California Medicare-Medicaid Plans, to all new Enrollees at the time of enrollment and annually thereafter;

2.17.5.10.1.3. When there is a significant change to the network, the Contractor must send a special mailing to Enrollees, as specified in Chapter 4 of the Medicare Managed Care Manual, immediately;

2.17.5.10.1.4. The Contractor must ensure an up-to-date copy is available on the Contractor's website, consistent with the requirements at 42 C.F.R. §§ 422.111(h) and 423.128(d);

2.17.5.10.2. Consistent with 42 C.F.R. § 422.111(e), make a good faith effort to provide written notice of termination of a contracted provider or pharmacy consistent with section 2.11.1.5 of this Contract to all Enrollees who regularly use the provider or pharmacy's services; if a contract termination involves a primary care professional, all Enrollees who are patients of that primary care professional must be notified; and

2.17.5.10.3. Include written and oral offers of such Provider/Pharmacy Network directory in its outreach and orientation sessions for new Enrollees.

2.17.5.11. Content of Provider/Pharmacy Network Directory. The Provider/Pharmacy Network directory must include, at a

minimum, the following information for all providers in the Contractor's Provider Network:

2.17.5.11.1. The names, addresses, and telephone numbers of all current Network Providers, and the total number of each type of provider, consistent with 42 C.F.R. § 422.111(h).

2.17.5.11.2. As applicable, Network Providers with training in and experience treating:

2.17.5.11.2.1. Persons with physical disabilities, chronic illness, HIV/AIDS, and/or persons with serious mental illness;

2.17.5.11.2.2. Homeless persons;

2.17.5.11.2.3. Persons who are deaf or hard-of-hearing and blind or visually impaired;

2.17.5.11.2.4. Persons with co-occurring disorders; and

2.17.5.11.2.5. Other conditions.

2.17.5.11.3. For Network Providers that are health care professionals or non-facility based and, as applicable, for facilities and facility-based Network Providers, office hours, including the names of any Network Provider sites open after 5:00 p.m. (Pacific Time) weekdays and on weekends;

2.17.5.11.4. As applicable, whether the health care professional or non-facility based Network Provider has completed cultural competence training;

2.17.5.11.5. For Network Providers that are health care professionals or non-facility based and, as applicable, for facilities and facility-based Network Provides, licensing information, such as license number or National Provider Identifier;

2.17.5.11.6. Whether the Network Provider has specific accommodations for people with physical disabilities, such as wide entry, wheelchair access, accessible exam rooms and tables, lifts, scales, bathrooms and stalls, grab bars, or other accessible equipment;

2.17.5.11.7. Whether the Network Provider is accepting new patients as of the date of publication of the directory;

2.17.5.11.8. Whether the Network Provider is on a public transportation route;

2.17.5.11.9. Any languages other than English, including ASL, spoken by Network Providers or offered by skilled medical interpreters at the provider's site;

2.17.5.11.10. As applicable, whether the Network Provider has access to language line interpreters;

2.17.5.11.11. For Behavioral Health Providers, training in and experience treating trauma, child welfare, and substance use;

2.17.5.11.12. A description of the roles of the PCP and ICT and the process by which Enrollees select and change PCPs.

2.17.5.12. The directory must include, at a minimum, the following information for all pharmacies in the Contractor's Pharmacy Network:

2.17.5.12.1. The names, addresses, and telephone numbers of all current Network Providers and pharmacies; and

2.17.5.12.2. Instructions for the Enrollee to contact the Contractor's toll-free Enrollee services telephone line (as described in Section 2.12.2.1) for assistance in finding a convenient pharmacy.

2.18. Financial Requirements

2.18.1. Financial Viability

2.18.1.1. As specified in the DHCS Request for Solutions procurement, the Contractor must meet and maintain financial viability/standards compliance for each of the following elements:

2.18.1.1.1. Minimum Required Tangible Net Equity

2.18.1.1.1.1. Contractor at all times shall be in compliance with the Tangible Net Equity (TNE) requirements in accordance with 28 CCR 1300.76. If the Contractor does not meet TNE in a given period, the CMT shall have the power and authority to take one or more of the following sanctions against the Contractor for non-compliance:

2.18.1.1.1.1.1. Require the Contractor to submit a Corrective Action Plan within thirty (30) days of request by the CMT;

2.18.1.1.1.1.2. Appointment of temporary management if the Contractor has repeatedly failed to meet the contractual requirements or applicable federal and State law or regulation. The Contractor cannot delay appointment of temporary management to provide a hearing before appointment. Temporary management will not be terminated until DHCS determines that Contractor's sanctioned behavior will not recur; and

2.18.1.1.1.1.3. Take other appropriate action as determined necessary by DHCS.

2.18.1.1.2. Contractor must provide assurances satisfactory to the State showing that its provision against the risk of financial instability is adequate to ensure that its Enrollees will not be liable for the entity's

debts if the entity becomes insolvent. Contractor shall demonstrate fiscal soundness and assumption of full financial risk in accordance with 28 CCR 1300.75.1.

2.18.2. Administrative costs

2.18.2.1. Contractor's administrative costs shall not exceed the guidelines established under 28 CCR section 1300.78.

2.18.2.2. Standards of Organization and Financial Soundness

2.18.2.2.1. Contractor shall maintain an organizational structure sufficient to conduct the proposed operations and ensure that its financial resources are sufficient for sound business operations in accordance with 28 CCR 1300.67.3, 1300.75.1, 1300.76.3, 1300.77.1, 1300.77.2, 1300.77.3, 1300.77.4, and Health and Safety Code Section 1375.1.

2.18.2.3. Working Capital Requirements

2.18.2.3.1. Contractor shall maintain a working capital and current ratio in accordance with 22 CCR 53864, which requires a TNE as defined in Title 28, Section 1300.76, or one of the following:

2.18.2.3.1.1. Current ratio of at least 1:1, or prior demonstration that the Contractor is now meeting financial obligations on a timely basis and has been doing so for at least the preceding two (2) years, or evidence that sufficient noncurrent assets, which are readily convertible to cash, are available to achieve an equivalent working capital ratio of 1:1, if the noncurrent assets are considered current; or

2.18.2.3.1.2. Demonstration through its history of plan operations that the plan's arrangements for health care are financially sound, and provide for the achievement and maintenance of a positive cash flow, including provisions for retirement of

existing and proposed indebtedness, or enrollment growth.

2.18.2.3.2. The Contractor receiving Cal MediConnect enrollment, must demonstrate and maintain adequate working capital as required in California Health and Safety Code Section 1375.1, which requires consideration of:

2.18.2.3.2.1. The financial soundness of the Contractor's arrangements for Covered Services and the schedule of rates and charges used by the Contractor;

2.18.2.3.2.2. The adequacy of working capital; and

2.18.2.3.2.3. Arrangements with providers for the provision of Covered Services.

2.18.3. Financial Stability

2.18.3.1. Throughout the term of the Contract, the Contractor must:

2.18.3.1.1. Remain financially stable;

2.18.3.1.2. Maintain adequate protection against insolvency in an amount determined by the DMHC as described in Title 28, CCR, Section 1300.75.1.

2.18.3.1.3. Demonstrate fiscal soundness and assumption of full financial risk in accordance with 28 CCR 1300.75.1 as follows:

2.18.3.1.3.1. Demonstrate through its history of operations and through projections, (which shall be supported by a statement as the facts and assumptions upon which they are based) that the Contractor's arrangements for health care services and the schedule of its rates and charges are financially sound, and provide for the achievement and maintenance of a positive cash flow, including provisions for retirement of existing and proposed indebtedness; and

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2.18.3.1.3.2. Attest that the Contractor's arrangements for Covered Services and the schedule of its rates and charges are financially sound, and provide for the achievement and maintenance of a positive cash flow, including provisions for retirement of existing and proposed indebtedness.

2.18.3.1.4. Demonstrate that its working capital is adequate, including provisions for contingencies;

2.18.3.1.5. Demonstrate an approach to the risk of insolvency which allows for the continuation of benefits for the duration of the Contract period for which payment has been made, the continuation of benefits to subscribers and Enrollees who are confined on the date of insolvency in an in-patient facility until their discharge, and payments to unaffiliated providers for services rendered; and

2.18.3.1.6. Obtain insurance or make other arrangements:

2.18.3.1.6.1. For the cost of providing to any Enrollee covered health care services the aggregate value of which exceeds $5,000 in any year;

2.18.3.1.6.2. For the cost of Covered Services provided to its Enrollees other than through the Contractor because medical necessity required their provision before they could be secured through the Contractor; and

2.18.3.1.6.3. For not more than ninety percent (90%) of the amount by which its costs for any of its fiscal years exceed one hundred fifteen percent (115%) of its income for such fiscal year.

2.18.4. Insolvency Reserve

2.18.4.1. The insolvency reserve shall have the same definition as minimum required TNE (see 2.18.1.1.1). The minimum TNE is defined by Title 28, CCR, Section 1300.76.

2.18.4.2. According to Title 28, CCR, Section 1300.76(e), California defines TNE as net equity reduced by the value assigned to intangible assets including, but not limited to, goodwill; going concern value; organizational expense; starting-up costs; obligations of officers, directors, owners, or affiliates which are not fully secured, except short-term obligations of affiliates for goods or services arising in the normal course of business which are payable on the same terms as equivalent transactions with non-affiliates and which are not past due; long term prepayments of deferred charges, and non-returnable deposits.

2.19. Data Submissions, Reporting Requirements, and Surveys

2.19.1. General Requirements for Data. The Contractor must provide and require its First Tier, Downstream and Related Entities to provide:

2.19.1.1. All information CMS and DHCS require under the Contract related to the performance of the Contractor's responsibilities, including non-medical information for the purposes of research and evaluation;

2.19.1.2. Any information CMS and DHCS require to comply with all applicable federal or State laws and regulations; and

2.19.1.3. Any information CMS or DHCS require for external rapid cycle evaluation including program expenditures, service utilization rates, rebalancing from institutional to community settings, Enrollee satisfaction, Enrollee complaints and Appeals and enrollment/disenrollment rates.

2.19.2. General Reporting Requirements. The Contractor shall:

2.19.2.1. Submit to DHCS all applicable Medi-Cal reporting requirements in compliance with 42 C.F.R. § 438.602-606.

2.19.2.2. Submit to CMS applicable reporting requirements in compliance with 42 C.F.R. §§ 422.516, 423.514, 438.604, and 438.606.

2.19.2.3. Submit to CMS and DHCS all applicable MMP reporting requirements.

2.19.2.4. Submit to CMS and DHCS all required data in accordance with the specifications, templates and time frames described in this Contract.

2.19.2.5. Report HEDIS, as well as measures related to Long-Term Services and Supports. HEDIS, HOS, and CAHPS measures will be reported consistent with Medicare requirements for HEDIS, plus additional Medi-Cal measures required by DHCS. All existing Part D metrics will be collected as well. Such measures shall include a combined set of core measures that the Contractor must report to CMS and DHCS.

2.19.2.6. Report rates for an under/over-utilization monitoring measure set based upon selected HEDIS use of service measures or any other standardized or DHCS-developed utilization measures selected by DHCS.

2.19.2.7. Submit additional reporting requirements as specified throughout this Contract, relevant regulation or law, or as provided through guidance.

2.19.2.8. Submit to CMS and DHCS all required reports and data in accordance with the specifications, templates, and time frames described in this Contract, unless otherwise directed or agreed to by CMS and DHCS.

2.19.2.9. Submit at the request of CMS or DHCS additional ad hoc or periodic reports or analyses of data related to the Contract.

2.19.2.10. Pursuant to 42 C.F.R. § 438.3(g), comply with any reporting requirements on Provider Preventable Conditions in the form and frequency as may be specified by DHCS in accordance with applicable DPL(s) as indicated in Section 2.5.1.

2.19.2.11. Submit to DHCS Part D subcontractor conflict of interest letters on an annual basis. For Part D PDE data requests, securing and submitting appropriate letter from the First Tier, Downstream Entity to address potential conflicts of interests for First Tier, Downstream Entity users that may be affiliated with Part D Contractor sponsors. Letters should indicate either (a) no affiliation or, (b) if there is affiliation,

how the data will be kept separate and secure from Part D Contractor plan operations.

2.19.3. Management Information Systems Capability. The Contractor shall:

2.19.3.1. Maintain Information Systems that will enable the Contractor to meet all of DHCS's requirements as outlined in this Contract. The Contractor's Systems shall be able to support current DHCS requirements, and any future IT architecture or program changes. Such requirements include, but are not limited to, the following DHCS standards:

2.19.3.1.1. The capability to capture, edit, and utilize various data elements for both internal management use as well as to meet the data completeness, timeliness, reasonability, and accuracy requirements of DHCS's Encounter Data submission. Contractor shall have and maintain a System that provides, at a minimum:

2.19.3.1.1.1. Eligibility data,

2.19.3.1.1.2. Information of Enrollees enrolled in Contractor's plan,

2.19.3.1.1.3. Provider claims status and payment data,

2.19.3.1.1.4. Health care services delivery Encounter Data,

2.19.3.1.1.5. Provider Network information, and

2.19.3.1.1.6. Financial information, as specified by DHCS.

2.19.3.2. Processes that support the interactions between financial, eligibility; provider; encounter claims; quality management/QI/utilization; and report generation subsystems. The interactions of the subsystems must be compatible, efficient and successful.

2.19.3.3. Ensure a secure, HIPAA-compliant exchange of Enrollee information between the Contractor and DHCS and any other entity deemed appropriate by DHCS. Such files shall

be transmitted to DHCS through secure FTP, HTS, or a similar secure data exchange as determined by DHCS;

2.19.3.4. Develop and maintain a website that is accurate and up-to-date, and that is designed in a way that enables Enrollees and providers to quickly and easily locate all relevant information. If directed by DHCS, establish appropriate links on the Contractor's website that direct users back to the DHCS website portal; and,

2.19.3.5. The Contractor shall cooperate with DHCS in its efforts to verify the accuracy of all Contractor data submissions to DHCS.

2.19.3.5.1. The Contractor shall conform to HIPAA compliant standards for data management and information exchange.

2.19.3.5.2. The Contractor shall demonstrate controls to maintain information integrity.

2.19.3.5.3. The Contractor shall maintain appropriate internal processes to determine the validity and completeness of data submitted to DHCS.

2.19.4. Accepting and Processing Assessment Data

2.19.4.1. System Access Management and Information Accessibility Requirements

2.19.4.1.1. The Contractor shall make all systems and system information available to authorized CMS, DHCS and other agency staff as determined by CMS or DHCS to evaluate the quality and effectiveness of the Contractor's data and systems.

2.19.4.1.2. The Contractor is prohibited from sharing or publishing CMS or DHCS data and information without prior written consent from CMS or DHCS.

2.19.5. System Availability and Performance Requirements

2.19.5.1. The Contractor shall ensure that its Enrollee and provider web portal functions and phone-based functions are

available to Enrollees and Providers twenty-four (24) hours a day, seven (7) days a week.

2.19.5.2. The Contractor shall draft an alternative plan that describes access to Enrollee and provider information in the event of system failure. Such plan shall be contained in the Contractor's Continuity of Operations Plan (COOP) and shall be updated annually and submitted to DHCS upon request. In the event of system failure or unavailability, the Contractor shall notify DHCS upon discovery and implement the COOP immediately.

2.19.5.3. The Contractor shall preserve the integrity of Enrollee-sensitive data that resides in both a live and archived environment.

2.20. Encounter Reporting

2.20.1. The Contractor must meet any diagnosis and encounter reporting requirements that are in place for Medicare Advantage plans and Medi-Cal managed care organizations. Furthermore, the Contractor's systems shall generate and transmit Encounter Data files to CMS according to additional specifications as shall be provided by CMS and DHCS and updated from time to time. CMS and DHCS will provide technical assistance to the Contractor for developing the capacity to meet encounter reporting requirements.

2.20.2. Encounter Data Submission

2.20.2.1. Contractor shall implement policies and procedures for ensuring the submission of complete, timely, reasonable, and accurate Encounter Data for all services for which Contractor has incurred any financial liability, whether directly or through subcontracts or other arrangements.

2.20.2.2. Contractor shall require First Tier, Downstream and Related Entities and non-contracting providers to provide claims and Encounter Data to Contractor, which allow Contractor to meet its administrative functions and the requirements set forth in this section. Contractor shall have in place mechanisms, including edits and reporting systems sufficient to assure Encounter Data is complete, timely, reasonable, and accurate prior to submission to CMS.

2.20.2.3. Contractor shall submit complete, timely, reasonable, and accurate Encounter Data to CMS no less than monthly in the form and manner specified by DHCS and CMS. CMS will forward Encounter Data directly to the State.

2.20.2.4. Contractor shall submit Encounter Data that is at a minimum standard for completeness and accuracy as defined by CMS and DHCS. The Contractor must also correct and resubmit denied encounters as necessary.

2.20.2.5. A percentage of the monthly capitation payments will be withheld as described in Section 4.8.1.

3. CMS and DHCS Responsibilities

3.1. Contract Management

3.1.1. Administration. CMS and DHCS will:

3.1.1.1. Designate a CMT that will include at least one (1) contract officer from CMS and at least one (1) contract officer from DHCS authorized and empowered to represent CMS and DHCS about all aspects of the Contract. Generally, the CMS part of the team will include the State Lead from the Medicare Medicaid Coordination Office (MMCO), Regional Office lead from the Consortium for Medicaid and Children's Health Operations (CMCHO), and an Account Manager from the Consortium for Health Plan Operations (CMHPO). The CMS representative and DHCS representatives will act as liaisons between the Contractor and CMS and DHCS for the duration of the Contract. The CMT will:

3.1.1.1.1. Monitor compliance with the terms of the Contract including issuance of joint notices of non-compliance/enforcement.

3.1.1.1.2. Coordinate periodic audits and surveys of the Contractor;

3.1.1.1.3. Receive and respond to complaints;

3.1.1.1.4. Conduct regular meetings with the Contractor;

3.1.1.1.5. Coordinate requests for assistance from the Contractor and assign CMS and DHCS staff with appropriate expertise to provide technical assistance to the Contractor;

3.1.1.1.6. Make best efforts to resolve any issues applicable to the Contract identified by the Contractor, CMS, or DHCS;

3.1.1.1.7. Inform the Contractor of any discretionary action by CMS or DHCS under the provisions of the Contract;

3.1.1.1.8. Coordinate review of marketing materials and procedures;

3.1.1.1.9. Coordinate review of Grievance and Appeals data, procedures; and

3.1.1.1.10. Review, approve, and monitor the Contractor's outreach and orientation materials and procedures.

3.1.1.2. Review, approve, and monitor the Contractor's complaint and Appeals procedures;

3.1.1.3. Apply one or more of the sanctions provided in Section 5.3.13, including termination of the Contract in accordance with Section 5.5, if CMS and DHCS determine that the Contractor is in violation of any of the terms of the Contract stated herein;

3.1.1.4. Conduct site visits as determined necessary by CMS and DHCS to verify the accuracy of reported data; and

3.1.1.5. Coordinate the Contractor's external quality reviews conducted by the EQRO.

3.1.2. Performance Evaluation. CMS and DHCS will, at their discretion:

3.1.2.1. Evaluate, through inspection or other means, the Contractor's compliance with the terms of this Contract, including but not limited to the reporting requirements in Sections 2.18 and 2.19, and the quality, appropriateness, and timeliness of services performed by the Contractor and its Provider Network. CMS and DHCS will provide the Contractor with the written results of these evaluations;

3.1.2.2. Conduct periodic audits of the Contractor, including, but not limited to an annual independent external review and an annual site visit;

3.1.2.3. Conduct annual Enrollee surveys and provide the Contractor with written results of such surveys.

3.2. Enrollment and Disenrollment Systems

3.2.1. CMS and DHCS will maintain systems to provide:

3.2.1.1. Enrollment and disenrollment information to the Contractor;

3.2.1.2. Continuous verification of eligibility status;

3.2.1.3. Identification of individuals determined as at risk or potentially at risk for abuse or overuse of specified prescription drugs per 42 C.F.R. §§ 432.100 and 423.153(f); and

3.2.1.4. For counties operating under COHS, DHCS will facilitate the Contractor in its responsibility for enrollment and disenrollment activities for Cal MediConnect.

3.2.2. Customer Service Team (CST) Enrollment Broker. DHCS or its designee shall assign a staff person(s) who shall have responsibility to:

3.2.2.1. Develop generic materials to assist potential Enrollees in choosing whether to enroll in Cal MediConnect. Said materials shall present the Cal MediConnect in an unbiased manner to potential Enrollees eligible to select a Cal MediConnect Plan. DHCS may collaborate with the Contractor in developing Cal MediConnect-specific materials;

3.2.2.2. Present the Cal MediConnect in an unbiased manner to potential Enrollees or those seeking to transfer from one Cal MediConnect to another. Such presentation(s) shall ensure that Enrollees are informed prior to enrollment of the following:

3.2.2.2.1. The rights and responsibilities of participation in Cal MediConnect;

3.2.2.2.2. The nature of the Contractor's care delivery system, including, but not limited to the Provider Network; and the HRA, and the ICT;

3.2.2.2.3. Orientation and other Enrollee services made available by the Contractor;

3.2.2.3. Ensure that Enrollees are informed at the time of enrollment or transfer of their right to terminate their enrollment voluntarily at any time, unless otherwise provided by federal law or waiver;

3.2.2.4. Be knowledgeable about the Contractor's policies, services, and procedures; and

3.2.2.5. At its discretion, develop and implement processes and standards to measure and improve the performance of the Enrollment Broker staff. The State shall monitor the activities of the Enrollment Broker.

4. Payment and Financial Provisions

4.1. General Financial Provisions

4.1.1. Capitation Payments. CMS and DHCS will each contribute to the total capitation payment. CMS and DHCS will each make monthly payments to the Contractor for their portion of the capitated rate, in accordance with the rates of payment and payment provisions set forth herein and subject to all applicable federal and State laws, regulations, rules, billing instructions, and bulletins, as amended. The Contractor will receive three (3) monthly payments for each Enrollee: one (1) amount from CMS reflecting coverage of Medicare Parts A/B services (Medicare Part A/B Component), one (1) amount from CMS reflecting coverage Medicare Part D services (Medicare Part D Component), and a third amount from DHCS reflecting coverage of Medi-Cal services (Medi-Cal Component).

4.1.1.1. On a regular basis, CMS will provide DHCS with the Contractor-level payment information in the Medicare Plan Payment Report. The use of such information by DHCS will be limited to financial monitoring, performing financial audits, and related activities, unless otherwise agreed to by CMS and the Contractor. On a regular basis, DHCS will also provide to CMS Contractor-level payment information including the Medicaid Capitation Payments.

4.1.2. Demonstration Year Dates. Capitation Rate updates will take place on January 1st of each calendar year for the Medicare components of the rates, with changes to savings percentages applicable on a Demonstration Year basis, as follows. Rate updates for the Medi-Cal component of the rates will take place at least once each calendar year. CMS and DHCS will provide the Contractor with a rate report at least annually to show applicable rates for the upcoming calendar year.

4.1.2.1. Demonstration Year Dates

Figure 4.1: Demonstration Year Dates

Demonstration Year	Calendar Dates
1	April 1, 2014 – December 31, 2015
2	January 1, 2016 – December 31, 2016
3	January 1, 2017 – December 31, 2017
4	January 1, 2018 – December 31, 2018
5	January 1, 2019 – December 31, 2019

Demonstration Year	Calendar Dates
6	January 1, 2020 – December 31, 2020
7	January 1, 2021 – December 31, 2021
8	January 1, 2022 – December 31, 2022

4.2. Capitated Rate Structure

4.2.1. Underlying Rate Structure for the Medi-Cal Component

4.2.1.1. The Medi-Cal component will be paid as a single, blended rate that takes into account the relative risk of the population actually enrolled in the Contractor's Cal MediConnect Plan and is weighted accordingly.

4.2.1.1.1. For Demonstration Years 1-3, the population will be categorized into four risk adjustment population categories:

4.2.1.1.1.1. Institutionalized: Enrollees in long-term care aid codes and/or residing in a long-term care facility for ninety (90) or more days.

4.2.1.1.1.2. HCBS High: Enrollees identified as high utilizers of home and community-based services. These are Enrollees who meet one (1) or more of the following criteria:

4.2.1.1.1.2.1. Enrollees who receive CBAS.

4.2.1.1.1.2.2. Enrollees who are clients of MSSP sites

4.2.1.1.1.2.3. Enrollees who receive IHSS and are classified under the IHSS program as "severely impaired" (SI).

4.2.1.1.1.3. HCBS Low: Enrollees identified as low utilizers of home and community-based services. These Enrollees are IHSS recipients and classified under the IHSS program as "not severely impaired."

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4.2.1.1.1.4. Community Well: All other Enrollees living in the community with no Medi-Cal covered HCBS services. These are all other Enrollees who are not resident in long-term care facilities and do not utilize CBAS, MSSP, or IHSS services.

4.2.1.1.2. For Demonstration Years 4-8, the population will be categorized into four risk adjustment population categories:

4.2.1.1.2.1. Institutionalized: Enrollees in long-term care aid codes and/or residing in a long-term care facility for ninety (90) or more days.

4.2.1.1.2.2. CBAS and MSSP: Enrollees identified as utilizers of CBAS or MSSP services. These are Enrollees who meet one (1) or more of the following criteria:

4.2.1.1.2.2.1. Enrollees who receive CBAS.

4.2.1.1.2.2.2. Enrollees who are clients of MSSP sites.

4.2.1.1.2.3. IHSS Only (no CBAS or MSSP): Enrollees identified as utilizers of IHSS services, who do not receive CBAS and are not clients of MSSP sites.

4.2.1.1.2.4. Community Well: All other Enrollees living in the community with no Medi-Cal covered HCBS services. These are all other Enrollees who are not resident in long-term care facilities and do not utilize CBAS, MSSP, or IHSS services.

4.2.1.1.3. The State may, in consultation with CMS, modify the composition of the risk adjustment population categories upon its determination that such changes are appropriate. The State will inform the Contractor of any changes prior to modifying the risk adjustment population categories.

4.2.1.2. The Medi-Cal component will utilize the risk adjustment methodology in the contracts that support the 1115(a) demonstration for the eligible population.

4.2.1.2.1. The Medi-Cal component will employ the population categories described above. Relative cost factors (RCF) will be established for each of the four (4) populations based on evaluation of the per member per month (PMPM) for each of the individual population groups, relative to the total Medi-Cal rate. As the total Medi-Cal rate incorporates incremental changes in population distribution (e.g. fewer Enrollees in institutional settings, increase in HCBS low for higher cost community well that may be more appropriately served by HCBS benefits), the calculation of the RCFs is also impacted by the assumed population distribution.

4.2.1.2.2. Contractor specific relative mix factors (RMF) will be computed through the use of RCFs and the proportion of each of the population category Enrollees in the plan. The RMFs will be computed by multiplying each Contractor's distribution of each of the population categories with the established RCFs to calculate a weighted average Contractor-specific RMF.

4.2.1.2.3. Contractor RMFs will be multiplied by the established Capitation Rate to determine the risk-adjusted Medi-Cal component payment rate.

4.2.1.3. The risk adjustment process will include three (3) distinct phases to address the stability of enrollment and to establish appropriate financial incentives for Contractor.

4.2.1.3.1. Phase I: The risk adjustment methodology will be applied monthly and retroactively to match actual enrollment into the Contractor's Cal MediConnect Plan. This phase will continue through each county's phase-in enrollment period for a minimum of one (1) year and will end at the start of the next fiscal quarter. For example, in a county with a 12-month phase-in that begins enrollment

in April 2014, this phase would last through the end of March 2015. For the county of San Mateo, due to the different enrollment phasing as described in Appendix K, there will be no Phase I.

4.2.1.3.2. Phase II: This phase will be for one (1) fiscal quarter. The risk adjustment methodology will be prospectively applied at the start of the quarter. Weighting the risk categories will be based on the preceding month to the quarter enrollment snapshot, which will be available after the quarter ends and will be retroactively applied to that period. For example, in a county with a 12-month phase-in that begins enrollment in April 2014, this Phase II would be applicable for the fiscal quarter of April 2015 through June 2015. Enrollment data from March 2015 would be utilized although the rate update would not occur until several months after the quarter to ensure data availability. For the county of San Mateo, due to the different enrollment phasing as described in Appendix K, the county will immediately enter Phase II of the risk adjustment. The Phase II for San Mateo will be done according to a separate timeline, such that the risk adjustment methodology will be prospectively applied at the start of the Demonstration in April 2014 and again for a second quarter from July 2014 through September 2014 after which San Mateo will move into Phase III.

4.2.1.3.3. Phase III: Contractor rates will be based on a targeted relative mix of the population and will not be adjusted during the year. The first year of this phase will be the remaining period in the calendar year. Phase III for the county of San Mateo will begin with the fiscal year starting October 2014. The targeted relative mix of the population for the year would be based on enrollment in the plan leading up to the start of the phase III year and will include an assumed shift in population mix.

4.2.1.3.3.1. Specific to Phase III, a targeted relative mix will be projected by the State and its actuaries. This mix will be designed to be achievable by the Contractor, based on assumptions about the plan's ability to promote community services and prevent or delay institutional placement.

4.2.1.3.3.2. If the population mix for the Contractor for the year results in a greater than 2.5% impact to the Medicaid component of the rate paid as compared to the rate that would have been paid based on the actual mix, then the Contractor and Medicaid would share equally in any cost increases/decreases beyond the 2.5%. Actual plan gain or loss does not factor into this calculation.

4.2.1.4. With the structure as described above, DHCS and its actuaries will establish actuarially sound Capitation Rates for the contracts that support the 1115(a) demonstration program for beneficiaries in the target population for Cal MediConnect. These rates will be consistent with 42 C.F.R. § 438.4 and reviewed by the CMS Regional Office. The CMS approved rates will serve as the baseline Medicaid costs.

4.2.1.5. Upon request prior to and throughout the Demonstration, the State and its actuaries will provide to CMS the underlying data for the rate calculations associated with the contracts that support the 1115(a) demonstration.

4.2.1.6. Medicaid payment rates will be determined by applying annual savings percentages in Figure 4.2 to the applicable Capitation Rates for the contracts that support the 1115(a) demonstration.

4.2.1.7. As allowed under the rates for the contracts that support the 1115(a) demonstration, DHCS and its actuaries will calculate a range of actuarially sound capitation payment rates including lower bound and upper rates. The application of the savings percentage will apply to all rates, including any prospective or retroactive adjustments, within actuarially sound rate range.

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4.2.1.8. Consistent with the Medicare rate updates at 4.2.2.2.6, the impact of the shift of nursing facility residents from MLTSS to Cal MediConnect in Los Angeles and Orange counties beginning in 2017 will be considered during Medicaid rate development for 2017 and subsequent years, as applicable.

4.2.2. Underlying Rate Structure for Medicare Components of the Capitation Rate.

4.2.2.1. Medicare will pay the Contractor a monthly capitation amount for the Medicare Parts A/B services (the Medicare A/B Component), risk adjusted using the Medicare Advantage CMS-HCC Model and the CMS-HCC ESRD Model, except as specified in Section 4.5. Medicare will also pay the Contractor a monthly capitation amount for Medicare Part D services, risk adjusted using the Part D RxHCC Model (the Medicare Part D Component).

4.2.2.2. Medicare A/B Component

4.2.2.2.1. The Medicare baseline spending for Parts A/B services are a blend of the Medicare FFS standardized county rates and the Medicare Advantage projected payment rates for each year, weighted by the proportion of the enrolled population enrolled in each program prior to the Demonstration. The FFS county rates will generally reflect amounts published with the April Medicare Advantage Final Rate Announcement, adjusted to fully incorporate more current hospital wage index and physician geographic practice cost index information; in this Demonstration, this adjustment will be fully applied to the FFS county rates in 2014, but the adjustment will otherwise use the same methodologies and timelines used to make the analogous adjustments in Medicare Advantage. CMS may also further adjust the Medicare FFS standardized county rates as necessary to calculate accurate payment rates for the Demonstration. To the extent that the published FFS county rates do not conform with current law in effect for Medicare during an applicable payment month, and to the extent that such nonconformance would have a significant

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fiscal impact on the Demonstration, CMS will update the baseline (and therefore the corresponding payment rate) to calculate and apply an accurate payment rate for such month. Such update may take place retroactively, as needed.

4.2.2.2.2. Separate baselines will exist for Enrollees meeting the Medicare ESRD criteria. For Enrollees with ESRD in the dialysis or transplant status phases, the Medicare Parts A/B baseline will be the ESRD dialysis state rate. For Enrollees in the functioning graft status phase, the Medicare Parts A/B baseline will be the Medicare Advantage 3.5% bonus county rate (benchmark) for the applicable county as of January 2015 (for CY 2014 the baseline was the 3-star county rate).

4.2.2.2.3. Both baseline spending and payment rates under the Demonstration for Medicare Parts A/B services will be calculated as PMPM standardized amounts for each county participating in the Demonstration for each year. Enrollee risk scores will be applied to the standardized rates at the time of payment.

4.2.2.2.4. The Medicare A/B Component will be updated annually consistent with annual FFS estimates and Medicare Advantage rates released each year with the annual rate announcement.

4.2.2.2.5. If an Enrollee elects to receive the Medicare hospice benefit, the Enrollee may remain in the Cal MediConnect Plan, but will obtain the hospice service through the Medicare FFS benefit and the Cal MediConnect Plan would no longer receive the Medicare Parts A/B component for that Enrollee as described in this section. Medicare hospice services and hospice drugs and all other original Medicare services would be paid for under Medicare FFS. Cal MediConnect Plans and providers of hospice services would be required to coordinate these services with the rest of the Enrollee's care. Cal MediConnect Plans would

continue to receive the Medicare Part D component for all non-hospice covered drugs. Election of hospice services does not change the Medi-Cal component unless otherwise specified in the DHCS 1115(a) demonstration.

4.2.2.2.6. Beginning January 2017, CMS will make an outlier adjustment for the Medicare A/B payments for non-ESRD beneficiaries served by the Contractor in Los Angeles and Orange Counties.

4.2.2.2.6.1. This adjustment will reflect the historical ratio of actual Medicare A/B FFS costs for the long term institutional (LTI) population in this county/counties to the predicted costs for this population, based on the standardized FFS county rates and the HCC risk adjustment model. This payment adjustment will be made retroactively after the end of each demonstration year, beginning in CY 2017 and going forward.

4.2.2.2.6.2. The outlier adjustment is a multiplicative factor equal to 95% of [the historical ratio minus 1 (one)] times the predicted rate for a baseline period. Specifically, the adjustment would be equal to: (the outlier adjustment percentage of 95%) times (this historical ratio from 4.2.2.2.6.1 minus 1(one)) times (the standardized FFS county rate for the applicable calendar year for the applicable county) times (the average final HCC risk score for the applicable calendar year for the population that meets the criteria in 4.2.2.2.6.3) times (the number of member months for the applicable calendar year associated with the population that meets the criteria in 4.2.2.2.6.3).

4.2.2.2.6.3. This adjustment is limited to those new Cal MediConnect members who newly enroll in the CalMediConnect demonstration as of January 1, 2017, or later; were in Medicare LTI status at the time of their Cal

MediConnect enrollment; and were in Medicare FFS at the time of their Cal MediConnect enrollment.

4.2.2.2.6.4. Plans must initiate and report on corresponding quality improvement activities focused on Cal MediConnect members in Medicare LTI status per Section 2.16.3.2.7.

4.2.2.3. Medicare Part D

4.2.2.3.1. The Medicare Part D component is comprised of the Part D direct subsidy set at the Part D national average monthly bid amount (NAMBA) for the calendar year, as well as CMS-estimated average monthly prospective payment amount for the low income cost-sharing subsidy and federal reinsurance amounts; these payments will be reconciled after the end of each payment year in the same manner as for all Part D sponsors.

4.2.2.3.2. The monthly Medicare Part D component for an Enrollee can be calculated by multiplying the Part D NAMBA by the RxHCC risk score assigned to the individual, and then adding to this the estimated average monthly prospective payment amount for the low income cost-sharing subsidy and federal reinsurance amounts.

4.2.3. Aggregate Savings Percentages

4.2.3.1. Aggregate savings percentages will be applied equally, as follows, to the baseline spending amounts for the Medicare A/B and Medi-Cal components of the capitated rate, provided that such savings percentages may be adjusted in accordance with Sections 4.2.3.2 herein.

4.2.3.2. Savings percentages will not be applied to the Part D Component of the rate. CMS will monitor Part D costs closely on an ongoing basis. Any material change in Part D costs relative to the baseline may be factored into future year savings percentages.

Figure 4.2: Savings Percentages

	Demonstration Year 1	Demonstration Year 2	Demonstration Years 3-8
Minimum Savings Percentages	**1.00%**	**2.00%**	**4.00%**
County Specific Interim Savings Percentages: the sum of the minimum savings percentages and the county-specific addition			
Los Angeles	+ 0.00%	+ 1.50%	+ 1.50%
Orange	+ 0.42%	+ 1.50%	+ 1.50%
Riverside	+ 0.22%	+ 1.50%	+ 1.14%
San Bernardino	+ 0.44%	+ 1.50%	+ 1.50%
San Diego	+ 0.23%	+ 1.50%	+ 1.10%
San Mateo	+ 0.47%	+ 0.33%	+ 0.00%
Santa Clara	+ 0.23%	+ 1.45%	+ 0.95%

4.2.3.3. Limited risk corridors will be applied as described in Sections 4.3 and 4.4 on a Contractor basis and be reconciled after application of any risk adjustment methodologies and any other adjustments, as described in Section 4.2.1.2.

4.2.3.3.1. Risk corridors will be reconciled as if the Contractor had received the full quality withhold payment.

4.2.3.3.2. The application of county-specific interim savings percentages in Section 4.2.3.1. establishes the initial Capitation Rates for purposes of the risk corridor calculation for Demonstration Years 1-3, as described in Section 4.3.

4.2.3.3.3. A limited one-sided risk corridor will apply for Demonstration Years 6-8, as described in Section 4.4.

4.3. Risk Corridors for Demonstration Years 1-3

4.3.1. General Provisions

4.3.1.1. Calculation of Gains and Losses: The risk-sharing arrangement described in this section of the Contract may result in payment by the State and CMS to the Contractor or by the Contractor to the State and CMS.

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4.3.1.1.1. All payments to be made by the State and CMS to the Contractor or by the Contractor to the State and CMS will be calculated and determined jointly by the State and CMS.

4.3.1.1.2. All calculations, determined jointly by the State and CMS, will be based on the Contractor's reporting of Adjusted Service Expenditures and Adjusted Non-Service Expenditures, as required in Section 4.3.3 All financial reporting will be subject to review and/or audit at the State's and CMS' discretion. As applicable, all calculations will sum the Contractor's expenditures and revenues across all counties in which the Contractor operates.

4.3.1.1.3. CMS and the State will perform a final settlement of the payments made by the Contractor to CMS and the State, or by CMS and the state to the Contractor, as described in Section 4.3.3.1.

4.3.1.2. Two-sided risk corridors will apply for Demonstration Years 1-3.

4.3.1.3. Allowable Expenditures

4.3.1.3.1. CMS and the State shall jointly determine the Adjusted Service Expenditures and the Adjusted Non-Service Expenditures, based on Encounter Data, cost data, and financial reporting data (including the State's rate development template) submitted by the Contractor (as required by Section 4.3.3, and Section 2.17-2.19 of this Contract). CMS and the State reserve the right to audit Actual Service Expenditure and Actual Non-Service Expenditure data.

4.3.1.3.2. CMS, the State, and the Contractor agree that to the extent there are differences in expenditure data reported across various sources, including the encounter, cost, financial reporting, or other data submitted by the Contractor, CMS, the State and the Contractor will confer and make a good

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faith effort to reconcile those differences before the calculation of the final settlement.

4.3.1.3.3. The review procedures may include a review of the Contractor's Encounter Data and/or audit, to be performed by the CMS and/or the State, or either party's authorized agents, to verify that all paid claims for Enrollees by the Contractor are for Covered Services and/or that provider reimbursement is not excessive. CMS and the State will jointly have the final decision on the resolution of any differences in the expenditure data reported.

4.3.1.3.4. The State and CMS reserve the right to adjust expenditures for services that are reimbursed at more than ten percent (10%) above the median reimbursement rate of all plans within a region. For the purposes of the risk corridor, the Regions are defined as the Northern Counties Region (San Mateo and Santa Clara Counties) and the Southern Counties Region (Los Angeles, Orange, Riverside, San Bernardino, and San Diego Counties).

4.3.1.3.5. The State and CMS reserve the right to adjust non-service expenditures that are greater than 125% of the median PMPM across all participating Contractors during the applicable Demonstration Year. Notwithstanding any contractual provision or legal right to the contrary, the Contractor agrees that there shall be no redress against CMS or the State for a determination to adjust or a failure to adjust expenditures for services of any Contractor.

4.3.2. Risk Corridor Parameters

4.3.2.1. The Demonstration will utilize a limited down-side risk corridor and a limited up-side risk corridor to include all Medicare A/B and Medicaid eligible Adjusted Service and Non-Service Expenditures. The risk corridors will be reconciled after the application of risk adjustment methodologies (e.g., CMS-HCC, Medicaid Relative Cost Factors and Relative Mix Factors), intergovernmental transfers, and as if all Contractors had received the full quality withhold payment.

4.3.2.1.1. Risk Corridor Share: The Medicare and Medicaid contributions to risk corridor payments or recoupments will be in proportion to their contributions to the Adjusted Interim Capitation Rate Revenue. Losses and gains will be determined using the approaches described in Section 4.3.2.1.3.

4.3.2.1.2. Adjusted Interim Capitation Rate Revenue and Adjusted Final Capitation Rate Revenue: As described in Section 4.2.3.1, the application of county-specific interim savings percentages in Figure 4-2, with the adjustments described in Section 4.3.2.1.6, establishes the Adjusted Interim Capitation Rate Revenue. The Adjusted Final Capitation Rate Revenue is the revenue, with the adjustments described under Section 4.3.2.1.6, that the Contractor would have received if the minimum savings percentages, rather that the county-specific interim savings percentages, were applied.

4.3.2.1.3. Definition of Gains/Losses: Gains and losses are defined as the Adjusted Interim Capitation Rate Revenue minus the Total Adjusted Expenditures, with positive figures defined as gains and negative figures defined as losses. The Adjusted Interim Capitation Rate Revenue and the Total Adjusted Expenditures will incorporate Contractor's revenue and expenditures across all counties in which the Contractor operates.

4.3.2.1.4. Down-Side Risk Corridor Payment/Recoupment

4.3.2.1.4.1. Losses will be compared to Contractor's underwriting profit/risk/contingency load. If losses exceed this amount, the difference of the loss less the underwriting profit/risk/contingency load shall be eligible for payment under the risk corridor. No payment shall be made for losses that are less than the underwriting profit/risk/contingency load.

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4.3.2.1.4.2. First Band: For losses in excess of the underwriting profit/risk/contingency load, the State and CMS will make payment to the Contractor of sixty-seven percent (67%) of the loss, with the maximum CMS/State payment to the Contractor not exceeding the Adjusted Final Capitation Rate Revenue minus the Adjusted Interim Capitation Rate Revenue. The share of the payment made by the State and CMS will be as described in Section 4.3.2.1.1. All losses in excess of the CMS/State payment are the responsibility of the Contractor.

4.3.2.1.5. Up-Side Risk Corridor Payment/Recoupment: For gains, the following bands apply:

4.3.2.1.5.1. First Band: The first band is equal to the difference between the Adjusted Interim Capitation Rate Revenue and the Adjusted Final Capitation Rate Revenue. For the purposes of the up-side risk corridor, for Contractors in counties where the interim saving percentage is equal to the minimum savings percentage, for the purposes of the up-side risk corridor, the Adjusted Interim Capitation Rate Revenue shall be further modified by applying savings percentages of one and a half percent (1.5%) in Demonstration Year 1, three and a half percent (3.5%) in Demonstration Year 2 and 5.5% in Demonstration Years 3, where applicable, rather than one percent (1.0%), two percent (2.0%) and four percent (4.0%), respectively; this is determined by multiplying the initial Adjusted Interim Capitation Rate Revenue by (1 – the applicable 1.5%, 3.5% or 5.5% savings percentages above) / (1- Interim Savings Percentage).

4.3.2.1.5.1.1. For the portion of gains in the first band, no payment will be made by

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the Contractor to the State and CMS.

4.3.2.1.5.2. Second Band: The second band is the same size as the first band. For the portion of gains in the second band, the Contractor will make payment to the State and CMS of fifty percent (50%) of this portion of the gain, with the share of the payment made to the State and CMS as described in Section 4.3.2.1.1.

4.3.2.1.5.3. Third Band: For the portion of gains greater than the upper limit of the second band, no payment will be made by the Contractor to the State and CMS.

Figure 4-3 Demonstration Years 1-3 Risk Sharing Corridor Table (for illustrative purposes only)

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Risk Corridor Band	Incremental Loss or Gain[1]	% Contractor Risk Sharing	% the State & CMS Risk Sharing	% CMS Risk Sharing	% the State Risk Sharing[2]
Loss Band 1	All Losses in Excess of Underwriting Profit/Risk/ Contingency Load	33%	67% (up to maximum not exceeding Adjusted Final Capitation Rate Revenue - Adjusted Interim Capitation Rate Revenue)	(67%) * (Medicare A/B Percent of Rate)	(67%)*(Medi-Cal Percent of Rate)
Gain Band 1	Gains ≤ (Adjusted Interim Capitation Rate Revenue – Adjusted Final Capitation Rate Revenue)[3]	100%	0%	0%	0%
Gain Band 2	Gains ≤ Band equal to size of *Gain Band 1*	50%	50%	(50%) * (Medicare A/B Percent of Rate)	(50%)*(Medi-Cal Percent of Rate)
Gain Band 3	Gains > Upper Limit of *Gain Band 2*	100%	0%	0%	0%

[1] Loss and gain reflected on an incremental basis. Gains in Gain Bands 3 still results in risk sharing reconciliation for the gain in Gain Band 2.

[2] All State Risk Sharing shall be treated as Medicaid expenditures eligible for FMAP.

[3] The Adjusted Interim Capitation Rate Revenue is modified for counties in which the Interim Savings Percentage equals the Minimum Savings Percentage.

4.3.3. Risk Sharing Settlement: CMS and the State shall determine a final settlement of payments made by the Contractor to CMS and the State, or by CMS and the State to the Contractor under this section. If any significant determinant of revenues or costs remains outstanding such that the timelines in this section do not apply, CMS and the State will establish reasonable timeframes for reporting payment and related final settlement timeframes.

4.3.3.1. Final settlement: CMS and the State shall determine a final settlement based on fifteen (15) months of claims run-out and an IBNR estimate.

4.3.3.1.1. For the purpose of the final settlement, the Contractor will jointly provide to CMS and the State the following within four hundred eighty (480) calendar days following the end of each applicable Demonstration Year, or within a timeline jointly agreed upon by CMS and the State. A complete and accurate report of Actual Non-Service Expenditures for Enrollees in the applicable Demonstration Year;

4.3.3.1.2. A complete and accurate report of Actual Service Expenditures, based on category of services, for Enrollees based on claims incurred for the applicable Demonstration Year, including fifteen (15) months of claims run-out;

4.3.3.1.3. The Contractor's best estimate of any claims incurred but not reported for claims run-out beyond fifteen (15) months and any IBNR completion factors by category of service;

4.3.3.1.4. A complete and accurate report of Part D revenue and expenditure, as required under 42 C.F.R. § 423.514(a)(1) of this Contract;

4.3.3.1.5. A complete and accurate report reflecting any recoveries from other payors outside of claims adjudication that are not reflected in the reported Actual Service Expenditures, including those pursuant to coordination of benefits, third party liability, rebates, supplemental payments,

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adjustments in claims paid, adjustments from providers including adjustments to claims paid, and Enrollee contributions to care;

4.3.3.1.6. A complete and accurate report of net reinsurance costs that are included in the reported Actual Non-Service Expenditures;

4.3.3.1.7. Financial reports;

4.3.3.1.8. Encounter Data, as required under Section 2.19 of this Contract;

4.3.3.2. CMS and the State shall provide the Contractor with a final reconciliation under the risk corridor arrangement within five hundred ten (510) calendar days following the end of each applicable Demonstration Year, or within a timeline jointly agreed upon by CMS and the State. Any balance due between the Contractor and CMS and the State shall be paid within sixty (60) days of the Contractor receiving the final reconciliation from CMS and the State; and

4.3.3.3. The Contractor shall provide any additional information upon request from CMS and the State necessary to calculate Total Adjusted Expenditures.

4.4. One-sided risk corridors will be established for Demonstration Years 6-8

4.4.1. General Provisions

4.4.1.1. The Demonstration will utilize a one-sided risk corridor for Demonstration Years 6 through 8. The one-sided risk corridor is designed to limit the profits received by Cal MediConnect MMPs to a reasonable percentage of total revenue.

4.4.1.2. Calculation of Gains and Losses: The risk sharing arrangement described in this section of the Contract may result in payment by the Contractor to the State and CMS.

4.4.1.2.1. All payments made by the Contractor to the State and CMS will be calculated and determined jointly by the State and CMS.

4.4.1.2.2. All calculations, determined jointly by the State and CMS, will be based on the Contractor's reporting of Adjusted Non-Service Expenditures and Adjusted Service Expenditures, as required in Section 4.4.3. All financial reporting will be subject to review and/or audit at the State's and CMS' discretion. As applicable, all calculations will sum the Contractor's expenditures and revenues across all counties in which the Contractor operates.

4.4.1.2.3. CMS and the State will perform a final settlement of the payments made by the Contractor to CMS and the State, as described in Section 4.4.3.

4.4.1.3. Allowable Expenditures

4.4.1.3.1. CMS and the State shall jointly determine the Adjusted Service Expenditures and the Adjusted Non-Service Expenditures, based on Encounter Data, cost data, and financial reporting data (including the State's rate development template) submitted by the Contractor (as required by Section 4.4.3 and Section 2.17-2.19 of this Contract). CMS and the State reserve the right to audit Actual Service Expenditure and Actual Non-Service Expenditure data.

4.4.1.3.2. CMS, the State, and the Contractor agree that to the extent there are differences in expenditure data reported across various sources, including the encounter, cost, financial reporting, or other data submitted by the Contractor, CMS, the State and the Contractor will confer and make a good faith effort to reconcile those differences before the calculation of the final settlement. The review procedures may include a review of the Contractor's Encounter Data and/or audit, to be performed by the CMS and/or the State, or either party's authorized agents, to verify that all paid claims for Enrollees by the Contractor are for Covered Services and/or that provider reimbursement is not excessive. CMS and the State

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will jointly have the final decision on the resolution of any differences in the expenditure data reported.

4.4.1.3.3. The State and CMS reserve the right to adjust expenditures for services that are reimbursed significantly above the median reimbursement rate of other comparable plans. The State and CMS reserve the right to adjust non-service expenditures that are greater than 125% of the median PMPM across all participating Contractors during the applicable Demonstration Year. The State and CMS will provide additional detail regarding the methodology for considering adjustments to expenditures in separate technical guidance. Notwithstanding any contractual provision or legal right to the contrary, the Contractor agrees that there shall be no redress against CMS or the State for a determination to adjust or a failure to adjust expenditures for services of any Contractor.

4.4.2. One-Sided Risk Corridor Parameters

4.4.2.1. The Demonstration will utilize a limited up-side risk corridor to include all Medicare A/B and Medicaid eligible Adjusted Service and Non-Service Expenditures. The risk corridors will be reconciled after the application of risk adjustment methodologies (e.g., CMS-HCC, Medicaid Relative Cost Factors and Relative Mix Factors), and intergovernmental transfers. The risk corridor will reflect the actual quality withhold payment received back by the Contractor.

4.4.2.1.1. Risk Corridor Share: The Medicare and Medicaid contributions to risk corridor payments will be in proportion to their contributions to the Adjusted Interim Capitation Rate Revenue. Losses and gains will be determined using the approaches described in Section 4.4.2.1.2.

4.4.2.1.2. Definition of Gains/Losses: Gains and losses are defined as the Adjusted Interim Capitation Rate Revenue minus the Total Adjusted Expenditures,

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with positive figures defined as gains and negative figures defined as losses. The Adjusted Interim Capitation Rate Revenue and the Total Adjusted Expenditures will incorporate Contractor's revenue and expenditures across all counties in which the Contractor operates.

4.4.2.1.3. Up-Side Risk Corridor Payment/Recoupment: For gains, the following bands apply:

4.4.2.1.3.1. First Band: The Contractor will retain all of the gains that are equal to or less than five percent (5%) of the Adjusted Interim Capitation Rate Revenue received by the Contractor.

4.4.2.1.3.2. Second Band: DHCS/CMS and the Contractor will share that portion of the gains that is over five percent (5%) and less than or equal to seven percent (7%) of the Adjusted Interim Capitation Rate revenue received by the Contractor, with seventy-five percent (75%) retained by the Contractor and twenty percent (25%) paid to DHCS/CMS.

4.4.2.1.3.3. Third Band: DHCS/CMS and the Contractor will share that portion of the gains that is over seven percent (7%) and less than or equal to nine percent (9%) of the Adjusted Interim Capitation Rate revenue received by the Contractor, with fifty percent (50%) retained by the Contractor and fifty percent (50%) paid to DHCS/CMS.

4.4.2.1.3.4. Fourth Band: DHCS/CMS and the Contractor will share that portion of the gains that is over nine percent (9%) and less than or equal to twelve percent (12%) of the

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Adjusted Interim Capitation Rate revenue received by the Contractor, with twenty-five percent (25%) retained by the Contractor and seventy-five percent (875%) paid to DHCS/CMS.

4.4.2.1.3.5. Fifth Band: DHCS/CMS will recoup the entire portion of the gains that exceeds twelve percent (12%) of the Adjusted Interim Capitation Rate Revenue received by the Contractor.

Figure 4-4 Demonstration Years 6-8 Risk Sharing Corridor Table (for illustrative purposes only)

Risk Corridor Band	**Incremental Gain[1]**	**% Contractor Gain Sharing**	**% State & CMS Gain Sharing**	**% CMS Gain Sharing**	**% State Gain Sharing**
Gain Band 1	Gains ≤ 5%	100%	0%	0%	0%
Gain Band 2	Gains >5% and ≤7%	75%	25%	(25%) * (Medicare A/B Percent of Rate)	(25%)*(Medi-Cal Percent of Rate)
Gain Band 3	Gains >7% and ≤9%	50%	50%	(75%) * (Medicare A/B Percent of Rate)	(75%)*(Medi-Cal Percent of Rate)
Gain Band 4	Gains >9% and ≤12%	25%	75%	(75%) * (Medicare A/B Percent of Rate)	(75%)*(Medi-Cal Percent of Rate)
Gain Band 5	Gains >12%	0%	100%	(100%) * (Medicare A/B Percent of Rate)	(100%)*(Medi-Cal Percent of Rate)

[1] Gain reflected on an incremental basis. Gains in Gain Band 5 still results in risk sharing reconciliation for the gain in Gain Bands 2-4.

4.4.3. Risk Sharing Settlement

4.4.3.1. CMS and the State shall determine final settlement of payments made by the Contractor to CMS and the State.

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4.4.3.2. Data Submission. The Contractor shall submit to DHCS and CMS, in the form and manner prescribed by DHCS and CMS, the necessary data to calculate and verify the final settlement after the end of each applicable Demonstration Year.

4.4.3.3. In the event the Contractor qualifies to make both a risk corridor payment to CMS and DHCS, as well as an MLR remittance as described in Section 4.12.1, the risk corridor calculation will be net of an MLR remittances.

4.5. Medicare Risk Adjustment Methodology

4.5.1. Medicare Parts A/B: The Medicare A/B Component will be risk adjusted based on the risk profile of each Enrollee. Except as specified below, the existing Medicare Advantage CMS-HCC and CMS-HCC ESRD risk adjustment methodology will be used for Cal MediConnect.

4.5.2. Coding Intensity Adjustment Factor

4.5.2.1. CMS will calculate calendar year 2014 rates as if the coding intensity adjustment factor were not applied, to reflect the fact that virtually all Enrollees were receiving care in FFS Medicare and thus there should be no coding pattern differences for which to adjust. Operationally CMS will still apply the coding intensity adjustment factor to the risk scores but will increase the Medicare A/B baseline for non-ESRD beneficiaries and beneficiaries with an ESRD status of functioning graft, to offset this.

4.5.2.2. In calendar year 2015, CMS will calculate and apply a coding intensity adjustment reflective of all Demonstration Enrollees except as indicated in Section 4.5.2.4. This will apply the prevailing Medicare Advantage coding intensity adjustment, on a county-specific basis, proportional to the anticipated proportion of Cal MediConnect Enrollees in 2015 with Medicare Advantage or Cal MediConnect experience in 2014, prior to September 30, 2014.

4.5.2.3. After calendar year 2015, CMS will apply the prevailing Medicare Advantage coding intensity adjustment to all Cal MediConnect Enrollees, with the exception of Cal MediConnect Enrollees in Orange County given the start date of enrollment in this county.

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4.5.2.3.1. For Orange County in CY 2016, CMS will apply the prevailing Medicare Advantage coding intensity adjustment proportional to the anticipated proportion of Orange County Cal MediConnect Enrollees in 2016 with Medicare Advantage or demonstration experience prior to September 30, 2015. After calendar year 2016, CMS will apply the prevailing Medicare Advantage coding intensity adjustment to Cal MediConnect Enrollees in Orange County.

4.5.2.4. The coding intensity adjustment factor will not be applied during the Demonstration to risk scores for Enrollees with an ESRD status of dialysis or transplant, consistent with Medicare Advantage policy. Medicare Part D: The Medicare Part D NAMBA will be risk adjusted in accordance with existing Part D RxHCC methodology. The estimated average monthly prospective payment amount for the low income cost-sharing subsidy and federal reinsurance amounts will not be risk adjusted.

4.5.3. Medi-Cal Component: For the Medi-Cal Component of the capitated rate, DHCS will rely on the methodology described in Section 4.2.1.3 to account for differences in risk among the eligible population.

4.6. Payment Terms

4.6.1. CMS and DHCS will each make monthly, prospective capitation payments to the Contractor, with retroactive adjustments, as applicable, as described in Sections 4.2.2.2.6, 4.2.2.3.1, 4.7 and 4.14.

4.6.1.1. The Medicare Parts A/B component will be the product of the Enrollee's CMS-HCC risk score multiplied by the relevant standard county payment rate (or the ESRD dialysis state rate by the HCC ESRD risk score, as applicable). The Medicare Part D Component will be the product of the Enrollee's RxHCC risk score multiplied by the Part D NAMBA, with the addition of the estimated average monthly prospective payment amount for the low income cost-sharing subsidy and federal reinsurance amounts. The payment period will commence on the Contract Operational Start Date.

4.6.1.2. DHCS shall remit to the Contractor a capitation payment each month for each Enrollee that appears on the approved

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list of Enrollees supplied to Contractor by DHCS. The Capitation Rate shall be the amount specified in Section 4.2.1.6. The payment period for health care services shall commence on the Contract Operational Start Date.

4.6.1.2.1. DHCS will pay an IHSS interim payment on behalf of the Contractor for IHSS Provider payroll as a portion of the covered Medicaid services. The IHSS interim payment will be reconciled as described in Section 4.14.3.1. This provision shall apply only with respect to IHSS provided on or before December 31, 2017. IHSS is no longer a Covered Service under this contract for service dates on or after January 1, 2018, pursuant to Statutes 2017, chapter 52 (S.B. 97).

4.7. Modifications to Capitation Rates. CMS and DHCS will jointly notify the Contractor in advance and in writing of any proposed changes to the Capitation Rates, and the Contractor shall accept such changes as payment in full as described in Section 4.15.

4.7.1. Rates will be updated using a similar process for each calendar year. Subject to Section 4.7.2., changes to the Medicare and Medicaid baselines outside of the annual Medicare Advantage and Part D rate announcements will be made only if and when CMS and DHCS jointly determine the change is necessary to calculate reasonable, appropriate, and attainable payment rates for Cal MediConnect. Such changes may be based on the following factors: shifts in enrollment assumptions; changes due to litigation; changes or discrepancies in federal law and/or State policy compared to assumptions about federal law and/or State law or policy used in the development of baseline estimates; changes in coding intensity; and other factors as determined appropriate and approved by CMS and the State.

4.7.2. For changes solely affecting the Medicare program baseline, CMS will update baselines by amounts identified by the independent Office of the Actuary necessary to best effectuate accurate payment rates for each month.

4.7.3. Subject to Section 4.7.2, if other statutory changes enacted after the annual baseline determination and rate development process are jointly determined by CMS and DHCS to have a material change in baseline estimates for any given payment year, baseline estimates and

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corresponding standardized payment rates shall be updated outside of the annual rate development process.

4.7.4. Changes to the savings percentages will be made if and when CMS and DHCS jointly determine that changes in Part D spending have resulted in materially higher or lower savings that need to be recouped through higher or lower savings percentages applied to the Medicare A/B baselines or if and when CMS and DHCS jointly determine the change is necessary to calculate reasonable, appropriate and attainable payment rates for Cal MediConnect.

4.7.5. IHSS wage adjustments may occur during Cal MediConnect. Changes to the Medi-Cal Component will be made annually by county and may be retroactively applied to account for IHSS wage adjustments that occurred during the calendar year, subject to CMS review. This provision shall apply only with respect to IHSS provided on or before December 31, 2017. IHSS is no longer a Covered Service under this contract for service dates on or after January 1, 2018, pursuant to Statutes 2017, chapter 52 (S.B. 97).

4.8. Quality Withhold Policy for Medi-Cal and Medicare A/B Components of the Integrated, Risk-Adjusted Rate

4.8.1. Under Cal MediConnect, both payers will withhold a percentage of their respective components of the Capitation Rate, with the exception of Part D component amounts. The withheld amounts will be repaid subject to the Contractor's performance consistent with established quality thresholds.

4.8.1.1. In Demonstration Year 1 of Cal MediConnect, the withhold will be 1% of the respective components of the Capitation Rate. **See Figure 4.5**.

4.8.1.2. For Demonstration Year 1, which crosses calendar years, the Contractor will be evaluated to determine whether it has met quality withhold requirements at the end of CY 2014 and at the end of CY 2015. The determination in CY 2014 will be based solely on those measures that can appropriately be calculated based on the actual enrollment volume during CY 2014. Consistent with such evaluations, the withheld amounts will be repaid separately for each calendar year.

Figure 4.5: Quality Withhold Measures for Demonstration Year 1

Measure	Source	CMS Core Withhold Measure	California Withhold Measure
Assessments	CMS defined process measure	X	
Consumer Governance Board	CMS defined process measure	X	
Getting Appointments and Care Quickly	AHRQ/CAHPS	X	
Customer Service	AHRQ/CAHPS	X	
Behavioral Health Shared Accountability Policies and Procedures	State defined process measure		X
Documentation of Care Goals	State defined process measure		X
Ensuring Physical Access to Buildings, Services and Equipment	State defined process measure		X
Interaction with Care Team	State defined process measure		X

4.8.1.3. The quality withhold will increase to two percent (2%) in Demonstration Year 2, three percent (3%) for Demonstration Years 3-5 and four percent (4%) for Demonstration Years 6-8. **See Figure 4.6.**

4.8.1.4. Payment will be based on performance on the quality withhold measures listed in Figure 4.6 below. The Contractor must report these measures according to the prevailing technical specifications for the applicable measurement year.

4.8.1.5. If the Contractor is unable to report at least three (3) of the quality withhold measures listed in Figure 4.6 for a given year due to low enrollment or inability to meet other reporting criteria, alternative measures will be used in the quality withhold analysis. Additional information about this policy is available in separate technical guidance.

Figure 4.6: Quality Withhold Measures for Demonstration Years 2 -8

Measure	Source	CMS Core Withhold Measure	California Withhold Measure
Encounter Data	CMS defined process measure	X	
Plan All-Cause Readmissions	NCQA/HEDIS	X	

	Source	CMS Core Withhold Measure	California Withhold Measure
Annual Flu Vaccine	AHRQ/CAHPS	X	
Follow-Up After Hospitalization for Mental Illness	NCQA/HEDIS	X	
Reducing the Risk of Falling	NCQA/HEDIS/HOS	X	
Controlling Blood Pressure	NCQA/HEDIS	X	
Part D Medication Adherence for Diabetes Medications	CMS/PDE Data	X	
Behavioral Health Shared Accountability Process Measure (DY 3 Only)	State-defined process measure		X
Behavioral Health Shared Accountability Outcome Measure	State-defined measure		X
Documentation of Care Goals	State defined process measure		X
Interaction with Care Team	State defined process measure		X

4.8.2. CMS and DHCS will evaluate the Contractor's performance according to the specified metrics required in order to earn back the quality withhold for a given year.

4.8.3. Whether or not the Contractor has met the quality requirements in a given year will be made public, as will relevant quality results in all Demonstration Years.

4.9. Shared Financial Accountability Strategy for Incentive Payments for Behavioral Health Services

4.9.1.1. Shared accountability between the Cal MediConnect Plan and county Behavioral Health agencies aims to promote Care Coordination to ensure Enrollees have access to all needed services. Shared accountability builds on the performance-based quality withhold from the plans' Capitation Rates of one percent, two percent, three percent, and four percent (1%, 2%, 3%, and 4%) in years one, two, three through five, and six through eight of the Demonstration. By meeting specified quality measures, the Contractor can earn back the withheld capitation revenue by meeting specified quality objectives. Under this shared accountability strategy, one (1) withhold measure in year

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one, one (1) withhold measure in year two, two (2) withhold measures in year three, and one (1) withhold measure in years four through eight will be tied to Behavioral Health coordination with the county.

4.9.1.2. The Contractor will be required to share with the applicable county Behavioral Health agencies a minimum amount of funds earned back through the shared accountability quality withhold measure each year. Contractor may choose to go above and beyond this minimum. This must be executed as directed in future guidance from DHCS.

4.9.1.3. The Contractor must provide an incentive payment each year to the county Behavioral Health agency that is equal to or greater than the value of each quality withhold measure multiplied by the proportion of Enrollees identified as having Behavioral Health needs and who are receiving county services. The proportion is defined as follows:

4.9.1.3.1. The denominator will be the total number of Enrollees with mental illness or substance use disorders, as defined for the emergency department reduction quality withhold measure for Years 2 through 8. The numerator would be the subset of those Enrollees who are receiving services through the county Behavioral Health agency.

4.9.1.3.2. In all counties except Los Angeles, the mental health and substance use departments are administratively combined. In Los Angeles County, the proportion of Enrollees with substance use disorders receiving county drug and alcohol services would be calculated separately from the Enrollees with mental illness population to identify the incentive payment amount paid to the Department of Public Health.

4.9.1.3.3. Assuming successful completion and equal weighting of each measure, total Behavioral Health shared accountability incentive payments in each year would equal:

- Year 1 Measure A = 0.001 multiplied by the total capitation multiplied by proportion of Enrollees with Behavioral Health disorders who are using county specialty mental health or Drug Medi-Cal services.
- Year 1 Measure B = 0.001 multiplied by the total capitation multiplied by proportion of Enrollees with Behavioral Health disorders who are using county specialty mental health or Drug Medi-Cal services.
- Year 2: ED Measure = 0.002 multiplied by the total capitation multiplied by proportion of Enrollees with Behavioral Health disorders who are using county specialty mental health or Drug Medi-Cal services.
- Year 3-8: ED Measure = 0.003 multiplied by the total capitation multiplied by proportion of Enrollees with Behavioral Health disorders who are using county specialty mental health or Drug Medi-Cal services.

4.10. Medicare A/B Disenrollment Penalty

4.10.1. Beginning in Demonstration Year 5 (CY 2019) CMS will implement a retrospective financial penalty in the Medicare A/B component of the Capitation Rate for Contractors with high disenrollment rates. This penalty is intended to address selection bias that may be impacting Medicare costs for the Cal MediConnect Demonstration and to align incentives for Contractors to improve quality for all Enrollees.

4.10.2. Performance will be evaluated annually using the existing Medicare Part C measure entitled "Members Choosing to Leave Plan." For DYs 5 and 6, CMS intends to maintain the benchmark at the median Contractor performance from measurement year 2017. For DYs 7 and 8, CMS will set the benchmark at the median Contractor performance from the most recent measurement year. Contractors with rates above the benchmark will be subject to the penalty on a sliding scale, starting at one percent (1%) and up to two percent (2%). Additional detail regarding the methodology will be provided in separate technical guidance.

4.10.3. Based on Contractor performance, CMS will recoup the Medicare A/B penalty retroactively, once performance for the applicable Demonstration year has been determined.

4.11. American Recovery and Reinvestment Act of 2009. All payments to the Contractor are conditioned on compliance with the provisions below and all other applicable provisions of the American Recovery and Reinvestment Act of 2009.

4.11.1. Suspension of Payments. DHCS shall suspend payments to Cal MediConnect in accordance with 42 C.F.R. § 455.23as as determined necessary or appropriate by DHCS.

4.11.2. Non-Payment and Reporting of Provider Preventable Conditions. Pursuant to 42 C.F.R. § 438.3(g), all payments to the Contractor are conditioned on the Contractor's compliance with all provisions related to Provider Preventable Conditions in accordance with the applicable DPL(s) as indicated in Section 2.1.5.

4.12. Medical Loss Ratio (MLR)

4.12.1. For Medicaid rating periods beginning on or after July 1, 2017, the Contractor is required to calculate and report their MLR experience for Medicaid, consistent with the requirements at 42 C.F.R. §§ 438.4, 438.5, 438.8 and 438.74, unless a joint MLR covering both Medicare and Medicaid experience is calculated and reported consistent with CMS and DHCS requirements.

4.12.2. Prior to the applicability of the requirements in 4.4.1 for all Demonstration Years in which the risk corridor applies, the Medicare Advantage MLR requirements are waived. To the extent the risk corridor ceases prior to the applicability of the requirements in 4.4.1 the Medicare Advantage MLR requirements will be reinstated for any applicable years in which the risk corridor is not in effect.

4.13. Risk Score Changes

4.13.1. Medicare Risk Score Changes: Medicare CMS-HCC, CMS-HCC ESRD, and RxHCC risk scores will be updated consistent with prevailing Medicare Advantage regulations and processes.

4.14. Reconciliation

4.14.1. CMS and DHCS will implement a process to reconcile enrollment and capitation payments for the Contractor that will take into

consideration the following circumstances: transitions between RCs; retroactive changes in eligibility, RCs, or Enrollee contribution amounts; changes in CMS-HCC and RxHCC risk scores; and changes through new enrollment, disenrollment, or death. The reconciliation may identify underpayments or overpayments to the Contractor.

4.14.2. Identified Overpayments

4.14.2.1. The Contractor shall promptly report to DHCS and CMS any such identified overpayments due to Fraud.

4.14.2.2. The Contractor shall report to DHCS and CMS within sixty (60) calendar days when it has identified the capitation payments or other payments in excess of amounts specified in the contract.

4.14.2.3. Recoveries by the Contractor of overpayments to providers. Consistent with Section 1128J(d) of the Social Security Act, the Contractor must adopt and implement policies for the treatment of recoveries of overpayments from the Contractor to a Network Provider.

4.14.3. Medi-Cal Component Reconciliation. The Medi-Cal Component reconciliation will occur a minimum of once a month. The monthly reconciliation process will reconcile retroactively up to twelve (12) months of historical enrollment changes or up to the effective date of the contract, whichever is sooner.

4.14.3.1. The Contractor is at full risk for IHSS Provider payments. On a quarterly basis, DHCS shall reconcile Actual IHSS expenditures against the IHSS Interim Payment. If Actual IHSS expenditures exceed the Interim Payment amount, DHCS shall invoice the Contractor for the difference with a thirty (30) day due date. DHCS shall pay California Department of Social Services within two (2) weeks of receipt from the Contractor. This provision shall apply only with respect to IHSS provided on or before December 31, 2017. IHSS is no longer a Covered Service under this Contract for service dates on or after January 1, 2018, pursuant to Statutes 2017, chapter 52 (S.B. 97).

4.14.4. Medicare Capitation Reconciliation: Medicare capitation reconciliation will comply with prevailing Medicare Advantage regulations and processes.

4.14.4.1. Final Medicare Reconciliation and Settlement: In the event the Contractor terminates or non-renews this Contract, CMS' final settlement phase for terminating contracts applies. This final settlement phase lasts for a minimum of eighteen (18) months after the end of the calendar year in which the termination date occurs. This final settlement will include reconciliation of any demonstration-specific payments or recoupments, including those related to joint Medicare A/B-Medicaid risk corridors, quality withholds, and medical loss ratios, as applicable, that are outstanding at the time of termination.

4.14.5. Audits/Monitoring: CMS and DHCS will conduct periodic audits to validate RC assignments or other coding. Audits may be conducted by a peer review organization or other entity assigned this responsibility by CMS and DHCS.

4.15. Payment in Full

4.15.1. The Contractor must accept, as payment in full for all Covered Services, the Capitation Rate(s) and the terms and conditions of payment set forth herein.

4.15.2. Notwithstanding any contractual provision or legal right to the contrary, the three (3) parties to this Contract (CMS, DHCS, and the Contractor), for Cal MediConnect agree there shall be no redress against either of the other two (2) parties, or their actuarial contractors, over the actuarial soundness of the Capitation Rates.

4.15.3. By signing this contract, the Contractor accepts that the Capitation Rate(s) offered is reasonable; that operating within this Capitation Rate(s) is the sole responsibility of the Contractor; and that while data is made available by the federal government to the Contractor, any entity participating in Cal MediConnect must rely on their own resource to project likely experience under Cal MediConnect.

5. Additional Terms and Conditions

5.1. Administration

5.1.1. Notification of Administrative Changes. The Contractor must notify CMS and DHCS through HPMS of all changes affecting the key functions for the delivery of care, the administration of its program, or its performance of Contract requirements. The Contractor must notify CMS and DHCS in HPMS no later than thirty (30) calendar days prior to any significant change to the manner in which services are rendered to Enrollees, including but not limited to reprocurement or termination of a First Tier, Downstream and Related Entity pursuant to Appendix C. The Contractor must notify CMS and DHCS in HPMS of all other changes no later than five (5) business days prior to the effective date of such change.

5.1.2. Assignment. The Contractor may not assign or transfer any right or interest in this Contract to any successor entity or other entity without the prior written consent of CMS and DHCS which may be withheld for any reason or for no reason at all.

5.1.3. Independent Contractors

5.1.3.1. The Contractor, its employees, First Tier, Downstream and Related Entities, and any other of its agents in the performance of this Contract, shall act in an independent capacity and not as officers, agents, or employees of the federal government, or DHCS.

5.1.3.2. The Contractor must ensure it evaluates the prospective First Tier, Downstream and Related Entities' abilities to perform activities to be delegated, as provided for in Appendix C.

5.1.4. Subrogation. Subject to CMS and DHCS lien and third-party recovery rights, the Contractor must:

5.1.4.1. Be subrogated and succeed to any right of recovery of an Enrollee against any person or organization, for any services, supplies, or both provided under this Contract up to the amount of the benefits provided hereunder;

5.1.4.2. Require that the Enrollee pay to the Contractor all such amounts recovered by suit, settlement, or otherwise from any third person or his or her insurer for other than Medi-

Cal and Medicare covered benefits, to the extent of the benefits provided hereunder, up to the value of the benefits provided hereunder. The Contractor may ask the Enrollee to:

5.1.4.2.1. Take such action, furnish such information and assistance, and execute such instruments as the Contractor may require to facilitate enforcement of its rights hereunder, and take no action prejudicing the rights and interest of the Contractor hereunder; and

5.1.4.2.2. Notify the Contractor hereunder and authorize the Contractor to make such investigations and take such action as the Contractor may deem appropriate to protect its rights hereunder whether or not such notice is given.

5.1.5. Prohibited Affiliations. In accordance with 42 U.S.C. § 1396 u-2(d)(1), the Contractor shall not knowingly have an employment, consulting, or other agreement for the provision of items and services that are significant and material to the Contractor's obligations under this Contract with any person, or affiliate of such person, who is excluded, under federal law or regulation, from certain procurement and non-procurement activities. Further, no such person may have beneficial ownership of more than five percent (5%) of the Contractor's equity or be permitted to serve as a director, officer, or partner of the Contractor.

5.1.6. Disclosure Requirements. The Contractor must disclose to CMS and DHCS information on ownership and control, business transactions, and persons convicted of crimes in accordance with 42 C.F.R. Part 455, Subpart B. The Contractor must obtain federally required disclosures from all Network Providers and applicants in accordance 42 C.F.R. § 1002.3, and as specified by DHCS, including but not limited to obtaining such information through provider enrollment forms and credentialing and recredentialing packages. The Contractor must maintain such disclosed information in a manner which can be periodically searched by the Contractor for exclusions and provided to DHCS in accordance with this Contract and relevant State and federal laws and regulations. In addition, the Contractor must comply with all reporting and disclosure requirements of 42 U.S.C. § 1396b(m)(4)(A) if the Contractor is not a federally qualified health maintenance organization under the Public Health Service Act. In addition, the Contractor shall make the information reported pursuant to 42 U.S.C. § 1396b(m)(4)(A) available to its Enrollees upon reasonable request.

5.1.7. Physician Incentive Plans.

5.1.7.1. The Contractor and its First Tier, Downstream and Related Entities must comply with all applicable requirements governing physician incentive plans, including but not limited to such requirements appearing at 42 C.F.R. Parts 417, 422, 434, 438.3(i), and 1003. The Contractor must submit all information required to be disclosed to CMS and the DHCS in the manner and format specified by CMS and the DHCS which, subject to federal approval, must be consistent with the format required by CMS for Medicare contracts.

5.1.7.2. The Contractor shall be liable for any and all loss of federal financial participation (FFP) incurred by the DHCS that results from the Contractor's or its First Tier, Downstream, or Related Entities' failure to comply with the requirements governing physician incentive plans at 42 C.F.R. Parts 417, 434 and 1003, however, the Contractor shall not be liable for any loss of FFP under this provision that exceeds the total FFP reduction attributable to Enrollees in the Contractor's plan, and the Contractor shall not be liable if it can demonstrate, to the satisfaction of CMS and the DHCS, that it has made a good faith effort to comply with the cited requirements. Federal financial participation is not available for any amounts paid to the Contractor if the Contractor could be excluded from participation in Medicare or Medicaid under section 1128(b)(8)(B) of the Social Security Act or for any of the reasons listed in 42 C.F.R. § 431.55(h).

5.1.7.3. Contractor may operate a PIP only if no specific payment can be made directly or indirectly under a PIP to a physician or physician group as an inducement to reduce or limit Medically Necessary Services furnished to an individual.

5.1.7.4. Contractor must provide information on its PIP to any Enrollee upon request as provided in 42 C.F.R. § 422.208.

5.1.8. Physician Identifier. The Contractor must require each physician providing Covered Services to Enrollees under this Contract to have a unique identifier in accordance with the system established under 42 U.S.C. § 1320d-2(b). The Contractor must provide such unique identifier to CMS and DHCS for each of its PCPs in the format and time-frame established by CMS and DHCS in consultation with the Contractor.

5.1.9. Timely Provider Payments. The Contractor must make timely payments to its Network Providers consistent with 42 C.F.R. § 447.45. The Contractor must ensure that ninety percent (90%) of claims from Network Providers (including Indian Health Care Providers) who are in individual or group practice, which can be processed without obtaining additional information from the physician or from a third party, will be paid within thirty (30) days of the date of receipt of the claim. In addition, ninety-nine percent (99%) of all clean claims from Network Providers will be paid within ninety (90) days of the date of receipt of the claim. The Contractor and its Network Providers may by mutual agreement, in writing, establish an alternative payment schedule. Generally, the date of receipt is the date the agency receives the claim, as indicated by its date stamp on the claim. The date of payment is the date of the check or other form of payment.

5.1.9.1. Pharmacy providers will be reimbursed in accordance with the prompt payment provisions at 42 C.F.R. § 423. 505(i)(3)(vi).

5.1.9.2. The Contractor shall pay ninety-five percent (95%) of clean claims from non-contracted providers within thirty (30) days of request. All other claims shall be paid or denied within sixty (60) days of request.

5.1.10. Provider Payments. The Contractor shall pay providers in accordance with Medicare and Medi-Cal coordination of benefits, per WIC Section 14182.16 and in accordance with applicable DPL(s) as indicated in Section 2.1.5.

5.1.10.1. Medi-Cal Alignment. The Contractor shall pay providers, including institutional providers, in accordance with the prompt payment provisions in compliance with 42 C.F.R. § 447.45, ARRA 5006(d) and as contained in each Contractor's Medi-Cal managed care contract with DHCS, including the ability to accept and pay electronic claims, excluding Part D.

5.1.10.2. Date of Receipt. The date of receipt is the date the agency receives the claim, as indicated by its date stamp on the claim. The date of payment is the date of the check or other form of payment.

5.1.10.3. Nursing Facility Rates. The Contractor shall not combine the rates of payment for post-acute skilled and rehabilitation care provided by a nursing facility and long-term and

chronic care provided by a nursing facility in order to establish a single payment rate for dual eligible beneficiaries requiring skilled nursing services. The Contractor shall pay nursing facilities providing post-acute skilled and rehabilitation care or long-term and chronic care rates that reflect the different level of services and intensity required to provide these services.

5.1.11. Protection of Enrollee-Provider Communications. In accordance with 42 USC § 1396 u-2(b)(3), the Contractor shall not prohibit or otherwise restrict a clinical First Tier, Downstream or Related Entity from advising an Enrollee about the health status of the Enrollee or medical care or treatment for the Enrollee's condition or disease; information the Enrollee needs in order to decide among all relevant treatment options; risk, benefits and consequences of treatment or non-treatment; and/or the Enrollee's rights to participate in decisions about his or her health care, including the right to refuse treatment and to express preferences about future treatment decisions, regardless of whether benefits for such care or treatment are provided under the Contract, if the clinical First Tier, Downstream, or Related Entity is acting within the lawful scope of practice.

5.1.12. Protecting Enrollee from Liability for Payment. The Contractor must:

5.1.12.1. In accordance with 42 C.F.R. § 438.106, not hold an Enrollee liable for:

5.1.12.1.1. Debts of the Contractor, in the event of the Contractor's insolvency;

5.1.12.1.2. Covered Services provided to the Enrollee in the event that the Contractor fails to receive payment from CMS or DHCS for such services; or

5.1.12.1.3. Payments to a clinical First Tier, Downstream and Related Entity in excess of the amount that would be owed by the Enrollee if the Contractor had directly provided the services;

5.1.12.2. Not charge Enrollees coinsurance, co-payments, deductibles, financial penalties, or any other amount in full or part, for any service provided under this Contract, except as otherwise provided in Appendix A below;

5.1.12.3. Not deny any service provided under this Contract to an Enrollee for failure or inability to pay any applicable charge; and

5.1.12.4. Not deny any service provided under this Contract to an Enrollee who, prior to becoming eligible, incurred a bill that has not been paid.

5.1.13. Third Party Liability (TPL)

5.1.13.1. General Requirements.

5.1.13.1.1. Coordination of Benefits means the process of utilizing TPL resources to ensure that Medi-Cal is the payer of last resort. This is accomplished by either operating a cost avoidance method of paying claims, when the existence of private health coverage is known at the time the claim is processed, or the method of post-payment recovery of the cost of services, if the coverage is identified retroactively.

5.1.13.1.2. DHCS shall refer to the Contractor the Enrollee's name and pertinent information where DHCS knows an Enrollee has been in an accident or had a traumatic event where a liable third party may exist.

5.1.13.1.3. The Contractor shall identify and notify the DHCS's TPL and Recovery Division of all instances or cases in which Contractor believes an action by the Enrollee involving casualty insurance or tort or Workers' Compensation liability of a third party could result in recovery by the Enrollee of funds to which DHCS has lien rights under Article 3.5 (commencing with Section 14124.70), Part 3, Division 9, WIC. Contractor shall make no claim for recovery of the value of Covered Services rendered to an Enrollee in such cases or instances and such case or instance shall be referred to State's TPL Branch within ten (10) calendar days of discovery. To assist DHCS in exercising its responsibility for such recoveries, Contractor shall meet the following requirements:

5.1.13.1.3.1. If DHCS requests service information and/or copies of paid invoices/claims for Covered Services to an Enrollee, Contractor shall deliver the requested information within thirty (30) calendar days of the request. Service information includes First Tier, Downstream, or Related Entity and out of plan 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 First Tier, Downstream, or Related Entity providers or out of plan providers for similar services, whichever is applicable under WIC Section 14124.90(c)(2).

5.1.13.1.3.2. Designate a TPL Benefit Coordinator who shall serve as a contact person for benefit coordination issues related to this Contract.

5.1.13.1.3.3. Designate one or more recoveries specialist(s), whose function shall be to investigate and process all transactions related to the identification of TPL.

5.1.14. Medicaid Drug Rebate

5.1.14.1. Non-Part D covered outpatient drugs dispensed to Enrollees shall be subject to the same rebate requirements as the State is subject under section 1927 of the Social Security Act and that the State shall collect such rebates from pharmaceutical manufacturers.

5.1.14.2. Contractor shall submit to DHCS, on a timely and periodic basis, no later than forty-five (45) calendar days after the end of each quarterly rebate period, information on the total number of units of each dosage form and strength and package size by National Drug Code of each non-Part D covered outpatient drug dispensed to Enrollees for which the Contractor is responsible for coverage and other data as DHCS determines necessary.

5.1.15. Moral or Religious Objections. The Contractor is not required to provide, reimburse for, or provide coverage of, a counseling or referral service that would otherwise be required if the Contractor objects to the service on moral or religious grounds. If the Contractor elects not to provide, pay for, or provide coverage of, a counseling or referral service because of an objection on moral or religious grounds, it must promptly notify DHCS and CMS in writing of its intent to exercise the objection. It must furnish information about the services it does not cover as follows:

5.1.15.1. To the State;

5.1.15.2. With its application for a contract;

5.1.15.3. Whenever it adopts the policy during the term of the Contract; and the information provided must be:

5.1.15.3.1. Consistent with the provisions of 42 C.F.R. § 438.10;

5.1.15.3.2. Provided to Eligible Beneficiaries before and during enrollment; and

5.1.15.3.3. Provided to Enrollees within ninety (90) days after adopting the policy with respect to any particular service.

5.2. Confidentiality

5.2.1. Statutory Requirements. The Contractor understands and agrees that CMS and DHCS may require specific written assurances and further agreements regarding the security and Privacy of protected health information that are deemed necessary to implement and comply with standards under the HIPAA as implemented in 45 C.F.R., Parts 160 and 164. The Contractor further represents and agrees that, in the performance of the services under this Contract, it will comply with all legal obligations as a holder of personal information under the California Information Practices Act (Civil Code Section 1798 et seq.). The Contractor represents that it currently has in place policies and procedures that will adequately safeguard any confidential personal data obtained or created in the course of fulfilling its obligations under

this Contract in accordance with applicable State and federal laws. The Contractor is required to design, develop, or operate a system of records on individuals, to accomplish an agency function subject to the Privacy Act of 1974, Public Law 93-579, December 31, 1974 (5 U.S.C. § 552a) and applicable agency regulations. Violation of the Act may involve the imposition of criminal penalties.

5.2.2. Personal Data. The Contractor must inform each of its employees having any involvement with personal data or other confidential information, whether with regard to design, development, operation, or maintenance, of the laws and regulations relating to confidentiality.

5.2.3. Data Security. The Contractor must take reasonable steps to ensure the physical security of personal data or other confidential information under its control, including, but not limited to: fire protection; protection against smoke and water damage; alarm systems; locked files, guards, or other devices reasonably expected to prevent loss or unauthorized removal of manually held data; passwords, access logs, badges, or other methods reasonably expected to prevent loss or unauthorized access to electronically or mechanically held data by ensuring limited terminal access; limited access to input documents and output documents; and design provisions to limit use of Enrollee names. The Contractor must put all appropriate administrative, technical, and physical safeguards in place before the start date to protect the Privacy and security of protected health information in accordance with 45 C.F.R. § 164.530(c). The Contractor must meet the security standards, requirements, and implementation specifications as set forth in 45 C.F.R. Part 164, subpart C, the HIPAA Security Rule. Contractor must follow the National Institute for Standards and Technology (NIST) Guidelines for the Risk Management Framework (RMF) to establish an information security program in accordance with the Federal Information Security Management Act (FISMA).

5.2.4. Return of Personal Data. The Contractor must return any and all personal data, with the exception of medical records, furnished pursuant to this Contract promptly at the request of CMS or DHCS in whatever form it is maintained by the Contractor. Upon the termination or completion of this Contract, the Contractor shall not use any such data or any material derived from the data for any purpose, and, where so instructed by CMS or DHCS will destroy such data or material.

5.2.5. Research Data. The Contractor must seek and obtain prior written authorization from CMS and DHCS for the use of any data pertaining

to this Contract for research or any other purposes not directly related to the Contractor's performance under this Contract.

5.3. General Terms and Conditions

5.3.1. Applicable Law. The term "applicable law," as used in this Contract, means, without limitation, all federal and California law, and the regulations, policies, procedures, and instructions of CMS and DHCS all as existing now or during the term of this Contract. All applicable law is hereby incorporated into this Contract by reference.

5.3.2. Sovereign Immunity. Nothing in this Contract will be construed to be a waiver by the State of California or CMS of its rights under the doctrine of sovereign immunity and the Eleventh Amendment to the United States Constitution.

5.3.3. Advance Directives. Nothing in this Contract shall be interpreted to require an Enrollee to execute an Advance Directive or agree to orders regarding the provision of life-sustaining treatment as a condition of receipt of services under the Medicare or Medi-Cal program.

5.3.4. Loss of Licensure. If, at any time during the term of this Contract, the Contractor or any of its First Tier, Downstream or Related Entities incurs loss of licensure at any of the Contractor's facilities or loss of necessary federal or State approvals, the Contractor must report such loss to CMS and DHCS. Such loss may be grounds for termination of this Contract under the provisions of Section 5.5.

5.3.5. Indemnification. The Contractor shall indemnify and hold harmless CMS, the federal government, and DHCS from and against any and all liability, loss, damage, costs, or expenses which CMS and or DHCS may sustain, incur, or be required to pay, arising out of or in connection with any negligent action, inaction, or willful misconduct of the Contractor, any person employed by the Contractor, or any of its First Tier, Downstream, or Related Entities provided that:

5.3.5.1. The Contractor is notified of any claims within a reasonable time from when CMS and DHCS become aware of the claim; and

5.3.5.2. The Contractor is afforded an opportunity to participate in the defense of such claims.

5.3.6. Prohibition against Discrimination.

5.3.6.1. In accordance with 42 USC § 1396 u-2(b)(7), the Contractor shall not discriminate with respect to participation, reimbursement, or indemnification of any provider in the Contractor's Provider Network who is acting within the scope of the provider's license or certification under applicable federal or State law, solely on the basis of such license or certification. This section does not prohibit the Contractor: from including providers in its Provider Network to the extent necessary to meet the needs of the Contractor's Enrollees; from using different reimbursement amounts for different specialties or for different practitioners in the same specialty; or from establishing any measure designed to maintain quality and control costs consistent with the responsibilities of the Contractor.

5.3.6.2. Contractor will give written notice of the reason for its decision when it declines to include individual or groups of providers in its network.

5.3.6.3. If a Complaint or claim against the Contractor is presented to DHCS or CMS, the Contractor must cooperate with in the investigation and disposition of such Complaint or claim.

5.3.7. Anti-Boycott Covenant. During the time this Contract is in effect, neither the Contractor nor any affiliated company, as hereafter defined, must participate in or cooperate with an international boycott, as defined in Section 999(b)(3) and (4) of the Internal Revenue Code of 1954, as amended, or engage in conduct declared to be unlawful by DHCS. Without limiting such other rights as it may have, CMS and DHCS will be entitled to rescind this Contract in the event of noncompliance with this Section. As used herein, an affiliated company is any business entity directly or indirectly owning at least fifty-one percent (51%) of the ownership interests of the Contractor.

5.3.8. Other Contracts. Nothing contained in this Contract must be construed to prevent the Contractor from operating other comprehensive health Care Plans or providing health care services to persons other than those eligible for coverage in the Contract; provided, however, that the Contractor must provide CMS and DHCS with a complete list of such plans and services, upon request. CMS and DHCS will exercise discretion in disclosing information that the Contractor may consider proprietary, except as required by law. Nothing in this Contract may be construed to prevent CMS or DHCS

from contracting with other comprehensive health Care Plans, or any other provider, in the same Service Area.

5.3.9. Counterparts. This Contract may be executed simultaneously in two or more counterparts, each of which will be deemed an original and all of which together will constitute one and the same instrument.

5.3.10. Entire Contract. This Contract constitutes the entire agreement of the parties with respect to the subject matter hereof, including all Attachments and Appendices hereto, and supersedes all prior agreements, representations, negotiations, and undertakings not set forth or incorporated herein. The terms of this Contract will prevail notwithstanding any variances with the terms and conditions of any verbal communication subsequently occurring.

5.3.11. No Third-Party Rights or Enforcement. No person not executing this Contract is entitled to enforce this Contract against a party hereto regarding such party's obligations under this Contract.

5.3.12. Corrective Action Plan. If, at any time, CMS and DHCS reasonably determine that the Contractor is deficient in the performance of its obligations under the Contract, CMS and DHCS may require the Contractor to develop and submit a corrective action plan that is designed to correct such deficiency. CMS and DHCS will approve, disapprove, or require modifications to the corrective action plan based on their reasonable judgment as to whether the corrective action plan will correct the deficiency. The Contractor must promptly and diligently implement the corrective action plan as approved by CMS and DHCS. Failure to implement the corrective action plan may subject the Contractor to termination of the Contract by CMS and DHCS or other intermediate sanctions as described in Section 5.3.13.

5.3.13. Intermediate Sanctions.

5.3.13.1. In addition to termination under Section 5.5, CMS and DHCS may, impose any or all of the sanctions in Section 5.3 upon any of the events below; provided, however, that CMS and DHCS will only impose those sanctions they determine to be reasonable and appropriate for the specific violations identified. CMS and DHCS may choose to provide warning notices and/or corrective action plans before sanctions. Sanctions may be imposed in accordance with this section for any failure to comply with this Contract, including but not limited to, if the Contractor:

5.3.13.1.1. Fails substantially to provide Covered Services required to be provided under this Contract to Enrollees;

5.3.13.1.2. Imposes charges on Enrollees in excess of any permitted under this Contract;

5.3.13.1.3. Discriminates among Enrollees or individuals eligible to enroll on the basis of health status or need for health care services, race, color or national origin, or uses any policy or practice that has the effect of discriminating on the basis of race, color, or national origin;

5.3.13.1.4. Misrepresents or falsifies information provided to CMS, DHCS, Enrollees, or its Provider Network;

5.3.13.1.5. Fails to comply with requirements regarding physician incentive plans (see Section 5.1.7);

5.3.13.1.6. Fails to comply with federal or State statutory or regulatory requirements related to this Contract;

5.3.13.1.7. Violates restrictions or other requirements regarding marketing;

5.3.13.1.8. Fails to comply with quality management requirements consistent with Section 2.16;

5.3.13.1.9. Fails to comply with any corrective action plan required by CMS and DHCS;

5.3.13.1.10. Fails to comply with financial solvency requirements;

5.3.13.1.11. Fails to comply with reporting requirements; or

5.3.13.1.12. Fails to comply with any other requirements of this Contract.

5.3.13.2. Such sanctions may include, but are not limited to:

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5.3.13.2.1. Intermediate sanctions and civil monetary penalties consistent with 42 C.F.R. § 422 Subpart O or § 438 Subpart I;

5.3.13.2.2. The appointment of temporary management to oversee the operation of the Contractor in those circumstances set forth in 42 U.S.C. § 1396 u-2(e)(2)(B);

5.3.13.2.3. Suspension of enrollment (including assignment of Enrollees);

5.3.13.2.4. Suspension of payment to the Contractor;

5.3.13.2.5. Disenrollment of Enrollees; and

5.3.13.2.6. Suspension of marketing.

5.3.13.2.7. Denial of payment as set forth in 42 C.F.R. § 438.730.

5.3.13.3. If CMS or DHCS have identified a deficiency in the performance of a First Tier, Downstream or Related Entity and the Contractor has not successfully implemented an approved corrective action plan in accordance with Section 5.3.12, CMS and DHCS may:

5.3.13.3.1. Require the Contractor to subcontract with a different First Tier, Downstream or Related Entity deemed satisfactory by CMS and DHCS; or

5.3.13.3.2. Require the Contractor to change the manner or method in which the Contractor ensures the performance of such contractual responsibility.

5.3.13.4. Additional Administrative Procedures. CMS and DHCS may, from time to time, issue program memoranda, bulletins, and DPLs clarifying, elaborating upon, explaining, or otherwise relating to Contract administration and other management matters. The Contractor must comply with all such program memoranda, bulletins, and letters as may be issued from time to time.

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5.3.13.5. Effect of Invalidity of Clauses. If any clause or provision of this Contract is in conflict with any federal or State law or regulation, that clause or provision will be null and void and any such invalidity will not affect the validity of the remainder of this Contract.

5.3.14. Before imposing any intermediate sanctions, consistent with 42 C.F.R. § 438.710, DHCS and CMS must give the Contractor timely written notice that explains the basis and nature of the sanction and other due process protections that DHCS and CMS elect to provide.

5.3.15. Conflict of Interest. Neither the Contractor, nor any First Tier, Downstream or Related Entity may, for the duration of the Contract, have any interest that will conflict, as determined by CMS and DHCS with the performance of services under the Contract, or that may be otherwise anticompetitive. The Contractor further certifies that it will comply with Section 1932(d) of the Social Security Act.

5.3.16. Insurance for Contractor's Employees. The Contractor must agree to maintain at the Contractor's expense all insurance required by law for its employees, including but not limited to, worker's compensation and unemployment compensation, and must provide CMS and DHCs with certification of same upon request. The Contractor, and its professional personnel providing services to Enrollees, must obtain and maintain appropriate professional liability insurance coverage. The Contractor must, at the request of CMS or DHCS, provide certification of professional liability insurance coverage.

5.3.17. Waiver. The Contractor, CMS, or DHCS shall not be deemed to have waived any of its rights hereunder unless such waiver is in writing and signed by a duly authorized representative. No delay or omission on the part of the Contractor, CMS, or DHCS in exercising any right shall operate as a waiver of such right or any other right. A waiver on any occasion shall not be construed as a bar to or waiver of any right or remedy on any future occasion. The acceptance or approval by CMS and DHCS of any materials including but not limited to, those materials submitted in relation to this Contract, does not constitute waiver of any requirements of this Contract.

5.3.18. Section Headings. The headings of the sections of this Contract are for convenience only and will not affect the construction hereof.

5.4. Record Retention, Inspection, and Audit

5.4.1. The Contractor must maintain books, records, documents, and other evidence of administrative, medical, and accounting procedures and practices for ten (10) years from the end of the final contract period or completion of audit, whichever is later.

5.4.2. The Contractor must make the records maintained by the Contractor and its Provider Network, as required by CMS and DHCS and other regulatory agencies, available to CMS and DHCS and its agents, designees or contractors or any other authorized representatives of the State of California or the United States Government, or their designees or contractors, at such times, places, and in such manner as such entities may reasonably request for the purposes of financial or medical audits, inspections, and examinations, provided that such activities are conducted during the normal business hours of the Contractor.

5.4.3. The Contractor further agrees that the Secretary of the U.S. Department of Health and Human Services or his or her designee, the Governor or his or her designee, Comptroller General, and the State Auditor or his or her designee have the right at reasonable times and upon reasonable notice to examine the books, records, and other compilations of data of the Contractor and its First Tier, Downstream and Related Entities that pertain to: the ability of the Contractor to bear the risk of potential financial losses; services performed; or determinations of amounts payable.

5.4.4. The Contractor must make available, for the purposes of record maintenance requirements, its premises, physical facilities and equipment, records relating to its Enrollees, and any additional relevant information that CMS or DHCS may require, in a manner that meets CMS and DHCS record maintenance requirements.

5.4.5. The Contractor must comply with the right of the U.S. Department of Health and Human Services, the Comptroller General, and their designees to inspect, evaluate, and audit records through ten (10) years from the final date of the Contract period or the completion of audit, whichever is later, in accordance with federal and State requirements.

5.4.6. Disputes. The Disputes procedure set forth in Appendix K will be used by the Contractor as the means of seeking resolution of disputes on contractual issues.

5.5. Termination of Contract

5.5.1. Termination without Prior Notice. In the event the Contractor substantially fails to meet its obligations under this Contract or has otherwise violated the laws, regulations, or rules that govern the Medicare or Medi-Cal programs, CMS or DHCS may take any or all action under this Contract, law, or equity, including but not limited to immediate termination of this Contract in accordance with regulations that are current at the time of the termination.

5.5.2. Without limiting the above, if CMS or DHCS determine that participation of the Contractor in the Medicare or Medi-Cal program or in the Demonstration, may threaten or endanger the health, safety, or welfare of Enrollees or compromise the integrity of the Medicare or Medi-Cal program, CMS or DHCS, without prior notice, may immediately terminate this Contract, suspend the Contractor from participation, withhold any future payments to the Contractor, or take any or all other actions under this Contract, law, or equity. Such action may precede beneficiary enrollment into any Contractor, and shall be taken upon a finding by CMS or DHCS that the Contractor has not achieved and demonstrated a state of readiness that will allow for the safe and efficient provision of Medicare-Medi-Cal services to Medicare-Medi-Cal beneficiaries.

5.5.3. United States law and California law, as appropriate, will apply to resolve any claim of breach of this Contract.

5.5.4. Termination with Prior Notice.

5.5.4.1. CMS or DHCS may terminate this Contract without cause upon no less than one hundred eighty (180) days prior written notice to the other party specifying the termination date, unless applicable law requires otherwise. Per Section 5.8, the Contractor may choose to non-renew this Agreement prior to the end of each term pursuant to 42 C.F.R. § 422.506(a). In considering requests for termination under 42 C.F.R. § 422.508, CMS and DHCS will consider, among other factors, financial performance and stability in granting consent for termination. Any written communications or oral scripts developed to implement the requirements of 42 C.F.R. § 422.506(a) must be submitted to and approved by CMS and DHCS prior to their use.

5.5.4.2. Pursuant to 42 C.F.R. §§ 422.506(a)(4) and 422.508(c), CMS considers Contractor termination of this Contract with prior notice as described in paragraph 5.5.2.1 and non-renewal of

this Contract as described in Section 5.8 to be circumstances warranting special consideration, and will not prohibit the Contractor from applying for new Medicare Advantage contracts or Service Area expansions for a period of two years due to termination.

5.5.5. Termination pursuant to Social Security Act § 1115A(b)(3)(B).

5.5.6. Termination for Cause. Any party may terminate this Agreement upon ninety (90) days' notice due to a material breach of a provision of this Contract unless CMS or DHCS determines that a delay in termination would pose an imminent and serious risk to the health of the individuals enrolled with the Contractor or the Contractor experiences financial difficulties so severe that its ability make necessary health services available is impaired to the point of posing an imminent and serious risk to the health of its Enrollees, whereby CMS or DHCS may expedite the termination.

5.5.6.1. Pre-termination Procedures. Before terminating a contract under 42 C.F.R. § 422.510 and § 438.708, the Contractor may request a pre-termination hearing or develop and implement a corrective action plan. CMS or DHCS must:

5.5.6.1.1. Give the Contractor written notice of its intent to terminate, the reason for termination, and a reasonable opportunity of at least thirty (30) calendar days to develop and implement a corrective action plan to correct the deficiencies; and/or

5.5.6.1.2. Notify the Contractor of its Appeal rights as provided in 42 C.F.R. § 422 Subpart N and § 438.710.

5.5.6.2. If Contractor fails to comply with the provisions of Section 5.5, CMS or DHCS may terminate this agreement upon thirty days' notice.

5.5.7. Termination due to a Change in Law. In addition, CMS or DHCS may terminate this agreement upon thirty (30) days notice due to a material change in law, or by operation of law, including a change in the State law authorizing the State's participation in the program, or with less or no notice if required by law.

5.5.8. Continued Obligations of the Parties.

5.5.8.1. In the event of termination, expiration, or non-renewal of this Contract, or if the Contractor otherwise withdraws from the Medicare or Medi-Cal programs, the Contractor shall continue to have the obligations imposed by this Contract or applicable law. These include, without limitation, the obligations to continue to provide Covered Services to each Enrollee at the time of such termination or withdrawal until the Enrollee has been disenrolled from the Contractor's Plan; provided, however, that CMS and DHCS will exercise best efforts to complete all disenrollment activities within six months from the date of termination or withdrawal.

5.5.8.2. In the event that this Contract is terminated, expires, or is not renewed for any reason:

5.5.8.2.1. If CMS or DHCS, or both, elect to terminate the Contract, CMS and DHCS will be responsible for notifying all Enrollees covered under this Contract of the date of termination and the process by which those Enrollees will continue to receive care under applicable laws, regulations, and provisions of this Contract. If the Contractor elects to terminate or not renew the Contract, the Contractor will be responsible for notifying all Enrollees and the general public, in accordance with federal and State requirements and the terms of this Contract;

5.5.8.2.2. The Contractor must promptly return to CMS and DHCS all payments advanced to the Contractor for Enrollees after the effective date of their disenrollment; and

5.5.8.2.3. The Contractor must supply to CMS and DHCS all information necessary for the payment of any outstanding claims determined by CMS and DHCS to be due to the Contractor, and any such claims will be paid in accordance with the terms of this Contract.

5.6. Impact of Termination

5.6.1. In the event this Contract is terminated, expires, or is not renewed for any reason, the State shall have the authority to crosswalk Enrollees

into a Medi-Cal Managed Care Plan for the purposes of the seamless provision of Medi-Cal managed care Covered Services.

5.6.2. The State shall provide such Enrollees with notice of this crosswalk and of any options Enrollees have to change Medi-Cal managed care plans for the provision of Medi-Cal Covered Services.

5.7. Order of Precedence

5.7.1. The following documents are incorporated into and made a part of this Contract:

5.7.1.1. Capitated Financial Alignment Application, a document issued by CMS and subject to modification each program year;

5.7.1.2. DHCS's Bridge to Health Reform Section 1115 waiver as amended for purposes of this demonstration;

5.7.1.3. CFAM-MOU, a document between CMS and DHCS regarding a Federal-State Partnership to Test a Capitated Financial Alignment Model for Medicare-Medicaid Enrollees (signed March 27, 2013);

5.7.1.4. The Contractor's Medi-Cal managed care contract;

5.7.1.5. All applicable federal and State regulations and laws, as well as DHCS DPLs, applicable DHCS APLs, CMS guidance, including but not limited to enrollment and marketing guidance, the annual rate report, plan letters, bulletins and guidance memoranda.

5.7.1.6. The Contractor's response to the Request for Solutions.

5.7.2. In the event of any conflict among the documents that are a part of this Contract, the order of priority to interpret the Contract shall be as follows:

5.7.2.1. The Contract terms and conditions, including all appendices;

5.7.2.2. Capitated Financial Alignment Application;

5.7.2.3. DHCS's Bridge to Health Reform Section 1115 waiver as amended for purposes of this demonstration;

5.7.2.4. CFAM-MOU, a document between CMS and DHCS Regarding a federal-State partnership to Test a Capitated Financial Alignment Model for Medicare-Medicaid Enrollees (signed March 27. 2013);

5.7.2.5. The Contractor's Medi-Cal managed care contract;

5.7.2.6. All applicable federal and State regulations and laws, as well as DHCS DPLs, applicable DHCS APLs, CMS guidance, including but not limited to enrollment and marketing guidance, bulletins, and guidance memoranda; and

5.7.2.7. The Contractor's response to the RFS.

5.7.3. In the event of any conflict between this Contract and the MOU, the Contract shall prevail.

5.8. Contract Term.

5.8.1. This Contract shall be in effect starting from the date on which all parties have signed the Contract and shall be effective, unless otherwise terminated, through December 31, 2015. The Contract shall be renewed in one-year terms through December 31, 2022, so long as the Contractor has not provided CMS and the State with a notice of intention not to renew, and CMS/State have not provided the Contractor with a notice of intention not to terminate, pursuant to 42 C.F.R. § 422.506 or Section 5.5 above This contract will terminate, or its effectuation will be delayed, unless the State receives all necessary approvals from CMS, including but not limited to § 1115(a) demonstration authority, and unless the Contractor is deemed ready to participate in the MMCO demonstration, as provided for in Section 2.2.1.3 of this Contract. Funds must not be expended or awarded until the State has received all necessary approvals from CMS. No payments will be made nor Medicaid federal Medical assistance payment (FMAP) funds drawn for any services provided or costs incurred prior to the later of the approval date for any necessary § 1115(a) authority, the Readiness Review approval, or the effective date of this Contract.

5.9. Amendments

5.9.1. The parties agree to negotiate in good faith to cure any omissions, ambiguities, or manifest errors herein. By mutual agreement, the parties may amend this Contract where such amendment does not violate federal or State statutory, regulatory, or waiver provisions,

provided that such amendment is in writing, signed by authorized representatives of all three parties, and attached hereto.

5.10. Written Notices

5.10.1. Notices to the parties as to any matter hereunder will be sufficient if given in writing and sent by certified mail, postage prepaid, or delivered in hand to:

To: Centers for Medicare and Medicaid Services
Medicare-Medicaid Coordination Office
7500 Security Boulevard, S3-13-23
Baltimore, MD 21244

To: California Department of Health Care Services
1501 Capitol Avenue, MS 0000, P.O. Box 997413
Sacramento, CA 95899-7413

To: Orange County Health Authority
505 City Parkway West
Orange, CA 92868

Email Copies to:
Silver Ho sho@caloptima.org

Annie Phillips aphillips@caloptima.org

Gisela Gomez ggomez@caloptima.org

Michael Schrader mschrader@caloptima.org

In Witness Whereof, CMS, DHCS, and the Contractor have caused this Agreement to be executed by their respective authorized officers:

Contractor:

	10/3/19
Paul Yost, Chair, CalOptima Board of Directors	Date

Orange County Health Authority

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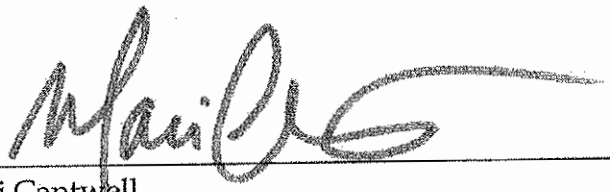
In Witness Whereof, CMS, DHCS, and the Contractor have caused this Agreement to be executed by their respective authorized officers:



Date 9/17/19

Mari Cantwell
Chief Deputy Director
Health Care Programs
State Medicaid Director
California Department of Health Care Services

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In Witness Whereof, CMS, DHCS, and the Contractor have caused this Agreement to be executed by their respective authorized officers:

Trinia J. Hunt

Trinia J. Hunt
Acting Director
Division of Medicaid Field Operations West
Centers for Medicare & Medicaid Services
United States Department of Health and Human Services

9/20/2019
Date

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In Witness Whereof, CMS, DHCS, and the Contractor have caused this Agreement to be executed by their respective authorized officers:

9/16/19
Date

Kathryn A. Coleman
Director
Medicare Drug & Health Plan Contract Administration Group
Centers for Medicare & Medicaid Services
United States Department of Health and Human Services

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SECTION 6: Appendices

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Appendix A: Covered Services

The Contractor shall provide services to Enrollees as follows:

A.1 Medical Necessity. The Contractor shall provide services to Enrollees as follows:

A.1.1 Authorize, arrange, coordinate, and provide to Enrollees all Covered Services that are Medically Necessary as specified in Section 2.4, in accordance with the requirements of the Contract.

A.1.2 Provide all Covered Services that are Medically Necessary, including but not limited to, those Covered Services that:

A.1.2.1. Prevent, diagnose, or treat health impairments;

A.1.2.2. Attain, maintain, or regain functional capacity.

A.1.3 Not arbitrarily deny or reduce the amount, duration, or scope of a required Covered Service solely because of diagnosis, type of illness, or condition of the Enrollee.

A.1.4 Not deny authorization for a Covered Service that the Enrollee or the Provider demonstrates is Medically Necessary.

A.1.5 The Contractor may place appropriate limits on a Covered Service on the basis of Medical Necessity, or for the purpose of utilization management, provided that the furnished services can reasonably be expected to achieve their purpose. The Contractor's Medical Necessity guidelines must, at a minimum, be:

A.1.5.1. Developed with input from practicing physicians in the Cal MediConnect's Service Area;

A.1.5.2. Developed in accordance with standards adopted by national accreditation organizations;

A.1.5.3. Developed in accordance with the definition of Medical Necessity in Section 2.4;

A.1.5.4. Updated at least annually or as new treatments, applications and technologies are adopted as generally accepted professional medical practice;

A.1.5.5. Evidence-based, if practicable; and

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A.1.5.6. Applied in a manner that considers the individual health care needs of the Enrollee.

A.1.6 The Contractor's Medical Necessity guidelines, program specifications and service components must, at a minimum, be submitted to DHCS annually for approval no later than 60 days prior to the start of a new Contract Year, and no later than 60 days prior to any change.

A.1.7 Offer and provide to all Enrollees any and all non-medical programs and services specific to Enrollees for which the Contractor has received CMS and DHCS approval.

A.2 Covered Services. Contractor agrees to provide Enrollees access to the following Covered Services:

A.2.1 All standard Medi-Cal fee-for-service benefits excluding:

A.2.1.1. ICF/MR services;

A.2.1.2. County-administered Medi-Cal Specialty Mental Health Services and substance use disorder services. This does not include Behavioral Health services that become Medi-Cal managed care benefits on January 1, 2014, pursuant to Welfare and Institutions Code Section 14132.03, which will be Covered Services under this contract;

A.2.1.3. State and County activities to administer IHSS, including determining eligibility, assessing, approving, and authorizing each current and new Enrollee's initial and continuing need for services, enrolling providers, conducting provider orientation, and retaining enrollment documentation, conducting criminal background checks on all potential providers, providing assistance to IHSS recipients in finding eligible providers through an established provider registry;

A.2.1.3.1 For dates of service on or before December 31, 2017. IHSS is no longer a Covered Service under this Contract for service dates on or after January 1, 2018, pursuant to Statutes 2017, chapter 52 (S.B. 97);

A.2.1.4. Medi-Cal Dental Services, known as Denti-Cal

A.2.2 All services provided under Medicare Part A

A.2.3 All services provided under Medicare Part B

A.2.4 All services provided under Medicare Part D

A.2.5 Particular pharmacy products that are covered by Medi-Cal and may not be covered under Medicare Part D.

- Contractors are encouraged to offer a broader drug formulary than minimum requirements.

A.3 In addition, Contractor agrees to provide the following:

A.3.1 Vision Benefit

A.3.1.1. $0 copay for one (1) routine eye exam every year

A.3.1.2. Every two years, $100 for eyeglasses (frames and lenses) or up to $100 for contact lenses

A.3.2 Non-Medical Transportation and Non-Emergency Medical Transportation Benefits

A.3.2.1. Contractors must provide transportation services to beneficiaries for Medically Necessary Services.

A.3.2.2. Contractors must provide transportation services pursuant to this Contract, applicable law including but not limited to Welfare & Institutions Code 14132(ad) and the requirements in applicable current and future DPLs.

A.3.3 Care Transitions Assistance provided across facility and community settings. Care Coordination shall be provided for transitions among levels of care and between service locations. Such services facilitate safe and coordinated transitions across care settings, which may be particularly appropriate for Enrollees who have experienced or are expecting an inpatient stay.

A.4 Cost-sharing for Covered Services

A.4.1 Except as described below, cost-sharing of any kind is not permitted in Cal MediConnect.

A.4.1.1. Co-pays charged by Demonstration Plans for Part D drugs must not exceed the applicable amounts for brand and generic drugs established yearly by CMS under the Part D Low Income Subsidy.

A.4.1.2. The Contractor may establish lower cost-sharing for prescription drugs than the maximum allowed.

A.4.1.3. Co-pays charged by Demonstration Plans for supplemental dental benefits.

A.5 Limitations on Covered Services.

A.5.1 – Termination of pregnancy may be provided only as allowed by applicable State and federal law and regulation (42 C.F.R. Part 441, Subpart E).

A.5.2 –Sterilization services may be provided only as allowed by State and federal law (see 42 C.F.R. Part 441, Subpart F).

Appendix B: Enrollee Rights

The Contractor must have written policies regarding the Enrollee rights specified in this appendix, as well as written policies specifying how information about these rights will be disseminated to Enrollees. Enrollees must be notified of these rights and protections at least annually, and in a manner that takes in to consideration cultural considerations, Functional Status and language needs. Enrollee rights include, but are not limited to, those rights and protections provided by 42 C.F.R. § 438.100, 42 C.F.R. §422 Subpart C, and the CFAM-MOU. Specifically, Enrollees must be guaranteed:

A. The right to be treated with dignity and respect.
B. The right to be afforded Privacy and confidentiality in all aspects of care and for all health care information, unless otherwise required by law.
C. The right to be provided a copy of his or her medical records, upon request, and to request corrections or amendments to these records, as specified in 45 C.F.R. part 164.
D. The right not to be discriminated against based on race, ethnicity, national origin, religion, sex, age, sexual orientation, medical or claims history, mental or physical disability, genetic information, or source of payment.
E. The right to have all plan options, rules, and benefits fully explained, including through use of a qualified interpreter if needed.
F. Access to an adequate network of primary and specialty providers who are capable of meeting the Enrollee's needs with respect to physical access, and communication and scheduling needs, and are subject to ongoing assessment of clinical quality including required reporting.
G. The right to choose a plan and provider at any time and have that choice be effective the first calendar day of the following month.
H. The right to participate in all aspects of care and to exercise all rights of Appeal. Enrollees have a responsibility to be fully involved in maintaining their health and making decisions about their health care, including the right to refuse treatment if desired, and must be appropriately informed and supported to this end. Specifically, Enrollees must:
    a. Receive a comprehensive Health Risk Assessment upon date of coverage in a plan and to participate in the development and implementation of an Individualized Care Plan. The assessment must include considerations of social, functional, medical, behavioral, wellness and prevention domains, an evaluation of the Enrollee's strengths and weaknesses, and a plan for managing and coordination of Enrollee's care. Enrollees, or their designated representative, also have the right to request a reassessment by the interdisciplinary team, and be fully involved in any such reassessment.
    b. Receive complete and accurate information on his or her health and

Functional Status by the interdisciplinary team.

c. Be provided information on all program services and health care options, including available treatment options and alternatives, presented in a culturally appropriate manner, taking in to consideration Enrollee's condition and ability to understand. A participant who is unable to participate fully in treatment decisions has the right to designate a representative. This includes the right to have translation services available to make information appropriately accessible. Information must be available:
    i. Before enrollment.
    ii. At enrollment.
    iii. At the time a participant's needs necessitate the disclosure and delivery of such information in order to allow the participant to make an informed choice.
d. Be encouraged to involve caregivers or family members in treatment discussions and decisions.
e. Receive reasonable advance notice, in writing, of any transfer to another treatment setting and the justification for the transfer.
f. Be afforded the opportunity to file an Appeal if services are denied that he or she thinks are medically indicated, and to be able to ultimately take that Appeal to an independent external system of review.

I. The right to receive medical and non-medical care from a team that meets the beneficiary's needs, in a manner that is sensitive to the beneficiary's language and culture, and in an appropriate care setting, including the home and community.
J. The right to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation.
K. Each Enrollee is free to exercise his or her rights and that the exercise of those rights does not adversely affect the way the Contractor and its providers or the DHCS treat the Enrollee.
L. The right to receive timely information about plan changes. This includes the right to request and obtain the information listed in the Orientation materials at least once per year, and, the right to receive notice of any significant change in the information provided in the Orientation materials at least 30 days prior to the intended effective date of the change. See 438.10 for G and H.
M. The right to be protected from liability for payment of any fees that are the obligation of the Contractor.
N. The right not to be charged any cost sharing for Medicare Parts A and B services.
O. The unconditional and exclusive right to hire, fire, and supervise his or her IHSS provider.
P. The right to receive their Medicare and Medi-Cal Appeals rights in a format and language understandable and accessible to them.
Q. The right to opt out of Cal MediConnect at any time, beginning at the first of the

following month.

Appendix C: Relationship with First Tier, Downstream, and Related Entities

A. Contractor shall ensure that any contracts or agreements with First Tier, Downstream and Related Entities performing functions on Contractor's behalf related to the operation of the Medicare-Medicaid plan are in compliance with 42 C.F.R. §§422.504, 423.505, and 438.3(k).

B. Contractor shall specifically ensure:
   1. HHS, the Comptroller General, or their designees have the right to audit, evaluate, and inspect and books, contracts, computer or other electronic systems, including medical records and documentation of the First Tier, Downstream and Related Entities; and
   2. HHS's, the Comptroller General's, or their designees right to inspect, evaluate, and audit any pertinent information for any particular contract period for ten years from the final date of the contract period or from the date of completion of any audit, whichever is later.

C. Contractor shall ensure that all contracts or arrangements with First Tier, Downstream and Related Entities contain the following:
   1. Enrollee protections that include prohibiting providers from holding an Enrollee liable for payment of any fees that are the obligation of the Contractor;
   2. Language that any services or other activity performed by a First Tier, Downstream and Related Entities is in accordance with the Contractor's contractual obligations to CMS and DHCS; including the requirements at 42 C.F.R. § 438.414 in relation to the Grievance system.
   3. Language that specifies the delegated activities and reporting requirements;
   4. Language that provides for revocation of the delegation activities and reporting requirements or specifies other remedies in instances where CMS, DHCS or the Contractor determine that such parties have not performed satisfactorily;
   5. Language that specifies the performance of the parties is monitored by the Contractor on an ongoing basis and the Contractor may impose corrective action as necessary;
   6. Language that specifies the First Tier, Downstream and Related Entities agree to safeguard Enrollee Privacy and confidentiality of Enrollee health records; and
   7. Language that specifies the First Tier, Downstream and Related Entities must comply with all federal and State laws, regulations and CMS instructions.

D. Contractor shall ensure that all contracts or arrangements with First Tier, Downstream and Related Entities that are for credentialing of medical providers contains the following language:
   1. The credentials of medical professionals affiliated with the party or parties will be either reviewed by the Contractor; or
   2. The credentialing process will be reviewed and approved by the Contractor and the Contractor must audit the credentialing process on an ongoing basis.

E. Contractor shall ensure that all contracts or arrangements with First Tier, Downstream and Related Entities that delegate the selection of providers must

include language that the Contractor retains the right to approve, suspend, or terminate any such arrangement.

F. Contractor shall ensure that all contracts or arrangements with First Tier, Downstream and Related Entities shall state that the Contractor shall provide a written statement to a provider of the reason or reasons for termination with cause.

G. Contractor shall ensure that all contracts or arrangements with First Tier, Downstream and Related Entities for medical providers include additional provisions. Such contracts or arrangements must contain the following:

1. Language that the Contractor is obligated to pay contracted medical providers under the terms of the contract between the Contractor and the medical provider. The contract must contain a prompt payment provision, the terms of which are developed and agreed to by both the Contractor and the relevant medical provider;
2. Language that services are provided in a culturally competent manner to all Enrollees, including those with limited English proficiency or reading skills, and diverse culturally and ethnic backgrounds;
3. Language that medical providers abide by all federal and State laws and regulations regarding confidentiality and disclosure of medical records, or other health and enrollment information;
4. Language that medical providers ensure that medical information is released in accordance with applicable federal or State law, or pursuant to court orders or subpoenas;
5. Language that medical providers maintain Enrollee records and information in an accurate and timely manner;
6. Language that medical providers ensure timely access by Enrollees to the records and information that pertain to them; and
7. Language that Enrollees will not be held liable for Medicare Part A and B cost sharing. Specifically, Medicare Parts A and B services must be provided at zero cost-sharing to Enrollees.
8. Language that clearly states the medical providers' EMTALA obligations and must not create any conflicts with hospital actions required to comply with EMTALA.
9. Language prohibiting providers, including, but not limited to PCPs, from closing or otherwise limiting their acceptance of Enrollees as patients unless the same limitations apply to all commercially insured Enrollees.
10. Language that prohibits the Contractor from refusing to contract or pay an otherwise eligible health care provider for the provision of Covered Services solely because such provider has in good faith:
    (a) Communicated with or advocated on behalf of one or more of his or her prospective, current or former patients regarding the provisions, terms or requirements of the Contractor's health benefit plans as they relate to the needs of such provider's patients; or
    (b) Communicated with one or more of his or her prospective, current or former

patients with respect to the method by which such provider is compensated by the Contractor for services provided to the patient.

11. Language that states the provider is not required to indemnify the Contractor for any expenses and liabilities, including, without limitation, judgments, settlements, attorneys' fees, court costs and any associated charges, incurred in connection with any claim or action brought against the Contractor based on the Contractor's management decisions, utilization review provisions or other policies, guidelines or actions.
12. Language that specifies the term of the contract, including the beginning and ending dates as well as methods of extension, renegotiation and termination.
13. Full disclosure of the method and amount of compensation or other consideration to be received from the Contractor.
14. Language that requires the medical provider to assist Contractor in the transfer of care.
15. Language that requires the medical provider to assist Contractor in the transfer of care in the event of sub-subcontract termination for any reason.
16. Notify DHCS in the event the agreement with the 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.
17. Assignment or delegation of the Subcontract will be void unless prior written approval is obtained from DHCS.
18. Timely gather, preserve and provide to DHCS, any records in the subcontractor's possession.
19. Provide interpreter services for Enrollees at all provider sites.
20. Right to submit a Grievance and Contractor's formal process to resolve Provider Grievances.
21. To participate and cooperate in the Contractor's Quality Improvement System.
22. If Contractor delegates Quality Improvement activities, Subcontract shall include provisions as specified by DHCS.

Appendix D: Quality Improvement Requirements

The Contractor will undertake the following quality improvement initiatives with the goal of identifying areas in need of improvement and undertaking quality improvement activities in response to the findings related to each initiative.

1. Emergency Department utilization. The goal of this initiative is to better understand reasons for ED utilization among Cal MediConnect Enrollees, and the impact of LTSS to such usage.
    - Contractor will identify a random sample of Enrollees each year who have utilized ED services. [
    - Contractor will engage an independent quality assurance entity to conduct interviews with each Enrollee in the sample to determine background & causes for ED visits, using a semi-structured interview tool provided by DHCS.
    - Contractor will analyze results of the surveys in order to understand the underlying causes of ED utilization, including the use of and/or or failure of LTSS, or there was a lack of appropriate LTSS to adequately support the Enrollee in his or her environment. Contractor will identify issues within its system of care that require improvement to promote appropriate utilization of both LTSS and emergency department services.
    - Contractor will report results to DHCS and to CMS.

2. Barriers to Health Access. The goal of this initiative is to better understand access issues experienced by Cal MediConnect Enrollees.
    - Contractor will identify a random representative sample size of Enrollees each year.
    - An independent quality assurance entity will conduct interviews with each Enrollee in the sample, using a semi-structured interview tool provided by DHCS, to determine if any barriers to health care were experienced and to understand the nature of those barriers. Examples of barriers include, but are not limited to, the following: inaccessible medical equipment in provider offices, inaccessible signage in provider

offices (i.e. no Braille writing on signs), inaccessible communication from the Cal MediConnect or providers (i.e. no access to ASL interpreters, no written communication in large print or plain language, or no access to someone who can explain information), inadequate access to appropriate physicians for intellectually disabled Enrollees, and incomplete or poor care due to negative attitudes about disability and/or recovery from providers.

Contractor will analyze results of the surveys in order to understand the underlying causes of these barriers to health care access. Contractor will identify issues within its system of care that require improvement to promote access and ADA

3. Other topic areas to be identified through annual guidance by CMS and DHCS in accordance with 42 C.F.R. § 422.152(c) and 422.152(d).

Appendix E: Addendum to Capitated Financial Alignment Contract

PURSUANT TO SECTIONS 1860D-1 THROUGH 1860D-43 OF THE SOCIAL SECURITY ACT FOR THE OPERATION OF A VOLUNTARY MEDICARE PRESCRIPTION DRUG PLAN

The Centers for Medicare & Medicaid Services (hereinafter referred to as "CMS"), the State of California, acting by and through the Department of Health Care Services (DHCS), and Orange County Health Authority, a Medicare-Medicaid managed care organization (hereinafter referred to as Contractor) agree to amend the contract H8016 governing Contractor's operation of a Medicare-Medicaid plan described in § 1851(a)(2)(A) of the Social Security Act (hereinafter referred to as "the Act") to include this addendum under which Contractor shall operate a Voluntary Medicare Prescription Drug Plan pursuant to §§1860D-1 through 1860D-43 (with the exception of §§1860D-22(a) and 1860D-31) of the Act.

Article I

Voluntary Medicare Prescription Drug Plan

A. Contractor agrees to operate one or more Medicare Voluntary Prescription Drug Plans as described in its application and related materials submitted to CMS for Medicare approval, including but not limited to all the attestations contained therein and all supplemental guidance, and in compliance with the provisions of this addendum, which incorporates in its entirety the *2013 Capitated Financial Alignment Application*, released on March 29, 2012 [(hereinafter collectively referred to as "the addendum"). Contractor also agrees to operate in accordance with the regulations at 42 C.F.R. Part 423 (with the exception of Subparts Q, R, and S), §§1860D-1 through 1860D-43 (with the exception of §§1860D-22(a) and 1860D-31) of the Act, and the applicable solicitation identified above, as well as all other applicable federal statutes, regulations, and policies. This addendum is deemed to incorporate any changes that are required by statute to be implemented during the term of this Contract and any regulations or policies implementing or interpreting such statutory or regulatory provisions.

B. CMS agrees to perform its obligations to Contractor consistent with the regulations at 42 C.F.R. Part423 (with the exception of Subparts Q, R, and S), §§1860D-1 through 1860D-43 (with the exception of §§1860D-22(a) and 1860D-31) of the Act, and the applicable solicitation, as well as all other applicable federal statutes, regulations, and policies.

C. CMS agrees that it will not implement, other than at the beginning of a calendar year, regulations under 42 C.F.R. Part 423 that impose new, significant regulatory requirements on Contractor. This provision does not apply to new requirements mandated by statute.

D. This addendum is in no way intended to supersede or modify 42 C.F.R., Parts 417, 422, 423, 431 or 438. Failure to reference a regulatory requirement in this addendum does not affect the applicability of such requirements to Contractor, DHCS, and CMS.

Article II
Functions to be Performed by Contractor

A. ENROLLMENT

1. Contractor agrees to enroll in its Medicare-Medicaid plan only Medicare-Medicaid eligible beneficiaries as they are defined in 42 C.F.R. §423.30(a) and who have elected to enroll in Contractor's Capitated Financial Alignment benefit.

B. PRESCRIPTION DRUG BENEFIT

1. Contractor agrees to provide the required prescription drug coverage as defined under 42 C.F.R. §423.100 and, to the extent applicable, supplemental benefits as defined in 42 C.F.R. §423.100 and in accordance with Subpart C of 42 C.F.R. Part 423. Contractor also agrees to provide Part D benefits as described in Contractor's Part D plan benefit package(s) approved each year by CMS (and in the Attestation of Benefit Plan and Price, attached hereto).

2. Contractor agrees to maintain administrative and management capabilities sufficient for the organization to organize, implement, and control the financial, communication, benefit administration, and quality assurance activities related to the delivery of Part D services as required by 42 C.F.R. §423.505(b)(25).

C. DISSEMINATION OF PLAN INFORMATION

1. Contractor agrees to provide the information required in 42 C.F.R. §423.48.

2. Contractor acknowledges that CMS releases to the public summary reconciled Part D Payment data after the reconciliation of Part D Payments for the Contract year as provided in 42 C.F.R. §423.505(o).

3. Contractor certifies that all materials it submits to CMS under the File and Use Certification authority described in the Medicare Communications and Marketing Guidelines are accurate, truthful, not misleading, and consistent with CMS marketing guidelines.

D. QUALITY ASSURANCE/UTILIZATION MANAGEMENT

1. Contractor agrees to operate quality assurance, drug utilization management, and medication therapy management programs, and to support electronic prescribing in accordance with Subpart D of 42 C.F.R. Part 423.

2. Contractor agrees to address Complaints received by CMS against the Contractor as required in 42 C.F.R. §423.505(b)(22) by:

   (a) Addressing and resolving Complaints in the CMS Complaint tracking system; and

   (b) Displaying a link to the electronic Complaint form on the Medicare.gov Internet Web site on the Part D plan's main Web page.

E. APPEALS AND GRIEVANCES

Contractor agrees to comply with all requirements in Subpart M of 42 C.F.R. Part 423 governing coverage determinations, Grievances and Appeals, and formulary exceptions and the relevant provisions of Subpart U governing reopenings. Contractor acknowledges that these requirements are separate and distinct from the Appeals and Grievances requirements applicable to Contractor through the operation of its Medicare Parts A and B and Medicaid benefits.

F. PAYMENT TO CONTRACTOR

Contractor and CMS and DHCS agree that payment paid for Part D services under the addendum will be governed by the rules in Subpart G of 42 C.F.R. Part 423.

G. PLAN BENEFIT SUBMISSION AND REVIEW

If Contractor intends to participate in the Part D program for the next program year, Contractor agrees to submit the next year's Part D plan benefit package including all required information on benefits and cost-sharing, by the applicable due date, as provided in Subpart F of 42 C.F.R. Part 423 so that CMS, DHCS and Contractor may conduct negotiations regarding the terms and conditions of the proposed benefit plan renewal. Contractor acknowledges that failure to submit a timely plan benefit package under this section may affect the Contractor's ability to offer a plan, pursuant to the provisions of 42 C.F.R. §422.4(c).

H. COORDINATION WITH OTHER PRESCRIPTION DRUG COVERAGE

1. Contractor agrees to comply with the coordination requirements with State Pharmacy Assistance Programs (SPAPs) and plans that provide other prescription drug coverage as described in Subpart J of 42 C.F.R. Part 423.

2. Contractor agrees to comply with Medicare Secondary Payer procedures as stated in 42 C.F.R. §423.462.

I. SERVICE AREA AND PHARMACY ACCESS

1. Contractor agrees to provide Part D benefits in the Service Area for which it has been approved by CMS and DHCS (as defined in Appendix I) to offer Medicare Parts A and B benefits and Medicaid benefits utilizing a pharmacy network and formulary approved by CMS and DHCS that meet the requirements of 42 C.F.R. §423.120.

2. Contractor agrees to provide Part D benefits through out-of-network pharmacies according to 42 C.F.R. §423.124.

3. Contractor agrees to provide benefits by means of point-of-service systems to adjudicate prescription drug claims in a timely and efficient manner in compliance with CMS standards, except when necessary to provide access in underserved areas, I/T/U pharmacies (as defined in 42 C.F.R. §423.100), and long-term care pharmacies (as defined in 42 C.F.R. §423.100) according to 42 C.F.R. §423.505(b)(17).

4. Contractor agrees to contract with any pharmacy that meets Contractor's reasonable and relevant standard terms and conditions according to 42 C.F.R. §423.505(b)(18), including making standard contracts available on request in accordance with the timelines specified in the regulation.

J. EFFECTIVE COMPLIANCE PROGRAM/PROGRAM INTEGRITY

Contractor agrees that it will develop and implement an effective compliance program that applies to its Part D-related operations, consistent with 42 C.F.R. §423.504(b)(4)(vi).

K. LOW-INCOME SUBSIDY

Contractor agrees that it will participate in the administration of subsidies for low-income subsidy eligible individuals according to Subpart P of 42 C.F.R. Part 423.

L. BENEFICIARY FINANCIAL PROTECTIONS

Contractor agrees to afford its Enrollees protection from liability for payment of fees that are the obligation of Contractor in accordance with 42 C.F.R. §423.505(g).

M. RELATIONSHIP WITH FIRST TIER, DOWNSTREAM, AND RELATED ENTITIES

1. Contractor agrees that it maintains ultimate responsibility for adhering to and otherwise fully complying with all terms and conditions of this addendum.

2. Contractor shall ensure that any contracts or agreements with First Tier, Downstream and Related Entities performing functions on Contractor's behalf related to the operation of the Part D benefit are in compliance with 42 C.F.R. §423.505(i).

N. CERTIFICATION OF DATA THAT DETERMINE PAYMENT

Contractor must provide certifications in accordance with 42 C.F.R. §423.505(k).

O. SUBMISSION OF PRESCRIPTION DRUG EVENT DATA

1. Contractor shall submit prescription drug event data in accordance with 42 C.F.R. §423.329(b)(3).

P. CONTRACTOR REIMBURSEMENT TO PHARMACIES

1. If Contractor uses a standard for reimbursement of pharmacies based on the cost of a drug, Contractor will update such standard not less frequently than once every 7 days, beginning with an initial update on January 1 of each year, to accurately reflect the market price of the drug.

2. Contractor will issue, mail, or otherwise transmit payment with respect to all claims submitted by pharmacies (other than pharmacies that dispense drugs by mail order only, or are located in, or contract with, a long-term care facility) within 14 days of receipt of an electronically submitted claim or within 30 days of receipt of a claim submitted otherwise.

3. Contractor must ensure that a pharmacy located in, or having a contract with, a long-term care facility will have not less than 30 days (but not more than 90 days) to submit claims to Contractor for reimbursement.

Article III
Record Retention and Reporting Requirements

A. RECORD MAINTENANCE AND ACCESS

Contractor agrees to maintain records and provide access in accordance with 42 C.F.R. §§ 423.505 (b)(10) and 423.505(i)(2).

B. GENERAL REPORTING REQUIREMENTS

Contractor agrees to submit information to CMS according to 42 C.F.R. §§423.505(f) and 423.514, and the "Final Medicare Part D Reporting Requirements," a document issued by CMS and subject to modification each program year.

C. CMS AND DHCSLICENSE FOR USE OF CONTRACTOR FORMULARY

Contractor agrees to submit to CMS and DHCS the Contractor's formulary information, including any changes to its formularies, and hereby grants to the

Government, and any person or entity who might receive the formulary from the Government, a non-exclusive license to use all or any portion of the formulary for any purpose related to the administration of the Part D program, including without limitation publicly distributing, displaying, publishing or reconfiguration of the information in any medium, including www.medicare.gov, and by any electronic, print or other means of distribution.

Article IV
HIPAA Provisions

A. Contractor agrees to comply with the confidentiality and Enrollee record accuracy requirements specified in 42 C.F.R. §423.136.

B. Contractor agrees to enter into a business associate agreement with the entity with which CMS has contracted to track Medicare beneficiaries' true out-of-pocket costs.

Article V
Addendum Term and Renewal

A. TERM OF ADDENDUM

This addendum is effective from the date of CMS' authorized representative's signature through December 31, 2013. This addendum shall be renewable for successive one-year periods thereafter according to 42 C.F.R. §423.506.

B. QUALIFICATION TO RENEW ADDENDUM

1. In accordance with 42 C.F.R. §423.507, Contractor will be determined qualified to renew this addendum annually only if—

   (a) Contractor has not provided CMS or DHCS with a notice of intention not to renew in accordance with Article VII of this addendum

2. Although Contractor may be determined qualified to renew its addendum under this Article, if Contractor, CMS, and DHCS cannot reach agreement on the Part D plan benefit package under Subpart F of 42 C.F.R. Part 423, no renewal takes place, and the failure to reach agreement is not subject to the Appeals provisions in Subpart N of 42 C.F.R. Parts 422 or 423. (Refer to Article X for consequences of non-renewal on the Capitated Financial Alignment Contract.)

Article VI
Nonrenewal of Addendum By Contractor

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A. Contractor may non-renew this addendum in accordance with 42 C.F.R. 423.507(a).

Article VII
Modification or Termination of Addendum by Mutual Consent

This addendum may be modified or terminated at any time by written mutual consent in accordance with 42 C.F.R. 423.508. (Refer to Article X for consequences of non-renewal on the Capitated Financial Alignment Contract.)

Article VIII
Termination of Addendum by CMS

CMS may terminate this addendum in accordance with 42 C.F.R. 423.509. (Refer to Article X for consequences of non-renewal on the Capitated Financial Alignment Contract.)

Article IX
Termination of Addendum by Contractor

A. Contractor may terminate this addendum only in accordance with 42 C.F.R. 423.510.

B. If the addendum is terminated under section A of this Article, Contractor must ensure the timely transfer of any data or files. (Refer to Article X for consequences of non-renewal on the Capitated Financial Alignment Contract.)

Article X
Relationship between Addendum and Capitated Financial Alignment Contract

A. Contractor acknowledges that, if it is a Capitated Financial Alignment contractor, the termination or nonrenewal of this addendum by any party may require CMS to terminate or non-renew the Contractor's Capitated Financial Alignment Contract in the event that such non-renewal or termination prevents Contractor from meeting the requirements of 42 C.F.R. §422.4(c), in which case the Contractor must provide the notices specified in this contract, as well as the notices specified under Subpart K of 42 C.F.R. Part 422.

B. The termination of this addendum by any party shall not, by itself, relieve the parties from their obligations under the Capitated Financial Alignment Contract to which this document is an addendum.

C. In the event that Contractor's Capitated Financial Alignment Contract is terminated or nonrenewed by any party, the provisions of this addendum shall also terminate.

In such an event, Contractor, DHCS and CMS shall provide notice to Enrollees and the public as described in this Contract as well as 42 C.F.R. Part 422, Subpart K or 42 C.F.R. Part 417, Subpart K, as applicable.

Article XI
Intermediate Sanctions

Consistent with Subpart O of 42 C.F.R. Part 423, Contractor shall be subject to sanctions and civil money penalties.

Article XII
Severability

Severability of the addendum shall be in accordance with 42 C.F.R. §423.504(e).

Article XIII
Miscellaneous

A. DEFINITIONS

Terms not otherwise defined in this addendum shall have the meaning given such terms at 42 C.F.R. Part 423 or, as applicable, 42 C.F.R. Parts 417, 422, 431 or Part 438.

B. ALTERATION TO ORIGINAL ADDENDUM TERMS

Contractor agrees that it has not altered in any way the terms of the Contractor addendum presented for signature by CMS. Contractor agrees that any alterations to the original text Contractor may make to this addendum shall not be binding on the parties.

C. ADDITIONAL CONTRACT TERMS

Contractor agrees to include in this addendum other terms and conditions in accordance with 42 C.F.R. §423.505(j).

D. CMS AND DHCS APPROVAL TO BEGIN MARKETING AND ENROLLMENT ACTIVITIES

Contractor agrees that it must complete CMS operational requirements related to its Part D benefit prior to receiving CMS and DHCS' approval to begin Contractor marketing activities relating to its Part D benefit. Such activities include, but are not limited to, establishing and successfully testing connectivity with CMS and DHCS systems to process enrollment applications (or contracting with an entity qualified to

perform such functions on Contractor's behalf) and successfully demonstrating the capability to submit accurate and timely price comparison data. To establish and successfully test connectivity, Contractor must, 1) establish and test physical connectivity to the CMS data center, 2) acquire user identifications and passwords, 3) receive, store, and maintain data necessary to send and receive transactions to and from CMS, and 4) check and receive transaction status information.

E. Pursuant to §13112 of the American Recovery and Reinvestment Act of 2009 (ARRA), Contractor agrees that as it implements, acquires, or upgrades its health information technology systems, it shall utilize, where available, health information technology systems and products that meet standards and implementation specifications adopted under § 3004 of the Public Health Service Act, as amended by §13101 of the ARRA.

F. Contractor agrees to maintain a fiscally sound operation by at least maintaining a positive net worth (total assets exceed total liabilities) as required in 42 C.F.R. §423.505(b)(23).

Appendix F: Data Use Attestation

The Contractor shall restrict its use and disclosure of Medicare and Medi-Cal data obtained from CMS and DHCS information systems (listed in Attachment A) to those purposes directly related to the administration of the Medicare/Medicaid managed care and/or outpatient prescription drug benefits for which it has contracted with the CMS and DHCS to administer. The Contractor shall only maintain data obtained from CMS and DHCS information systems that are needed to administer the Medicare/Medicaid managed care and/or outpatient prescription drug benefits that it has contracted with CMS and DHCS to administer. The Contractor (or its First Tier, Downstream or other Related Entities) may not re-use or provide other entities access to the CMS information system, or data obtained from the system or DHCS, to support any line of business other than the Medicare/Medicaid managed care and/or outpatient prescription drug benefit for which the Contractor contracted with CMS and DHCS.

The Contractor further attests that it shall limit the use of information it obtains from its Medicare-Medicaid Enrollees to those purposes directly related to the administration of such plan. The Contractor acknowledges two exceptions to this limitation. First, the Contractor may provide its Medicare-Medicaid Enrollees information about non-health related services after obtaining consent. Second, the Contractor may provide information about health-related services without obtaining prior consent, as long as the Contractor affords the Enrollee an opportunity to elect not to receive such information.

CMS may terminate the Contractor's access to the CMS data systems immediately upon determining that the Contractor has used its access to a data system, data obtained from such systems, or data supplied by its Medicare-Medicaid Enrollees beyond the scope for which CMS and DHCS have authorized under this agreement. A termination of this data use agreement may result in CMS or DHCS terminating the Contractor's Medicare-Medicaid contract(s) on the basis that it is no longer qualified as an Integrated Care Organization (Cal MediConnect). This agreement shall remain in effect as long as the Contractor remains a Cal MediConnect sponsor. This agreement excludes any public use files or other publicly available reports or files that CMS or DHCS make available to the general public on their websites.

Attachment A

The following list contains a representative (but not comprehensive) list of CMS information systems to which the Data Use Attestation applies. CMS will update the list periodically as necessary to reflect changes in the agency's information systems

Automated Plan Payment System (APPS)
Common Medicare Environment (CME)
Common Working File (CWF)
Coordination of Benefits Contractor (COBC)
Drug Data Processing System (DDPS)
Electronic Correspondence Referral System (ECRS)
Enrollment Database (EDB)
Financial Accounting and Control System (FACS)
Front End Risk Adjustment System (FERAS)
Health Plan Management System (HPMS), including Complaints Tracking and all other modules
HI Master Record (HIMR)
Individuals Authorized Access to CMS Computer Services (IACS)
Integrated User Interface (IUI)
Medicare Advantage Prescription Drug System (MARx)
Medicare Appeals System (MAS)
Medicare Beneficiary Database (MBD)
Payment Reconciliation System (PRS)
Premium Withholding System (PWS)
Prescription Drug Event Front End System (PDFS)
Retiree Drug System (RDS)
Risk Adjustments Processing Systems (RAPS)

Appendix G: Model File & Use Certification Form

Pursuant to the Contract between the Centers for Medicare & Medicaid Services (CMS), the State of California, acting by and through the Department of Health Care Services (DHCS) and Plan hereafter referred to as the Contractor, governing the operations of the following health plan: Orange County Health Authority, the Contractor hereby certifies that all qualified materials for the Demonstration is accurate, truthful and not misleading. Organizations using File & Use Certification agree to retract and revise any materials (without cost to the government) that are determined by CMS or DHCS to be misleading or inaccurate or that do not follow established Medicare Communications and Marketing Guidelines, Regulations, and sub-regulatory guidance. In addition, organizations may be held accountable for any beneficiary financial loss as a result of mistakes in marketing materials or for misleading information that results in uninformed decision by a beneficiary to elect the plan. Compliance criteria include, without limitation, the requirements in 42 C.F.R. §§422.2260 – 422.2276 and 42 C.F.R. §422.111 for Cal MediConnect and the Medicare Communications and Marketing Guidelines.

I agree that CMS or DHCS may inspect any and all information including those held at the premises of the Contractor to ensure compliance with these requirements. I further agree to notify CMS and DHCS immediately if I become aware of any circumstances that indicate noncompliance with the requirements described above.

I possess the requisite authority to make this certification on behalf of the Contractor.

Appendix H: Medicare Mark License Agreement

THIS AGREEMENT is made and entered into January 1, 2018

by and between

THE CENTERS FOR MEDICARE & MEDICAID SERVICES (hereinafter "Licensor"),
with offices located at 7500 Security Blvd., Baltimore, MD 21244

and

Orange County Health Authority (hereinafter "Licensee"),
with offices located at 505 City Parkway West, Orange, CA 92868.

CMS Contract ID: H8016

WITNESSETH

WHEREAS, Licensor is the owner of the Medicare Prescription Drug Benefit program, a program authorized under Title XVIII, Part D of the Social Security Act (Part D), Mark (the "Mark").

WHEREAS, Licensee desires to use the Mark on Part D marketing materials (including the identification card) beginning September 1, 2019.

WHEREAS, both parties, in consideration of the premises and promises contained herein and other good and valuable consideration which the parties agree is sufficient, and each intending to be legally bound thereby, the parties agree as follows:

1. Subject to the terms and conditions of this Agreement, Licensor hereby grants to Licensee a non-exclusive right to use the Mark in their Part D marketing materials.
2. Licensee acknowledges Licensor's exclusive right, title, and interest in and to the Mark and will not, at any time, do or cause to be done any act or thing contesting or in any way impairing or tending to impair any part of such right, title, and interest. Licensee acknowledges that the sole right granted under this Agreement with respect to the Mark is for the purposes described herein, and for no other purpose whatsoever.
3. Licensor retains the right to use the Mark in the manner or style it has done so prior to this Agreement and in any other lawful manner.
4. This Agreement and any rights hereunder are not assignable by Licensee and any attempt at assignment by Licensee shall be null and void.
5. Licensor, or its authorized representative, has the right, at all reasonable times, to inspect any material on which the Mark is to be used, in order that Licensor may satisfy itself that the material on which the Mark appears meets with the standards, specifications, and instructions submitted or approved by Licensor. Licensee shall use the Mark without modification and in accordance with the Mark usage policies described within the Medicare Communications and Marketing Guidelines. Licensee shall not take any action inconsistent with the Licensor's ownership of the Mark, and any goodwill accruing from use of such Mark shall automatically vest in Licensor.
6. This agreement shall be effective on the date of signature by the Licensee's authorized representative through December 31, 2019, concurrent with the execution of the Part D addendum to the three way contract. This Agreement may be terminated by either party upon written notice at any time. Licensee agrees, upon written notice from Licensor, to discontinue any use of the Mark immediately. Starting December 31, 2019, this agreement shall be renewable for

successive one-year periods running concurrently with the term of the Licensee's Part D contract. This agreement shall terminate, without written notice, upon the effective date of termination or non-renewal of the Licensee's Part D contract (or Part D addendum to a Capitated Financial Alignment Demonstration contract).

7. Licensee shall indemnify, defend and hold harmless Licensor from and against all liability, demands, claims, suits, losses, damages, infringement of proprietary rights, causes of action, fines, or judgments (including costs, attorneys' and witnesses' fees, and expenses incident thereto), arising out of Licensee's use of the Mark.
8. Licensor will not be liable to Licensee for indirect, special, punitive, or consequential damages (or any loss of revenue, profits, or data) arising in connection with this Agreement even if Licensor has been advised of the possibility of such damages.
9. This Agreement is the entire agreement between the parties with respect to the subject matter hereto.
10. Federal law shall govern this Agreement.

Appendix I: Service Area

The Service Area outlined below is contingent upon the Contractor meeting all Readiness Review requirements in each county. CMS and DHCS reserve the right to amend Appendix I to revise the Service Area based on final Readiness Review results or subsequent determinations made by CMS and DHCS.

County Service Area:

Orange

Appendix J: Eligible Populations

Enrollment into Cal MediConnect will be available to individuals who meet all of the following criteria:

- Age 21 and older at the time of enrollment;
- Entitled to, or enrolled for, benefits under Part A of title XVIII of the Social Security Act, or enrolled for benefits under Part B of title XVIII of such Act, and is eligible for medical assistance under a State plan under title XIX of such Act or under a waiver of such plan;
- Eligible for full Medicaid (Medi-Cal), including
    - Individuals enrolled in the Multipurpose Senior Services Program (MSSP).
    - Individuals who meet the share of cost provisions described below:
        - Nursing facility residents with a share of cost,
        - MSSP Enrollees with a share of cost, and
        - IHSS recipients with a share of cost.
    - Individuals eligible for full Medicaid (Medi-Cal) per the spousal impoverishment rule codified at section 1924 of the Social Security Act as described below:
        - For those Enrollees who are nursing facility level of care, subacute facility level of care, or intermediate care facility level of care and reside or could reside outside of a hospital or nursing facility, the Department or its designee shall make a Medi-Cal eligibility determination "as if" the beneficiary were in a long-term care facility. Specifically, the spousal impoverishment rule codified section 1924 of the Act will apply to Enrollees. The terms "intermediate care facility level of care" and "nursing facility level of care" and "subacute facility level of care" shall have the same meaning as defined in Title 22 of the California Code of Regulations sections 51120, 51124, and 52224.5.
- Reside in one of the following Demonstration counties: Los Angeles, Orange, Riverside, San Bernardino, San Diego, San Mateo, and Santa Clara.
    - Up to 200,000 individuals in Los Angeles may be enrolled in the Demonstration. CMS and the State will monitor the enrollment and stop participation when this enrollment cap is met.
- Individuals residing in San Mateo or Orange county with a diagnosis of end stage renal disease (ESRD) at the time of enrollment.

The following populations will be excluded from enrollment:

- Individuals under age 21;
- Individuals with other private or public health insurance;
- Individuals receiving services through California's regional centers or State developmental centers or intermediate care facilities for the developmentally

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disabled in Los Angeles, Orange, Riverside, San Bernardino, San Diego, and Santa Clara counties;

- Individuals with a share of cost that do not meet the requirements outlined above;
- Individuals residing in one of the Veterans' Homes of California;
- Individuals living in the following rural zip codes:
    - San Bernardino County – 92242, 92267, 92280, 92323, 92332, 92363, 92364, 92366, 93562, 92280, 93592, and 93558
    - Los Angeles County - 90704
    - Riverside County - 92225, 92226, 92239;
- Individuals with a diagnosis of end stage renal disease (ESRD) at the time of enrollment and residing in Los Angeles, Riverside, San Bernardino, San Diego, and Santa Clara, unless they are already enrolled in a separate line of business operated by the Contractor. Individuals enrolled in the Demonstration who are subsequently diagnosed with ESRD, as with all Enrollees, may choose to disenroll from the Demonstration or may choose to stay enrolled.

Individuals that may enroll but may not be passively enrolled include (see section C.2 for a description of Passive Enrollment):

- Individuals residing in the following rural zip codes in San Bernardino County in which only one Cal MediConnect Plan operates: 92252, 92256, 92268, 92277, 92278, 92284, 92285, 92286, 92304, 92305, 92309, 92310, 92311, 92312, 92314, 92315, 92317, 92321, 92322, 92325, 92326, 92327, 92333, 92338, 92339, 92341, 92342, 92347, 92352, 92356, 92365, 92368, 92372, 92378, 92382, 92385, 92386, 92391, 92397, and 92398;
- Individuals enrolled in Medicare Advantage in 2014;
- Individuals in one of the following programs may enroll only after they have disenrolled from the program:
    - Individuals enrolled in the following 1915(c) waivers: Nursing Facility/Acute hospital Waiver, HIV/AIDS Waiver, Assisted Living Waiver, and In Home Operations Waiver; and
    - Individuals enrolled in Program of All-Inclusive Care for the Elderly (PACE) or the AIDS Healthcare Foundation.

Appendix K: Disputes

Contractor also agrees to the following:

1. This Disputes section will be used by the Contractor as the means of seeking resolution of disputes on contractual issues. It shall not be used with respect to any dispute regarding the actuarial soundness of the capitated rate, as provided in paragraph 4.6.2. Filing a dispute will not preclude DHCS and CMS from recouping the value of the amount in dispute from the Contractor or from offsetting this amount from subsequent capitation payment(s). If the amount to be recouped exceeds twenty-five (25) percent of the capitation payment, amounts of up to twenty-five (25) percent will be withheld from successive capitation payments until the amount in dispute is fully recouped.
2. Disputes Resolution by Negotiation
    a. DHCS, CMS and Contractor agree to try to resolve all contractual issues by negotiation and mutual agreement at the Contract Management Team (CMT) without litigation. The parties recognize that the implementation of this policy depends on open-mindedness, and the need for both sides to present adequate supporting information on matters in question.
3. Notification of Dispute
    a. Within fifteen (15) calendar days of the date the dispute concerning performance of this Contract arises or otherwise becomes known to the Contractor, the Contractor will notify the CMT in writing of the dispute, describing the conduct (including actions, inactions, and written or oral communications) which it is disputing.
    b. The Contractor's notification will state, on the basis of the most accurate information then available to the Contractor, the following:
        i. That it is a dispute pursuant to this section.
        ii. The date, nature, and circumstances of the conduct which is subject of the dispute.
        iii. The names, phone numbers, function, and activity of each Contractor, subcontractor, DHCS/State official or CMS employee involved in or knowledgeable about the conduct.
        iv. The identification of any documents and the substances of any oral communications involved in the conduct. Copies of all identified documents will be attached.
        v. The reason the Contractor is disputing the conduct.
        vi. The cost impact to the Contractor directly attributable to the alleged conduct, if any.
        vii. The Contractor's desired remedy.

c. The required documentation, including cost impact data, will be carefully prepared and submitted with substantiating documentation by the Contractor. This documentation will serve as the basis for any subsequent Appeal.

d. Following submission of the required notification, with supporting documentation, the Contractor will comply with the requirements of Title 22 CCR Section 53851(d) and diligently continue performance of this Contract, including matters identified in the Notification of Dispute, to the maximum extent possible.

4. CMT or Alternate Dispute Officer's Decision

a. Pursuant to a request by Contractor, the CMT may provide for a dispute to be decided by an alternate dispute officer designated by DHCS and CMS, who is not a member of the CMT and is not directly involved in Medicare or the Medi-Cal Managed Care Program, as appropriate for the issue involved. Any disputes concerning performance of this Contract shall be decided by the CMT or the alternate dispute officer in a written decision stating the factual basis for the decision. Within thirty (30) calendar days of receipt of a Notification of Dispute, the CMT or the alternate dispute officer, shall either:

i. Find in favor of Contractor, in which case the CMT or alternate dispute officer may:

A. Countermand the earlier conduct which caused Contractor to file a dispute; or

ii. Or,

A. Deny Contractor's dispute and, where necessary, direct the manner of future performance; or

B. Request additional substantiating documentation in the event the information in Contractor's notification is inadequate to permit a decision to be made under 1) or 2) above, and shall advise Contractor as to what additional information is required, and establish how that information shall be furnished. Contractor shall have 30 calendar days to respond to the CMT or alternate dispute officer's request for further information. Upon receipt of this additional requested information, the CMT or alternate dispute officer shall have 30 calendar days to respond with a decision. Failure to supply additional information required by the CMT or alternate dispute officer within the time period specified above shall constitute waiver by Contractor of all claims in accordance with Paragraph F. Waiver of Claims, below. A copy of the decision shall be served on Contractor.

5. Appeal of CMT or Alternate Dispute Officer's Decision

a. Contractor shall have thirty (30) calendar days following the receipt of the decision to file an Appeal of the decision to the Director and the Medicare Drug & Health Plan Contract Administration Group Director, Center for Medicare. All Appeals

shall be governed by Health and Safety Code Section 100171, except for those provisions of Section 100171(d)(1) relating to accusations, statements of issues, statement to respondent, and notice of defense. All Appeals shall be in writing and shall be filed with DHCS' Office of Administrative Hearings and Appeals. An Appeal shall be deemed filed on the date it is received by the Office of Administrative Hearings and Appeals. An Appeal shall specifically set forth each issue in dispute, and include Contractor's contentions as to those issues. However, Contractor's Appeal shall be limited to those issues raised in its Notification of Dispute filed pursuant to Paragraph B. Notification of Dispute above. Failure to timely Appeal the decision shall constitute a waiver by Contractor of all claims arising out of that conduct, in accordance with Paragraph 7, Waiver of Claims below, Contractor shall exhaust all procedures provided for in this Appendix K, Disputes, prior to initiating any other action to enforce this Contract.

6. Contractor Duty to Perform

    a. Pending final determination of any dispute hereunder, Contractor shall comply with the requirements of Title 22 CCR Section 53851(d) and proceed diligently with the performance of this Contract and in accordance with the CMT or alternate dispute officer's decision. If pursuant to an Appeal under Paragraph 5, Appeal of CMT or Alternate Dispute Officer's Decision above, the CMT or alternate dispute officer's decision is reversed, the effect of the decision pursuant to Paragraph 5. shall be retroactive to the date of the CMT or alternate dispute officer's decision, and Contractor shall promptly receive any benefits of such decision. CMS and DHCS shall not pay interest on any amounts paid pursuant to a CMT or alternate dispute officer's decision or any Appeal of such decision, or any subsequent court decision or court order regarding the subject matter of the Notification of Dispute.

7. Waiver of Claims

    a. If Contractor fails to submit a Notification of Dispute, supporting and substantiating documentation, any additionally required information, or an Appeal of the CMT or alternate dispute officer's decision, in the manner and within the time specified in this Appendix K, Disputes, that failure shall constitute a waiver by Contractor of all claims arising out of that conduct, whether direct or consequential in nature.

Appendix L: Additional Medicare Waivers

In addition to the waivers granted for the Cal MediConnect demonstration in the MOU, CMS hereby waives Section 1860-D1 of the Social Security Act, as implemented in 42 C.F.R. § 423.38(c)((4)(i), and extend Sections 1851(a), (c), (e), and (g) of the Social Security Act, as implemented in 42 C.F.R. Part 422, Subpart B only insofar as such provisions are inconsistent with allowing dually eligible beneficiaries to change enrollment on a monthly basis.

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,

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.

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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.

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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

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- 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

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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

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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

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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.

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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

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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

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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.

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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.

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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.

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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.

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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.

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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.

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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

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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;

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- 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.

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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.

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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

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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.

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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.

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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;

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- 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.

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- 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.

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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

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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.

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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

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- 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

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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;

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- 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.

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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.

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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.

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- 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

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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

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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

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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

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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

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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

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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.

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- 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

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- 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

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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:

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- **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.

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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.

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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.

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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

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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

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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

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- 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

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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.

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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.

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- 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.

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- **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.

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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

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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

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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

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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,

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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.

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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.

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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.

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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.

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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

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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.

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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.

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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

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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

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- 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.

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- **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.

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- **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

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  - 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

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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

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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

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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:

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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

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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.

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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

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- **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

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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:

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- 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.**

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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.

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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:**

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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

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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

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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;

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- 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.

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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

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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

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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

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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*

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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

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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,

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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

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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;

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- 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;

o 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.

o 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

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(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.

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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):

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- 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

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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:

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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:

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(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

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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

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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

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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.

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- 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:

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- 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.

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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

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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.

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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

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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

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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.

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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

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- 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.

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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.

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- 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

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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

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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;

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- 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

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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

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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;

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        - 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 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.

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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.

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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:

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- 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

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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

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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

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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.

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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.

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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

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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;

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        - 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

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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

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- 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.

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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

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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

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- 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.

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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

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- 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.

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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

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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.

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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.

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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

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- 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.

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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.

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- 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.

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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

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- 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

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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.

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- 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

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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.

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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

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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

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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.

AMENDMENT # TO
PROFESSIONAL SERVICES CONTRACT

THIS AMENDMENT # TO THE PROFESSIONAL SERVICES CONTRACT ("Amendment #") shall become effective on January 1, 2023 by and between Orange County Health Authority, a Public Agency, dba CalOptima ("CalOptima"), and _____ ("Professional"), with respect to the following facts:

RECITALS

A. CalOptima and Professional entered into a Professional Services Contract, by which Professional has agreed to provide or arrange for the provision of Covered Services to Members.

B. CalOptima and Professional desire to amend this Contract on the terms and conditions set forth herein.

NOW, THEREFORE, the parties agree as follows:

1. Recital E shall be added to the Contract as follows and subsequent Recitals will be renumbered:

"E. CalOptima has entered into a contract with the Department of Health and Human Services ("HHS"), Centers for Medicare and Medicaid Services ("CMS"), (CMS Contract") to operate a Medicare Advantage ("MA") plan and to offer Medicare covered items and services to eligible individuals (referred to herein as the "OneCare Program". CalOptima may only enroll those dual eligible individuals who meet all applicable Medicare Advantage eligibility requirements, and who are eligible to be enrolled in CalOptima's Medi-Cal Managed Care plan, as described in the contract between CalOptima and DHCS.

2. Article 1, Section 1.2, "Addendums" shall be deleted in its entirety and replaced with the following:

"1.2 Addendums

1.2.1 The Addendums are terms and conditions that apply specifically to items and services provided to Members under the CalOptima Programs as follows:

1.2.1.1 Addendum 1: Medi-Cal Program Requirements
1.2.1.2 Addendum 2: PACE Program Requirements
1.2.1.3 Addendum 3: Medicare Advantage Program Requirements
1.2.1.4 Addendum 4: Certification Regarding Lobbying"

3. Article 2, Section 2.14 "CalOptima Programs(s)" shall be deleted and replaced with the following:

"2.14 "CalOptima Programs(s)" means the Medi-Cal, PACE, and Medicare Advantage Programs administered by CalOptima. Professional participates in the specific CalOptima program(s) identified on Attachment A."

4. Article 3, Section 3.1.4 shall be deleted and replaced with the following:

"3.1.4 Only Practitioners who CalOptima has determined meet applicable CalOptima credentialing criteria may be listed as contracted. This Contract may be amended for the addition or deletion of Practitioners credentialed by CalOptima upon Professional giving CalOptima written notice of such addition or deletion at least

forty five (45) days prior to the effective date of such addition or deletion. Professional shall provide an updated list of its Practitioners as needed or upon request from CalOptima."

5. Attachment A, Section 1.1 shall be deleted and replaced with the following:

"1.1 CalOptima Program. Professional shall furnish Covered Services to eligible Members in the following CalOptima Programs:

_____ Medi-Cal Program (CalOptima Community Network and CalOptima Direct-Administrative)

_____ PACE Program

_____ Medicare Advantage Program (CalOptima Community Network)"

6. Attachment B, "Compensation" shall be deleted in its entirety and replaced with "Attachment B-Amendment {# } - Compensation".

7. Addendum 3, "Cal MediConnect Program Requirements" shall be deleted in its entirety and replaced with Addendum 3, "Medicare Advantage Program Requirements" attached herewith.

8. CONTRACT REMAINS IN FULL FORCE AND EFFECT – Except as specifically amended by this Amendment, all other conditions contained in the Contract as previously amended shall continue in full force and effect.

IN WITNESS WHEREOF, CalOptima and _____ have executed this Amendment.

FOR PROFESSIONAL:	FOR CALOPTIMA:
_____	_____
SIGNATURE	SIGNATURE
_____	Ladan Khamseh
PRINT NAME	PRINT NAME
_____	Interim Chief Operating Officer
TITLE	TITLE
_____	_____
DATE	DATE

ATTACHMENT B – Amendment I

COMPENSATION

CalOptima shall reimburse Professional and Professional shall accept as payment in full from CalOptima, the lesser of billed charges or the following amounts:

I. MEDI-CAL PROGRAM

A. Primary Care Services

For Covered Services provided to Assigned COD-Administrative and Community Network Members, or as otherwise noted below, CalOptima shall reimburse Professional, and Professional shall accept as payment in full from CalOptima, the lesser of:

1. Billed charges, or

    1.1. **XX%** of the **Current CalOptima Medi-Cal Fee Schedule** on a fee-for-service basis for **primary care**, as defined in CalOptima Policies.

    1.2. **XX%** of the **Current CalOptima Medi-Cal Fee Schedule** on a fee-for-service basis for **non professional services**, as defined in CalOptima Policies.

2. Services with Unestablished Fees. If a fee has not been established by Medi-Cal for a particular procedure, and CalOptima has provided authorization for Professional to provide such service, CalOptima shall reimburse Professional under the following guidelines:

    2.1. "By Report & Unlisted" codes that CalOptima has provided authorization for Professional to provide such service will be paid according to Medi-Cal billing and payment guidelines.

    2.2. Professional shall utilize current payment codes and modifiers for Med-Cal.

    2.3. CPT or HCPC codes not contained in the Medi-Cal fee schedule at the time of service are not reimbursable.

    2.4. If the billed charges are determined to be unallowable, in excess of usual and customary charges, or inappropriate pursuant to a medical review by CalOptima, CalOptima will contact Professional for additional justification and these will be handled on a case-by-case basis.

3. Supplemental Pay-for-Performance Payment. CalOptima may authorize supplemental payments to PCP yearly or quarterly based on PCP's quality performance and achievement of specified program goals which are determined by CalOptima. The amount of supplemental compensation may be a certain percentage of Community Network's annual fee-for-service payments made to the PCP. CalOptima shall not pay PCP any supplemental payments if this Contract is terminated.

B. Specialist Services

For Covered Services provided to referred Community Network Members in accordance with CalOptima referral Policies, and as to COD Administrative Members as noted below, CalOptima shall reimburse Professional, and Professional shall accept as payment in full from CalOptima, the lesser of:

1. Billed charges, or

1.1. **Specialist Professional** services shall be paid at **XX%** of the **Current CalOptima Medi-Cal Fee Schedule** on a fee-for-service basis for, as defined in the CalOptima Policies.

1.2. **Non Professional** services shall be paid at **XX%** of the **Current CalOptima Medi-Cal Fee Schedule** on a fee-for-service basis, as defined in the CalOptima Policies.

1.3. For **Professional services** provided by a qualifying **CCS paneled Specialist Professional** to a Community Network or COD-Administrative Member less than 21 years of age, CalOptima shall pay Professional **XX%** of the **Current Medi-Cal Fee Schedule**, as defined in CalOptima Policy, for services for which CalOptima is financially responsible. **Non Professional** services shall be paid at **XX%** of the **Current Medi-Cal Fee Schedule** on a fee-for-service basis, as defined in the CalOptima Policies.

1.4. For Specialist Physician Services provided to an **Adult Expansion Member** in accordance with CalOptima Policies, and as noted below, CalOptima shall reimburse Professional, and Professional shall accept as payment in full from CalOptima, the lesser of billed charges, or

CPT Code Range	Type of Service	Fee Schedule
10000-69999	**Surgical Range**	**XX% of Medi-Cal**
70000-79999	**Radiology and Radiation Therapy Professional and Technical Components**	**XX% of Medi-Cal**
80000-89999	**Lab and Pathology**	**XX% of Medi-Cal**
90000-99999	**Professional Services**	**XX% of Medi-Cal**
HCPC Codes		**XX% of Medi-Cal**

1.4.1. Rates for Adult Expansion Members may be different than those included herein as determined by DHCS. Should DHCS make a change in future payments to CalOptima, CalOptima will adjust payments made to Professional.

2. Professional shall not be paid for services provided to **Community Network Members** if Member is not referred by a Participating PCP to Professional in accordance with CalOptima referral Policies, except with regard to Emergency Services and CHDP Services, as provided in this Contract. This shall be effective upon the implementation of the Community Network program. Professional will be advised by CalOptima on the implementation date of the Community Network program.

3. Services with Unestablished Fees. If a fee has not been established by Medi-Cal for a particular procedure, and CalOptima has provided authorization for Professional to provide such service, CalOptima shall reimburse Professional under the following guidelines:

3.1. "By Report & Unlisted" codes that CalOptima has provided authorization for Professional to provide such service will be paid according to Medi-Cal billing and payment guidelines.

3.2. Professional shall utilize current payment codes and modifiers for Med-Cal.

3.3. CPT or HCPC codes not contained in the Medi-Cal fee schedule at the time of service are not reimbursable.

3.4. If the billed charges are determined to be unallowable, in excess of usual and customary charges, or inappropriate pursuant to a medical review by CalOptima, CalOptima will contact Professional for additional justification and these will be handled on a case-by-case basis.

II. PACE PROGRAM

1. For Covered Services provided to PACE Members, CalOptima shall reimburse Professional, and Professional shall accept as payment in full from CalOptima, the lesser of billed charges or **{xxxxx}** percent **(XX%)** of the Current CalOptima Medicare Allowable Participating Provider Fee Schedule for locality 26.

2. Prior authorization rules apply for payment of services.

3. Medicare billing rules and payment Policies and guidelines for billing and payment will apply.

4. Services with Unestablished Fees. If a fee has not been established by Medicare for a particular procedure, and CalOptima has provided authorization for Professional to provide such service, CalOptima shall reimburse Professional under the following guidelines:

   4.1 "By Report & Unlisted" codes that CalOptima has provided authorization for Professional to provide such service will be paid according to Medicare billing and payment guidelines.

   4.2 Professional shall utilize current payment codes and modifiers for Medicare.

   4.3 CPT or HCPC codes not contained in the Medicare fee schedule at the time of service are not reimbursable.

   4.4 If the billed charges are determined to be unallowable, in excess of usual and customary charges, or inappropriate pursuant to a medical review by CalOptima, CalOptima will contact Professional for additional justification and these will be handled on a case-by-case basis.

5. Should Medicare consider a service as non-covered, then Medi-Cal guidelines shall be applied. Provider may need to resubmit claim in accordance with Medi-Cal codes, billing rules, Policies, and guidelines for reimbursement.

III. MEDICARE ADVANTAGE

1. For Covered Services provided to Medicare Advantage Member, CalOptima shall reimburse Professional, and Professional shall accept as payment in full from CalOptima, the lesser of billed charges, or **{xxxxx}** percent **(XX%)** of the Current CalOptima Medicare Allowable Participating Provider Fee Schedule for locality 26.

2. Prior authorization rules apply for payment of services.

3. Medicare billing rules and payment Policies and guidelines for billing and payment will apply.

4. Services with Unestablished Fees. If a fee has not been established by Medicare for a particular procedure, and CalOptima has provided authorization for Professional to provide such service, CalOptima shall reimburse Professional under the following guidelines:

   4.1 "By Report & Unlisted" codes that CalOptima has provided authorization for Professional to provide such services will be paid in accordance to Medicare billing and payment guidelines .

   4.2 Professional shall utilize current payment codes and modifiers for Medicare.

   4.3 CPT or HCPCS codes not contained in the Medicare fee schedule at the time of service are not reimbursable.

   4.4 Should Medicare consider a service as non-covered, then Medi-Cal guidelines and reimbursement shall be applied in accordance with the guidelines identified in this contract. Professional may need to resubmit claim in accordance with Medi-Cal codes, billing rules, Policies, and guidelines for reimbursement.

   4.5 If the billed charges are determined to be unallowable, in excess of usual and customary charges, or inappropriate pursuant to a medical review by CalOptima, CalOptima will contact Professional for additional justification and these will be handled on a case-by-case basis.

IV. PAYMENT PROCEDURES

1. CalOptima agrees to grant Professional access to Member management information systems. Professional agrees to verify each Member's eligibility to receive Covered Services on the date of service. In addition, for PCP services, Professional must verify that CalOptima has not assigned Member receiving Covered Services from Professional to a Provider other than Professional prior to providing such services.

2. Billing and Claims Submission. Professional shall submit Claims for Covered Services in accordance with CalOptima Policies applicable to the Claims submission process.

3. Prompt Payment. CalOptima shall make payments to Professional in the time and manner set forth in CalOptima Policies and Procedures.

4. Claim Completion and Accuracy. Professional shall be responsible for the completion and accuracy of all Claims submitted, whether on paper forms or electronically, including claims submitted for the Professional by other parties. Use of a billing agent does not abrogate Professional's responsibility for the truth and accuracy of the submitted information. A Claim may not be submitted before the delivery of service. Professional acknowledges that Professional remains responsible for all Claims and that anyone who misrepresents, falsifies, or causes to be misrepresented or falsified, any records or other information relating to that Claim may be subject to legal action.

5. Claims Deficiencies. Any Claim that fails to meet CalOptima requirements for claims processing shall be denied and Professional notified of denial pursuant to CalOptima Policies and applicable

Federal and/or State laws and regulations.

6. Coordination of Benefits (COB). Professional shall coordinate benefits with other programs or entitlements recognizing where Other Health Coverage (OHC) is primary coverage in accordance with CalOptima Program requirements. Professional acknowledges that Medi-Cal is the payor of last resort.

7. Crossover Claims – Dual Eligible Members. "Crossover Claims" are claims for Dual Eligible Members where Medi-Cal is the secondary payer and Medicare or other health care coverage (OHC) is the Primary payor for dates of service during which the Dual Eligible Member was not assigned to one of CalOptima's Programs. California law limits Medi-Cal's reimbursement for a crossover claim to an amount that, when combined with the Medicare payment, should not exceed Medi-Cal's maximum allowed for similar services (Refer to Welfare and Institutions Code, Section 14109.5.)

   "Dual Eligible Members" are members who are eligible for both Medicare or other health care coverage (OHC) and Medi-Cal benefits.

   The Medi-Cal reimbursement rates in this contract will not apply to Crossover Claims for Dual Eligible Members. For Crossover Claims payment CalOptima will reimburse in accordance with CalOptima Policies, and state and federal regulations.

8. Member Financial Protections. Professional shall comply with Member financial protections as follows:

   8.1 Professional agrees to indemnify and hold Members harmless from all efforts to seek compensation and any claims for compensation from Members for Covered Services under this Contract. In no event shall a Member be liable to Professional for any amounts which are owed by, or are the obligation of, CalOptima.

   8.2 Professional agrees to hold Member harmless and not liable for Medicare Part A and B cost sharing when the State is responsible for paying such amounts. Professional agrees that Members will not be held liable for Medicare Part A and B cost sharing when the State is responsible for paying such amounts and that the provider will (A) accept the plan payment as payment in full, or (B) bill the appropriate State source as required at 42 CFR §422.504(g)(1)(iii). Professional will:

      1) accept the plan payment as payment in full, or

      2) bill the appropriate State source.

   8.3 In no event, including, but not limited to, non-payment by CalOptima, CalOptima's or the Professional's insolvency, or breach of this contract by CalOptima, shall the Professional, or any of its Practitioners, bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against the State of California or any Member or person acting on behalf of a Member for Covered Services pursuant to this Contract. Notwithstanding the foregoing, Professional may collect SOC, co-payments, and deductibles if, and to the extent, required under a specific CalOptima Program and applicable law.

   8.4 This provision does not prohibit Professional from billing and collecting payment for non-Covered Services if the CalOptima Member agrees to the payment in writing prior to the actual delivery of non-Covered Services and a copy of such agreement is given to the Member and placed in the Member's medical record prior to rendering such services.

   8.5 Upon receiving notice of Professional invoicing or balance billing a Member for the

difference between the Professional's billed charges and the reimbursement paid by CalOptima for any Covered Services, CalOptima may sanction the Professional or take other action as provided in this Contract.

This section shall survive the termination of this Contract for Covered Services furnished to CalOptima Members prior to the termination of this Contract, regardless of the cause giving rise to termination, and shall be construed to be for the benefit of Members. This section shall supersede any oral or written contrary agreement now existing or hereafter entered into between Professional and its Practitioners. Language to ensure the foregoing shall be included by Professional in all of Professional's Subcontracts.

ADDENDUM 3
MEDICARE ADVANTAGE PROGRAM REQUIREMENTS

The following additional terms and conditions apply to items and services furnished to Members under the CalOptima Medicare Advantage Program (OneCare):

1. Record Retention. Professional and it Subcontractors agree to retain books, records, contracts, computer or other electronic systems information, medical records, and documents related to this Contract and/or CMS Contract for at least ten (10) years from the final date of the CMS Contract period, or the date of completion of any audit, whichever is later, unless a longer period is required by law.

2. Right of Inspection, Evaluation, Audit of Records. Professional and its Subcontractors agree:

   2.1 To maintain and make available contracts, books, computer or other electronic systems, medical records, documents, and records related to this Contract and/or CMS Contract to CalOptima, DMHC, HHS, the Comptroller General, the U.S. General Accounting Office ("GAO"), any Quality Improvement Organization ("QIO") or accrediting organizations, including NCQA, and other representatives of regulatory agency or accrediting organizations or their designees to inspect, evaluate, collect, and audit for ten (10) years from the final date of the CMS Contract period or from the date of completion of any audit, whichever is later.

   2.2 For purposes of utilization management, quality improvement and other CalOptima administrative purposes, CalOptima and officials referred to in Section 2.1 of this Addendum 5, shall have access to, and copies of, at reasonable time upon request, the medical records, books, charts, and papers relating to the Professional's provision of health care services to Members, the cost of such services, and payments received by Professional from Members (or from others on their behalf). Medical records shall be provided at no charge to Members or CalOptima.

   2.3 For records subject to review under Section 2.1 of this Addendum 5 by HHS, the Comptroller General, or their designees, CMS will, except in exceptional circumstances, provide notification to CalOptima that a direct request for information has been initiated.

3. Accountability Acknowledgement. Professional further agrees and acknowledges that CalOptima oversees and is accountable to CMS for functions or responsibilities described in MA regulations; that CalOptima may only delegate activities or functions in a manner consistent with the MA program delegation requirements; and that any services or other activities performed by Professional pursuant to the Contract relative to the OneCare Program are consistent and comply with CalOptima's contractual obligations under the CMS Contract and adhere to delegation requirements set forth by MA statutes, regulations and/or other guidance. Where delegated responsibilities are identified in this Contract, the following shall apply:

   (a) Delegation by CalOptima. To the extent that responsibilities are delegated to Professional under this Contract, Professional warrants that it meets CalOptima delegation criteria set forth in the Attachment to this Contract and agrees to accept delegated responsibility for those listed activities. Professional agrees to perform the delegated activities in a manner consistent with the delegation criteria. Professional agrees to notify CalOptima of any change in its eligibility under the delegation criteria within twenty-four (24) hours from the date it fails to meet such delegation criteria. Professional

acknowledges that delegation to another entity does not alter Professional's ultimate obligations and responsibilities set forth in this Contract. Professional acknowledges and agrees that CalOptima retains final authority and responsibility for activities delegated under this Contract. Activities not expressly delegated herein by CalOptima or for which delegation is terminated are the responsibility of CalOptima.

(b) Reports on Delegated Activities. Professional agrees to provide CalOptima with periodic reports on delegated activities performed by Professional as provided in the delegation criteria. The report shall be in a form and contain such information as shall be agreed upon between the parties. Professional agrees to take those corrective actions identified by CalOptima through the audit review process.

(c) CalOptima Oversight of Delegation. The delegation of the functions and responsibilities stated herein does not relieve CalOptima of any of its accountability to CMS and obligations to its Members under applicable law. CalOptima is authorized to perform and remains liable for the performance of such obligations, notwithstanding any delegation of some or all of those obligations by Professional, which will be monitored by CalOptima on an ongoing basis. In the event Professional breaches its obligation to perform any delegated duties, CalOptima shall have all remedies set forth in this Contract, including, but not limited to, penalties or termination of the delegation of such functions to Professional as set forth in this Contract. Moreover, CalOptima shall have the right to require Professional to terminate any Subcontracting Professional for good cause, including but not limited to breach of its obligations to perform any delegated duties.

(d) Review of Credentials. Professional shall ensure that the credentials of medical professionals affiliated with the Professional are reviewed by it. Professional agrees that CalOptima will review and approve Professional's credentialing process on ongoing basis.

4. COB Requirements.

(a) MSP Obligations. Professional agrees to comply with MSP requirements. Professional shall coordinate with CalOptima for proper determination of COB and to bill and collect from other payers and third party liens such charges for which the other payer is responsible. Professional agrees to establish procedures to effectively identify, at the time of service and as part of their claims payment procedures, individuals and services for which there may be a financially responsible party other than MA Program. Professional will bill and collect from other payers such amounts for Covered Services for which the other payer is responsible.

(b) Professional Authority to Bill Third Party Payers. Professional may bill other individuals or entities for Covered Services for which Medicare is not the primary payer, as specified herein. If a Medicare Member receives from Professional Covered Services that are also covered under State or Federal workers' compensation, any no-fault insurance, or any liability insurance policy or plan, including a self-insured plan, Professional may bill any of the following— (1) the insurance carrier, the employer, or any other entity that is liable for payment for the services under section 1862(b) of the Act and 42 C.F.R. part 411 or (2) the Medicare enrollee, to the extent that he or she has been paid by the carrier, employer, or entity for covered medical expenses.

5. Reporting Requirements. Professional shall comply with CalOptima's reporting requirements in order that it may meet the requirements set forth in MA laws and regulations for submitting

encounter and other data including, without limitation, 42 CFR § 422.516. Professional also agrees to furnish medical records that may be required to obtain any additional information or corroborate the encounter data.

6. Submission and Prompt Payment of Claims. Professional agrees to submit claims to CalOptima in such format as CalOptima may require (but at minimum the CMS forms 1500, UB 04 or other form as appropriate) within ninety (90) days after the services are rendered. CalOptima reserves the right to deny claims that are not submitted within ninety (90) days of the date of service, except where Professional bills a third party payor as primary. Professional agrees to refrain from duplicate billing any claims submitted to CalOptima, unless expressly approved by CalOptima in order to process coordination of benefit claims. CalOptima shall provide payment to Professional within forty-five (45) business days of CalOptima's receipt of a clean and uncontested claim from Professional, or, CalOptima will contest or deny Professional's claim within forty-five (45) business days following CalOptima's receipt thereof.

7. In addition to Section 2.26 of this Contract, Professional and its Subcontractors shall ensure that payments are not made to individuals or entities included on the Preclusion List.

8. Additional Subcontractor Requirements. If any Covered Services relative to the OneCare Program under this Contract are to be provided by a Subcontractor on behalf of Professional, Professional shall ensure that such subcontracts are in writing and include the following:

8.1 An agreement to comply with the HHS and the Comptroller General, or their designees' right to directly audit, evaluate, collect, and inspect Subcontractors books, contracts, computer or other electronic systems, including medical records and documentation related to CMS' OneCare contract with CalOptima, for any particular contract period for ten (10) years from the final date of the contract period or from the date of completion of any audit, whichever is later.

8.2 For records subject to review under Section 8.1 of this Addendum 5, except in exceptional circumstances, CMS will provide notification to CalOptima that a direct request for information has been initiated.

8.3 An agreement to Member financial protections in accordance with Section 4.6 of the Contract, including prohibiting Subcontractors from holding a Member liable for payment of any fees that are the legal obligation of Professional.

8.4 An agreement to provide for continuation of health care benefits for the duration of the contract period for which CMS payments have been made; and for Members who are hospitalized on the date its contract with Professional terminates, or, in the event of Professional's insolvency, through the date of discharge.

8.5 An agreement that CalOptima may only delegate activities or functions to a Subcontractor in a manner consistent with requirements set forth in Section 8.7 of this Addendum 5.

8.6 An agreement to ensure that delegated activities or functions are consistent with CalOptima's OneCare contract requirements set forth by CMS.

8.7 If any of CalOptima's activities or responsibilities under this Contract are delegated to a Subcontractor, the following requirements apply and such subcontract must specify:

8.7.1 the delegated activities and reporting responsibilities.

8.7.2 either a provision for revocation of the delegation activities and reporting requirements or specify other remedies in instances where CMS or CalOptima determine that such parties have not performed satisfactorily.

8.7.3 that performance of the parties is monitored by CalOptima on an ongoing basis.

8.7.4 that the credentials of medical professionals affiliated with Subcontractor will be either reviewed by CalOptima; or the credentialing process will be reviewed and approved by CalOptima, and CalOptima must audit the credentialing process on an ongoing basis.

8.7.5 an agreement to comply with all applicable Medicare laws, regulations and CMS instructions.

8.8 If CalOptima delegates selection of Professionals, contractors, or subcontractors to Professional or Subcontractor, CalOptima retains the right to approve, suspend, or terminate such arrangement

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken June 2, 2022
Regular Meeting of the CalOptima Board of Directors

Report Item

21. Approve New OneCare Health Network Health Maintenance Organization, Shared-Risk Group, and Physician Hospital Consortia Contract Templates, and Authorize Template Use for New Contracts to be Executed with ARTA Western California Inc., Talbert Medical Group P.C., Monarch Healthcare, A Medical Group, and Monarch Health Plan Inc.

Contact

Yunkyung Kim, Chief Operating Officer 714-246-8408

Recommended Actions

1. Approve the new OneCare health network Health Maintenance Organization (HMO), Shared-Risk Group (SRG), Physician Hospital Consortia-Physician (PHC-P), and Physician Hospital Consortia-Hospital (PHC-H) contract templates, effective January 1, 2023.

2. Authorize the Chief Executive Officer (CEO) to use the new OneCare contract templates to execute contracts with ARTA Western California Inc., Talbert Medical Group P.C., Monarch Healthcare, A Medical Group, and Monarch Health Plan Inc., effective January 1, 2023, within the parameters set forth in the Fiscal Year (FY) 2022-23 Operating Budget as approved by the Board of Directors.

Background and Discussion

Staff requests that the Board of Directors (Board) approve the new OneCare HMO, SRG, PHC-P, and PHC-H health network contract templates and authorize the CEO to execute contracts with ARTA Western California Inc., Talbert Medical Group P.C., Monarch Healthcare, A Medical Group, and Monarch Health Plan Inc., effective January 1, 2023.

The State's Cal MediConnect program is set to end on December 31, 2022, at which time CalOptima will discontinue its OneCare Connect program. Starting January 1, 2023, OneCare will formally serve as the network for all of CalOptima's OneCare Connect members, as well as future Dual Eligible Special Needs Plan (D-SNP) members. OneCare will assume the same integrated, coordinated approach to care provided under OneCare Connect, providing the full spectrum of medical, home, and community-based services, as well as medical supplies and medications.

In anticipation of CalOptima's current OneCare Connect members' migration into OneCare and new D-SNP enrollment, staff is actively expanding the OneCare network. An amendment allowing CalOptima Community Network providers to serve under OneCare was approved by the Board on February 3, 2022. The OneCare health network HMO, SRG, PHC-P, and PHC-H contract templates currently under consideration will allow new health networks to participate under these contract models, outlining the terms for providing delegated services under OneCare. Existing contracted health networks wishing to participate in OneCare may do so under their original contract model to mitigate any potential disruption to member care. Existing networks wanting to join OneCare will have a 5-year term, under which they can terminate without cause upon providing a 180-day notice. New networks wishing to contract under OneCare will have a 5-year initial term that needs to be satisfied prior to giving 180-day notification of termination without cause.

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For uninterrupted access to care during the transition from OneCare Connect to OneCare, and to maintain a robust provider network, staff requests approval of the new OneCare HMO, SRG, PHC-P, and PHC-H, contract templates, and authority to execute contracts with ARTA Western California Inc., Talbert Medical Group P.C., Monarch Healthcare, A Medical Group, and Monarch Health Plan Inc., effective January 1, 2023.

Management will inform the Board of the status of the OneCare health networks and any risk arrangement changes and return to the Board with recommendations on new health network contracts, if necessary.

Fiscal Impact

The proposed CalOptima FY 2022-23 Operating Budget includes medical costs for the OneCare and OneCare Connect programs, including the transition of the OneCare Connect program to OneCare on January 1, 2023. The recommended action to execute new OneCare contracts with currently participating OneCare and OneCare Connect health networks effective January 1, 2023, has no additional fiscal impact.

Rationale for Recommendation

Approving the new OneCare HMO, SRG, PHC-P, and PHC-H contract templates will allow for seamless member transition out of OneCare Connect and maintain a robust provider network.

Concurrence

Troy R. Szabo, Outside General Counsel, Kennaday Leavitt

Attachments

1. Entities Covered by this Recommended Board Action
2. Proposed HMO contract template
3. Proposed SRG contract template
4. Proposed PHC-P contract template
5. Proposed PHC-H contract template
6. Previous Board Action dated February 3, 2022: "Authorize Amendments to the CalOptima Community Network Professional Services Contracts to Add OneCare as a Covered CalOptima Program"

/s/ Michael Hunn *05/27/2022*

Authorized Signature **Date**

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ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

OneCare Health Networks				
Name	**Address**	**City**	**State**	**Zip Code**
ARTA Western California, Inc.	2175 Park Place	El Segundo	CA	90245
Monarch Healthcare, A Medical Group, Inc.	11 Technology Dr.	Irvine	CA	92618
Talbert Medical Group, P.C.	2175 Park Place	El Segundo	CA	90245
OneCare Health Connect Networks				
Name	**Address**	**City**	**State**	**Zip Code**
ARTA Western California, Inc.	2175 Park Place	El Segundo	CA	90245
Monarch Health Plan, Inc.	11 Technology Dr.	Irvine	CA	92618
Talbert Medical Group, P.C.	2175 Park Place	El Segundo	CA	90245

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MEDICARE ADVANTAGE – HMO SERVICES CONTRACT

BETWEEN

ORANGE COUNTY HEALTH AUTHORITY DBA CALOPTIMA

AND

_____

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MEDICARE ADVANTAGE HMO SERVICES CONTRACT

This Medicare Advantage HMO Services Contract ("**Contract**") is January 1, 2023 ("**Effective Date**") by and between Orange County Health Authority, a public agency dba CalOptima ("**CalOptima**"), and _____ ("**HMOHMO**"), a California corporation organized under the laws of the State of California. CalOptima and HMO may each be referred to herein as a "**Party**" and collectively as the "**Parties**".

RECITALS

A. CalOptima is a County Organized Health System ("**COHS**") organized under Welfare & Institutions Section 14087.54 and Orange County Ordinance No. 3896.

B. CalOptima is licensed as a health care service plan by the California Department of Managed Health Care ("**DMHC**") under the Knox-Keene Health Care Service Plan Act of 1975 and its implementing regulations (collectively the "**Knox-Keene Act**") and authorized to offer a Medicare Advantage ("**MA**") plan pursuant to Title 42 of the United States Code, Chapter 7, Subchapter XVIII, Part C and its implementing regulations for individuals covered under the federal Medicare program.

C. CalOptima, as a dual–eligible special needs plan ("**DSNP**"), may only enroll those dual eligible individuals who meet all applicable Medicare Advantage eligibility requirements, and who are eligible to be enrolled in CalOptima's Medi-Cal Managed Care plan, as described in the contract between CalOptima and the California Department of Health Care Services ("**DHCS**").

D. HMO is licensed as a restricted health care service plan by the DMHC and provides or arranges for the provision of health care services to its assigned enrollees.

E. CalOptima and HMO desire to enter into the Contract whereby HMO will perform delegated administrative services and arrange for or furnish health care items and services as described herein to certain Enrollees enrolled in CalOptima's MA plan and assigned to HMO.

F. Unless defined elsewhere in the Contract, the defined terms used in this Contract shall have the meanings set forth in Attachment A.

NOW, THEREFORE, in consideration of the promises and the mutual covenants herein stated, it is agreed by and between the Parties as follows:

I. HMO SERVICE OBLIGATIONS

1.1 **Covered Services**. HMO shall provide Covered Services to Enrollees selecting, and/or assigned to, HMO in accordance with all provisions of this Contract and CalOptima Policies. The Covered Services that are to be provided by and are the financial responsibility of HMO are described in Attachment B. HMO specifically agrees to accept financial risk and responsibility for injectables pursuant to Health & Safety Code Section 1375.8.

1.1.1 HMO shall provide Covered Services: (i) in the same manner, in accordance with the same standards, and within the same time availability as offered to non-CalOptima patients; (ii) in accordance with professionally recognized standards of practice, (iii) in a culturally

competent manner to all Enrollees, including those with limited English proficiency or reading skills and from diverse cultural and ethnic backgrounds; and (iv) not discriminate in the provision of such Covered Services because of an Enrollee's race, ethnicity, color, national origin, religion, sex, sexual orientation, age, medical or claims history, mental or physical disability, genetic information, or source of payment.

1.1.2 HMO is prohibited from closing or otherwise limiting its acceptance of Enrollees as patients unless the same limitations apply to all of its commercially insured patients.

1.1.3 HMO shall use its best efforts, where consistent with sound medical practice, to ensure that Covered Services are provided only by HMO Physicians and/or other Participating Providers, except in cases of Emergency Services or Urgent Care Services, or if no such HMO Physician or Participating Provider is available to perform the appropriate Covered Services.

1.1.4 HMO shall be liable for the provision and payment of all Covered Services notwithstanding a delay in payment of the Capitation Payment.

1.1.5 HMO acknowledges that the determination of whether a service or supply was/is a Covered Service delegated to HMO rests with CalOptima, subject to the Evidence of Coverage and Appeals procedures established by the DMHC and CMS.

1.1.6 CalOptima may incorporate any change in Covered Services mandated by Laws into the Contract effective the date the change goes into effect. Whenever possible, CalOptima shall give the HMO thirty (30) calendar days' prior notice of any such change to the Contract. CalOptima shall determine the effective date of the change in Covered Services. Attachment B shall not be amended during the current Term without mutual consent of the Parties, except as may be required for continued compliance with Laws.

1.1.7 Decisions concerning whether to provide or authorize Covered Services under this Contract shall be based solely on Medical Necessity. HMO shall not deny Authorization for a Covered Service that the Enrollee or the Provider demonstrates is Medically Necessary. The actual provision of any Covered Service is subject to the professional judgment of the PCP or other physicians and/or Providers participating with HMO as to the Medical Necessity of the Covered Service, except that each Physician shall provide assessment and evaluation services ordered by a court or legal mandate. HMO acknowledges that disputes between the HMO and Enrollees about Medical Necessity can be appealed pursuant to CalOptima Policies and Laws.

1.1.8 HMO may not arbitrarily deny or reduce the amount, duration, or scope of a required Covered Service solely because of the diagnosis, type of illness, or condition. HMO may place appropriate limits on a service on the basis of criteria such as Medical Necessity or for utilization control, provided the services furnished can reasonably be expected to achieve their purpose and such a limitation complies with Laws.

1.2 **Confidentiality**. HMO and CalOptima agree to safeguard the confidentiality of Enrollee information and comply with all Laws (including, but limited to, the Health Insurance Portability and Accountability Act ("HIPAA"), 42 CFR Section 431.300 *et seq*., California Welfare and Institutions Code Section 14100.2, California Civil Code Section 56 *et seq.*, and the California Information Practices Act, Civil Code Section 1798) regarding the confidentiality and disclosure of Enrollee names, health, enrollment and personal information (including medical and Behavioral

Health information contained in Medical Records). HMO shall provide counseling to Enrollees on their right to confidentiality and obtain Enrollee consent prior to releasing confidential information unless such consent is not required pursuant to Title 22 CCR Section 51009.

1.3 **Emergency Services and Urgent Care**. HMO shall insure that it provides and pays for all Emergency Services and Urgent Care, including those services provided by Non-Participating Providers, without prior Authorization, twenty-four (24) hours each day, seven (7) days a week, in accordance with Laws and CalOptima Policies. HMO shall coordinate access to Emergency Services in accordance with CalOptima's emergency department protocol. HMO shall ensure adequate follow-up care for those Enrollees who have been screened in the emergency room and require non-Emergency Services. HMO may not specify what constitutes an Emergency Medical Condition on the basis of lists of diagnoses or symptoms.

1.4 **Days to Appointment**. HMO shall ensure that appointments for non-Emergency Services and non-Urgent Care Covered Services are scheduled within ten (10) business days of the Enrollee's request for PCP and fifteen (15) business days of Enrollee's request for Specialist Physician; that health assessments and general physical examinations and all preventative Covered Services are scheduled within thirty (30) calendar days of Enrollee's request for an appointment, and that, if HMO supplies maternity Covered Services, HMO shall ensure that the most current standards and guidelines of the American College of Obstetricians and Gynecologists are utilized as the minimum measure of quality for perinatal services. HMO shall also have a process in place for follow-up on Enrollee missed appointments.

1.5 **Twenty-Four (24) Hour HMO Coverage**. HMO shall ensure that it has, at a minimum, two HMO Physicians as follows: One (1) HMO Physician who is available twenty-four (24) hours a day to authorize Medically Necessary, Post-Stabilization Care Services and coordinate transfer of stabilized Enrollees in an emergency department, if necessary, and one (1) HMO Physician available twenty-four (24) hours a day, seven (7) days a week to resolve disputed requests for Authorizations.

1.6 **Clinical Laboratory Improvement Amendments**. HMO shall only use laboratories with a Clinical Laboratory Improvement Amendments ("**CLIA**") certificate of waiver or a certificate of registration along with a CLIA identification number.

1.7 **CalOptima Formulary Compliance**. Participating Providers shall comply with the CalOptima Formulary and its associated drug utilization and disease management guidelines and protocols. Requests for items not included in the CalOptima Formulary shall require prior Authorization by CalOptima. The prescribing Physician shall be responsible for obtaining Authorization through CalOptima and/or its designated pharmacy benefit management contractor ("**PBM**"), as appropriate. The prescribing Physician shall provide CalOptima and/or the PBM with all information necessary to process Authorization requests.

1.8 **Enrollee Access**. HMO and its Downstream Entities shall comply with all Laws and CalOptima Policies governing Enrollee access to Covered Services.

1.8.1 If HMO is unable to provide necessary Covered Services to a particular Enrollee, HMO must adequately and timely cover these services with Non-Participating Providers for the Enrollee, for as long as HMO is unable to provide them. HMO shall make prior arrangements with Non-Participating Providers for the provision of such services, shall be fully responsible for arranging and paying for such services, and shall comply with all

applicable CalOptima Policies with regard to the payment and Authorization of Non-Participating Providers.

1.8.2 HMO shall ensure that PCPs as well as Specialty Physicians are located so as to assure sufficient geographic and physical access of Enrollees to such providers as required by Laws and CalOptima Policies.

1.8.3 HMO shall ensure that each Enrollee has a PCP who is available and physically present at the service site for sufficient time to ensure access for the assigned Enrollee when medically required. This requirement does not preclude an appropriately licensed professional from being a substitute for the PCP in the event of the PCP's vacation, illness, or other unforeseen circumstances.

1.8.4 HMO shall ensure female Enrollees have direct access to a women's health specialist within the network to provide women's routine and preventative health care services. Such access may be in addition to the Enrollee's PCP.

1.8.5 HMO shall cover family planning services for all Enrollees whether they are provided by a Participating Provider or Non-Participating Provider.

1.8.6 HMO shall reasonably accommodate Enrollees and ensure programs and services are as accessible (including a sufficient number of Providers and geographic access) to an Enrollee with disabilities as they are to an Enrollee without disabilities in accordance with CalOptima Policies. HMO's facilities shall comply with the requirements of Title III of the Americans with Disabilities Act of 1990 ("**ADA**") and shall ensure access for the disabled, including, but not limited to, ramps, elevators, restrooms, designated parking spaces, and drinking water provisions. HMO shall have policies to ensure that physical, communication and programmatic barriers do not inhibit Enrollees with disabilities from obtaining all Covered Services, including addressing reasonable accommodations required by the CMS Contract and CalOptima Policies. HMO will comply with CalOptima Policies and work plan requirements related to ADA compliance relevant to services under this Contract.

1.9 **Provider Network Maintenance**. HMO agrees to employ or contract with a sufficient number of Physicians and other Providers representing the range of medical specialties necessary, in the determination of CalOptima, CMS, and the DMHC to ensure Enrollees of reasonable access to the full range of Covered Services.

1.9.1 During the Term, all Participating Providers of Covered Services must: (i) be and remain qualified in accordance with current applicable legal, professional, and technical standards; (ii) be and remain appropriately licensed, certified or registered; (iii) be and remain in good standing with Medicare and not be terminated or suspended from participation in the Medicare and/or Medi-Cal programs; and (v) have a valid NPI number, as applicable. HMO shall ensure that PCPs are located so as to assure sufficient geographic and physical access of Enrollees to such Physicians under Laws and CalOptima Policies.

1.9.2 HMO shall ensure that Participating Providers have the requisite training and experience in dealing with the medical problems frequently encountered in elderly, disabled, and special needs individuals.

1.9.3 HMO shall use primary source verification to confirm the board certification in each clinical specialty area for which the Physician is being credentialed if the Physician lists such board certification on credentialing applications.

1.9.4 HMO acknowledges that the requirements of this Section 1.9 apply to each individual Provider who is affiliated with and/or part of any medical group, independent physician associations ("**IPA**"), and/or other organization or entity that contracts with HMO to furnish Covered Services to Enrollees.

1.9.5 HMO will maintain accurate records, including records detailing the status, membership, and qualifications of the Participating Providers in the HMO's network.

1.9.6 If a Provider who seeks to become a Participating Provider is denied a contract with HMO or a Participating Provider is suspended or terminated for cause, HMO shall provide the Provider with written notice of the reason for the action, as required by Laws, including any standards and profiling data HMO used to evaluate the provider, the number and mix of similar health care Providers that HMO needs (if applicable), and notice of the Provider's right to appeal the action, including notice of the process and timing to request a hearing. In the event HMO terminates a contract with a Participating Provider for deficiencies in the quality of care provided, HMO shall give notice of the action to CalOptima, as provided by CalOptima Policies, and to the appropriate licensing and disciplinary bodies, as provided by law.

1.9.7 In the event that a Provider, including a PCP, is terminated or leaves the HMO for any reason, HMO shall give written notification of termination of such Provider to CalOptima within fifteen (15) days after receipt or issuance of the termination notice.

1.9.8 In the event that a Provider, including a PCP, is terminated or leaves the HMO for any reason, HMO shall ensure that there is no disruption in services provided to Enrollees who are receiving treatment for a chronic or ongoing medical condition in accordance with applicable Laws.

1.9.9 HMO shall notify CalOptima at least sixty (60) days before any significant change in HMO's provider network that renders HMO unable to provide one or more Covered Services within CalOptima's access to care standards. If such notice is not possible because the providers terminate their participation with less than sixty (60) days' notice or HMO terminates the providers without prior notice as a result of their endangering the health and safety of Enrollees, providers committed criminal or fraudulent acts, or providers engaged in grossly unprofessional conduct, then HMO shall notify CalOptima immediately upon receipt of notice of the termination, or sending notice to the providers of a HMO-initiated termination.

1.9.10 HMO shall ensure that no Provider who fails to meet the requirements of this section furnishes items and/or services to Enrollees, submits claims and/or receives reimbursement for any Covered Services.

1.9.11 HMO agrees that each Participating Provider with whom HMO contracts to provide Covered Services will be required to execute a contract with HMO. Such an agreement will require all Participating Providers to comply with those aspects of this Contract relating to activities of Participating Providers and with Laws, including the standards of accrediting and regulatory agencies governing CalOptima's MA Program, and any and all

provisions required by MA regulations. The HMO agreement with Participating Providers shall be made available to CalOptima and its regulatory agencies for inspection and copying upon request. HMO shall ensure that all contracts with Participating Providers allow for termination of the contract for failure to meet the requirements of this Section 1.9.

1.10 **Enrollment**. HMO shall accept as Enrollees all persons indicated as Enrollees by the CalOptima information system and transmitted to HMO and shall comply with requirements to provide notices to Enrollees in accordance with CalOptima Policies.

1.11 **Primary Care Physician**. HMO agrees that each Enrollee will select or be assigned a PCP. Enrollee must request a PCP assignment from CalOptima's Customer Service department. If the Enrollee has not selected a PCP, CalOptima shall assign the PCP per its policies. HMO agrees that it will ensure that the PCP shall be responsible for the provision, coordination, referral, and Authorization of Covered Services in accordance with the utilization management ("**UM**") program and prevailing standards of medical practice so that there is a Physician who has ultimate responsibility for the Enrollee's care management.

1.12 **HMO Medical Director**. HMO shall designate a HMO Physician as Medical Director for purposes of this Contract. The HMO Medical Director will be a member of the HMO's quality management and UM committee(s) and will be the individual to whom CalOptima communicates regarding provision of professional medical care and quality and/or appropriate utilization of medical services. The HMO Medical Director will be the individual responsible for representing HMO in the resolution of any Grievances presented to CalOptima by Enrollees related to the provision of medical care.

1.13 **Care Coordination**. CalOptima shall retain the responsibility for the initial HRA and an HRA annually thereafter in accordance with CalOptima Policies, but any update during the course of the year due to change in Enrollee's condition/circumstance would be the responsibility of the HMO, per policy. HMO shall offer care coordination and case management services to all Enrollees, which shall: (i) include coordination of care across the full continuum of service providers as appropriate to Covered Services under this Contract; (ii) ensure that care coordination services reflect a person-centered, outcome-based approach, consistent with the Model of Care and CalOptima Policies; (iii) follow Enrollee direction about level of involvement of his or her caregivers or medical providers; (iv) include the assignment of a qualified Care Coordinator to each Enrollee needing or requesting one; and (v) reflect access to appropriate community resources with a focus on providing services in the least restrictive setting and transitions between the facilities and the community.

1.14 **Model of Care**. HMO shall furnish Covered Services in compliance with CalOptima's Model of Care, including the PCC component, HRA, ICP and ICT requirements.

1.14.1 CalOptima will complete and communicate the HRA to HMO. HMO shall, upon notification by CalOptima of the need to follow-up on the results of an HRA administered by CalOptima, perform and provide any follow-up required by CalOptima.

1.14.2 HMO shall develop an ICP for each Enrollee and engage Enrollees and/or their representative in the design of the ICP in accordance with CalOptima Policies.

1.14.3 HMO shall offer an ICT for each Enrollee, as necessary, which will be developed around the Enrollee and integrate medical and LTSS and the coordination of Behavioral Health

services. Enrollees shall not be required to participate in the ICT and may opt-out at any time. Enrollees may not be dis-enrolled from the ICT for lack of participation on the ICT. The ICT shall comply with CalOptima Policies.

1.14.4 PCPs and/or the Care Coordinator, in collaboration with CalOptima, will provide basic case management services to Enrollees in accordance with CalOptima's Policies. If the Enrollee has been identified as potentially benefiting from complex case management services, HMO shall provide such services to the Enrollee.

1.14.5 HMO shall ensure the provision of discharge planning when an Enrollee is admitted to a Hospital or institution and continues into the post-discharge period. Discharge planning shall include ensuring that the necessary care, services, and supports are in place in the community for the Enrollee once he or she is discharged, including scheduling an outpatient appointment and/or conducting follow-up with the Enrollee or caregiver. HMO shall comply with CalOptima Policies addressing minimum criteria requirements for discharge planning.

1.15 **Behavioral Health Services Referrals**. HMO shall furnish and/or coordinate Behavioral Health services as specified in CalOptima Policies and this Contract.

1.15.1 For Specialty Mental Health Services, HMO shall refer Enrollees to CalOptima as the Administrative Service Organization contracted to provide assessment, referral and Authorization services.

1.15.2 For Outpatient Mental Health Services that are within a HMO' PCP's scope of practice, HMO shall manage according to current appropriate treatment guidelines. If the Outpatient Mental Health Services are outside its PCPs' scope of practice, HMO shall refer Enrollees to CalOptima's contracted behavioral health provider.

1.15.3 For Enrollees requiring alcohol or substance use disorder treatment, HMO shall manage according to the appropriate PCP treatment guidelines. If the alcohol or substance use disorder treatment are outside its PCPs' scope of practice, HMO shall refer Enrollees to CalOptima's contracted behavioral health provider. Coordination of care through the ICT will occur as is specified in CalOptima Policies and this Contract.

1.16 **LTSS Referrals**. HMO shall refer Enrollees to CalOptima for LTSS pursuant to CalOptima Policies.

1.17 **Facility Site and Medical Record Reviews**. HMO shall participate in, and comply with requirements for, PCP site and medical reviews, including facility site physical accessibility reviews, in accordance with CalOptima Policies and guidance issued by CalOptima's Regulators, including requirements, if any, related to collaborative programs.

1.18 **Transfers**. HMO agrees to assist CalOptima in facilitating the transfer of care of Enrollees if determined medically acceptable by attending Physicians and the CalOptima Medical Director. HMO will be responsible for the cost of Covered Services provided if HMO refuses to accept such transfer.

1.19 **Delegation by CalOptima to HMO**. HMO agrees to accept delegated responsibility for those activities listed in the Delegation Agreement and to perform the delegated activities in a manner consistent with the Delegation Criteria. HMO warrants that it meets CalOptima's Delegation

Criteria and acknowledges that delegation to another entity does not alter HMO's ultimate obligations and responsibilities set forth in this Contract. HMO agrees to notify CalOptima of any change in its ability to meet the Delegation Criteria within twenty-four (24) hours from the date it fails to meet such Delegation Criteria. At CalOptima's request, HMO shall identify the Compliance Officer or other appropriate health network representative to be the liaison expressly responsible for oversight of delegated obligations.

1.19.1 HMO acknowledges that it is CalOptima's responsibility to oversee, monitor and evaluate HMO's ongoing eligibility for delegation according to the Delegation Criteria and performance of the delegated activities according to the Delegation Criteria. HMO agrees to cooperate with CalOptima's oversight, monitoring, and evaluation of HMO's eligibility and performance of delegated activities, including the provision of reasonable access during regular business hours to the Enrollee inquiry files, credentialing files, clinical and Medical Records of Enrollees, and all other information requested by CalOptima. HMO shall comply with corrective actions imposed by CalOptima and/or CalOptima's Regulators in the time and manner required by them.

1.19.2 HMO acknowledges and agrees that CalOptima retains final authority and responsibility for activities delegated under this Contract. Activities not expressly delegated herein and in the Delegation Agreement by CalOptima or for which delegation is terminated are the responsibility of CalOptima.

1.19.3 HMO agrees to provide CalOptima with periodic reports on delegated activities performed by HMO as provided in the Delegation Criteria or specified in CalOptima Policies.

1.19.4 In the event CalOptima, DMHC, or CMS is dissatisfied with the performance of delegated functions and activities by HMO or its Downstream Entities, CalOptima may, in its sole discretion, modify HMO's delegated status (in respect to all or a particular delegated activity), including from fully delegated to delegated with corrective action, or may immediately revoke all or part of the delegated activities. In the event HMO breaches its obligation to perform any delegated obligations, CalOptima shall have all remedies set forth in this Contract, including the right to revoke delegation of such function(s) and impose financial and other penalties. Moreover, CalOptima shall have the right to require HMO to terminate any Downstream Entity for good cause, including breach of its obligations to perform any delegated duties. Nothing herein is intended to limit CalOptima's remedies as provided for in this Contract or at law.

1.19.5 HMO acknowledges and agrees that CalOptima, in its sole and absolute discretion, may reduce HMO's Capitation Payments to recoup additional administrative costs where CalOptima revokes or modifies activities or functions delegated to HMO under this Contract.

1.20 **Delegation and Subcontracting of Administrative Services by HMO**. Except as otherwise limited by this Contract and/or CalOptima Policies, HMO may sub-delegate Administrative Services required of HMO to a management services organization ("**MSO**"), medical group and/or IPA. Delegation shall not absolve HMO of oversight responsibilities or its obligations under this Contract. All requests for delegation of Administrative Services (i) must be in writing; (ii) are subject to successful completion of CalOptima's readiness assessment requirements; and (iii) must be approved by CalOptima in advance of undertaking the Administrative Services. HMO shall obtain written approval of delegation from CalOptima pursuant to the process detailed in CalOptima Policies.

1.21 **Subcontracts**. HMO is required to inform CalOptima of the name and business addresses of all subcontracted Downstream Entities. HMO is required to ensure that all such subcontracts are in writing and include all provisions required by this Contract to be incorporated into subcontracts. HMO acknowledges that CalOptima's FDR subcontracts are subject to the review and approval of CMS.

1.22 **Payment to Providers**. CalOptima hereby delegates claims processing functions to HMO. HMO shall review, adjudicate, and pay (as appropriate) all claims in accordance with the benefits set forth in the Evidence of Coverage, the requirements established by Laws, and the terms of this Contract. In making payments to Providers, HMO shall comply with the provisions of Attachment D, including requirements related to payment of Non-Participating Provider Emergency Services and Urgent Care claims.

1.23 **Documentation and Data Submission Integrity**. HMO and its Downstream Entities shall not submit false claims or financial reports, encounter data, and other information to CalOptima, CMS or DMHC, whether by commission or omission. HMO and applicable Downstream Entities shall implement and maintain policies and procedures that address correct completion of claims, financial reports, encounter data, and other documentation requirements and penalties for falsifying such reports and other information that require all new and current employees and/or agents compiling or providing this information to sign a statement of attestation that will acknowledge understanding and compliance with said HMO policy.

1.24 **Advance Directives**. HMO shall maintain written policies and procedures related to Advanced Directives in compliance with Laws. Providers shall document Advance Directives in patient records in accordance with Laws. HMO shall not discriminate against any Enrollee on the basis of that Enrollee's Advance Directive status. Nothing in this Contract shall be interpreted to require an Enrollee to execute an Advance Directive or agree to orders regarding the provision of life-sustaining treatment as a condition of receipt of services.

1.25 **Enrollee Appeals**. Enrollees will be notified of all applicable MA and/or Medicare Appeal rights, the form and content of which is approved by CMS. . Medicare Appeal rights and protections will be maintained and enhanced for Medicare services. HMO agrees to cooperate with CalOptima in resolving Appeals related to HMO or HMO's Participating Providers and will comply with CalOptima Policies related to Appeals.

1.26 **Organization Determination Process**. HMO agrees to comply with CMS regulations and instructions and CalOptima Policies pertaining to timely organization determination by HMO with regard to the provision, denial, reduction, or suspension of a Covered Service to an Enrollee. "**Organization determination**" is defined as a decision to provide or deny service based on CMS and CalOptima criteria. Such determinations shall be made in accordance with procedures and instructions set forth in the CalOptima Policies and Laws. HMO shall immediately notify CalOptima of any request for an expedited initial organization determination and submit to CalOptima on a monthly basis a report which tracks the requests for standard and expedited organization determinations and the timeframe within which Enrollees were informed of decisions made by HMO.

1.27 **Expedited Review Process**. HMO shall comply with CMS regulations and CalOptima Policies pertaining to expedited initial organization determinations of Enrollee's medical care and reconsideration (Appeals) thereof in the time sensitive situations. Time sensitive situations are those outlined by CMS which include medical conditions that require initial determinations to be

made within seventy-two (72) hours upon HMO receiving a request for an expedited review from a Provider, Enrollee, or CalOptima.

1.28 **Linguistic and Cultural Sensitivity**. HMO shall comply with all requirements related to the provision of linguistic and culturally sensitive services in accordance to this Contract, CalOptima's Cultural and Linguistic Services Program, and CalOptima Policies. HMO shall address the special health needs of Enrollees who are of any minority, are homeless, are disabled (both congenital and acquired disabilities), or are part of other special populations served by the CalOptima MA Program, including the capacity to communicate with Enrollees in languages other than English, when necessary, as well as those Enrollees who are deaf, hard-of-hearing, and/or visually impaired. Physician shall, in policies, administration, and services, practice the values of: (a) honoring the Enrollees' beliefs, traditions and customs; (b) recognizing individual differences within a culture; (c) creating an open, supportive, and responsive organization in which differences are valued, respected and managed; (d) through cultural diversity training, foster in staff and Participating Providers attitudes and interpersonal communication styles that respect Enrollees' cultural backgrounds and are sensitive to their special needs; and (e) referring Enrollees to linguistically and culturally sensitive programs. Pursuant to CalOptima Policies, HMO shall provide translation of written materials in the Threshold Languages as provided by CalOptima Policies. Written materials to be translated include, but are not limited to, signage, the Enrollee services guide, Enrollee information, Explanation of Coverage, Enrollee forms, Enrollee notices, and Enrollee welcome packages.

1.29 **Provision of Interpreters**. Oral interpreters, signers, and bilingual Provider services shall be provided in all languages spoken by all MA Enrollees. HMO shall provide linguistic interpreter/translator services for Enrollees as necessary at all HMO sites to ensure the availability of effective communication regarding treatment, diagnosis, medical history, and health education to Enrollees. HMO shall provide twenty-four (24)-hour access to interpreter services for all Enrollees. Upon an Enrollee or Participating Provider request for interpreter services in a specific situation where care is needed, HMO shall make all reasonable efforts to provide an interpreter in time to assist adequately with all necessary Covered Services, including Urgent Care Services and Emergency Services, as required by Laws. HMO shall routinely document all such efforts and make this documentation available to CalOptima at its request. Interpreters shall be used where needed where technical, medical, or treatment information is to be discussed. HMO shall not require an Enrollee to use friends or family as interpreters. However, a family member or friend may be used when the use of the family member or friend: (i) is requested by the Enrollee; (ii) will not compromise the effectiveness of service; (iii) will not violate Enrollee's confidentiality; and (iv) the Enrollee is advised that an interpreter is available at no cost to the Enrollee. HMO shall maintain a contract with an interpreter service agency that is on "on call" status to provide interpreter services.

1.30 **Identification of HMO and HMO Physicians**. HMO agrees that CalOptima may list the HMO's name, address, and telephone number and that of its HMO Physicians and Downstream Entities in CalOptima's roster of Participating Providers that is given to Enrollees and prospective Enrollees, and CalOptima may use such names for advertising/marketing purposes. However, CalOptima is not obligated to list the name of any particular HMO Physician in the roster of Participating Providers. The use of HMO's trademarks or logos by CalOptima is prohibited without HMO's prior written approval.

1.31 **Liaisons**. HMO shall designate an individual(s) who will assume the day-to-day responsibilities with regard to HMO's obligations under this Contract and to serve as liaison with CalOptima. HMO will also designate an individual(s) to be responsible for answering Enrollee inquiries and

responding promptly to any Enrollee grievance in accordance with CalOptima's grievance procedures and Laws.

1.32 **Provider Private Contract**. HMO understands that CalOptima is prohibited by CMS from paying capitation to, or including in its provider network, any provider that has entered into a private contract with a Medicare beneficiary for the provision of Covered Services. HMO shall notify CalOptima immediately in the event that any HMO Physician has a private contract with a Medicare beneficiary. In such an event, CalOptima reserves the right to exclude any such HMO Physician from its provider network. In addition, HMO agrees that CalOptima shall have the right to offset the amount of any reimbursement that was paid either directly or indirectly to such Provider(s) against Capitation Payments or other amounts due from CalOptima to HMO, if any.

1.33 **Disclosure of HMO PIPs**. In the event that HMO implements and maintains a physician incentive plan ("**PIP**"), HMO and its Downstream Entities must comply with all applicable requirements governing PIPs, including such requirements appearing at 42 CFR Parts 417, 422, 434, 438.6(h), and 1003.

1.33.1 HMO shall ensure that no specific payment is made directly or indirectly under a PIP to a Physician or HMO as an inducement to reduce or limit Medically Necessary services furnished to an Enrollee.

1.33.2 On an annual basis, HMO and its Downstream Entities must submit to CalOptima all information required to be disclosed to CMS and the DMHC in the manner and format specified by them.

1.33.3 HMO must provide information on its PIP to any Enrollee upon request as provided in 42 CFR Section 422.208.

1.33.4 In the event that CalOptima's Regulators find that HMO (or its Downstream Entities) has failed to comply with the requirements governing physician incentive plans and CalOptima's Regulators offset, recoup and/or otherwise seek recovery of federal financial participation ("**FFP**") amounts from CalOptima, HMO agrees that CalOptima may recover such FFP amounts attributable to HMO from HMO, including through recoupment or offset to future Capitation Payments or other amounts due from CalOptima to HMO, if any.

1.34 **Provider Grievance Process**. HMO shall establish and maintain a Provider dispute resolution process that at all times complies with the requirements of Laws. HMO shall provide CalOptima with all necessary information and reports regarding the provider dispute resolution process as required by CalOptima to meet its obligations under the CMS Contract and Laws. If HMO fails to maintain a process that complies with the requirements stated in Laws and CalOptima Policies, then following written notice of such deficiency from CalOptima to HMO, CalOptima may revoke the delegation and assume responsibility for the administration of HMO's Provider dispute resolution process.

1.35 **Provider Education**. HMO acknowledges that CMS requires that CalOptima furnish to Participating Providers certain training, education, and orientation related to the MA Program in order to operate in full compliance with this Contract and Laws. Such training and education may address the MA Program, Enrollee rights, cultural competency and clinical protocols, evidence-based guidelines and cultural awareness and sensitivity instruction. HMO and its Participating

Providers shall participate in such training, education, and orientation programs, as required by CalOptima, and shall attest to compliance with training requirements as required by CalOptima.

1.36 **State Licensure**. HMO shall maintain at all times during the Term a valid, restricted health care service Plan license with the DMHC in accordance with the Knox-Keene Act and have no adverse actions with regard to enforcement or quality management.

1.37 **CalOptima's Regulator Requirements**. The MA Program is subject to oversight by CalOptima's Regulators, which mandate that CalOptima and its FDRs comply with certain terms and conditions in rendering services to Enrollees and that certain terms be incorporated in FDR subcontracts. HMO acknowledges that it will comply with CalOptima's Regulators' requirements set forth in Attachment E.

1.38 **COB Obligations of HMO**. HMO agrees to coordinate with CalOptima for proper determination of COB and to bill and collect from other payers and third-party liens such charges for which the other payer is responsible pursuant to CalOptima Policies. HMO agrees to establish procedures to effectively identify, at the time of service and as part of its claims payment procedures, individuals and services for which there may be a financially responsible party other than the CalOptima MA Program.

1.39 **CMS Lien Rights.** HMO shall coordinate benefits either operating a cost avoidance method of paying claims, when the existence of private health coverage is known at the time the claim is processed, or using the method of post-payment recovery of the cost of services, if the coverage is identified retroactively, as set forth in CalOptima Policies. Nothing herein shall be interpreted to, in any manner, impair any lien rights retained by the U.S. Department of Health and Human Services ("**HHS**") through CMS. HMO shall make no claim for the recovery of the value of Covered Services rendered to an Enrollee when such recovery would result from an action involving tort liability of a third party, recovery from the estate of deceased Enrollee, Workers' Compensation, or casualty liability insurance awards and uninsured motorist coverage. HMO shall identify and notify CalOptima, within five (5) calendar days of discovery of potential third-party liability ("**TPL**") claims, and provide information relative to potential TPL claims, in accordance with CalOptima Policies.

1.40 **Provider Training.** HMO shall ensure that all network Providers receive training regarding the MA Program in order to operate in full compliance with all Laws, including rights and responsibilities pertaining to grievance and appeals procedures and timelines under this Contract. HMO shall ensure that network Provider training relates to MA services, policies, procedures and any modifications to existing services, policies or procedures. Training shall include methods for sharing information among network Providers, Enrollees, and/or other healthcare professionals. HMO shall conduct training for all network Providers within thirty (30) working days after the HMO places a newly contracted Provider on active status. HMO shall ensure that network Provider training includes information on all Enrollee rights, including the right to full disclosure of health care information and the right to actively participate in health care decisions. HMO will maintain policies and procedures on advance directives pursuant to 42 CFR §§ 422.128, 438.3(j), and 489.102, and will educate its network Providers concerning its policies and procedures on Advance Directives. HMO shall ensure that ongoing training is conducted when deemed necessary by either the HMO or CMS.

1.41 **Notification of Inpatient Facility Discharge Appeal Rights**. HMO's contracted Hospitals shall issue the advance written notice to Enrollees of their Hospital discharge rights upon admission and before discharge from the Hospital.

II. HMO FINANCIAL OBLIGATIONS

2.1 **Financial Security Requirements**. HMO must establish and maintain during the Term financial security requirements as specified in Article 9 of Chapter 2 of Division 1 of Title 28 of the California Code of Regulations (SB 260 Regulations), and in compliance with CalOptima Policies. HMO must establish and maintain, throughout the Term, financial security reserves, in the form of time certificates of deposit, irrevocable standby letters of credit, surety bonds naming CalOptima as beneficiary, and/or other forms of financial instruments acceptable by CalOptima, as required in CalOptima Policies.

2.2 **Financial Viability Standards and Reporting**. HMO must establish and maintain a minimum reserve of twenty-five percent (25%) of one month's Capitation Payment. Physician shall have thirty (30) days upon receiving notice from CalOptima to cure any deficit. HMO shall maintain a cash-to-claims ratio of no less than 0.75 at all times during the Term. HMO shall substantiate compliance with this requirement by submitting all applicable reports to the DMHC that are required under Title 28 CCR Section 1300.75.4.2.

2.3 **Medical Loss Ratio**. HMO shall ensure that it maintains a minimum acceptable loss ratio (as defined by CalOptima Policies) of eight five percent (85%). HMO shall comply with CalOptima requirements related to limitations on administrative costs, as set forth in CalOptima Policies.

2.4 **Termination of HMO Health Network**. If this Contract terminates or expires for any reason, CalOptima may require that HMO take certain actions and/or CalOptima may take certain actions to ensure that all items and services for which HMO is delegated financial risk under this Contract are reimbursed by HMO, including the following: (i) require HMO to reserve sufficient funds to pay any claims run out; (ii) offset HMO's future Capitation Payments or other amounts due from CalOptima to HMO under this Contract or any other agreement, if any, in order to pay HMO's claims; and/or (iii) withhold or offset HMO's Capitation Payments or other amounts due from CalOptima to HMO, including to pay-for-performance, quality incentives, and shared risk pool surpluses, if any, in order to pay amounts owed by HMO to Providers.

2.5 **Conversion of Health Network Model**. If CalOptima approves a change in the delegated model of HMO at any time during the Term, CalOptima may require additional financial protections as a condition precedent to such approval, including: (i) require HMO to reserve sufficient funds to pay any claims run out related to claims which are the financial responsibility of HMO under the existing delegated relationship; (ii) require HMO to meet additional financial security requirements, including the maintenance of financial deposits; and/or (iii) withhold or offset HMO's Capitation Payments or other amounts due from CalOptima to HMO, including pay-for-performance, quality incentives and shared risk pool surpluses, if any, in order to pay amounts owed by HMO to Providers.

2.6 **Cooperation with DMHC**. HMO shall fully cooperate and comply with the DMHC's review and audit process and permit DMHC to obtain and evaluate supplemental financial information related to HMO, in accordance with Title 28 CCR Section 1300.75.4.7. HMO shall also fully cooperate and participate in DMHC's Corrective Action Plan process, in accordance with Title 28 CCR Section 1300.75.4.8.

III. CALOPTIMA OBLIGATIONS

3.1 **CalOptima Services**. CalOptima agrees to provide certain Enrollee and Administrative Services, including processing Enrollee applications, maintaining eligibility records and a system of

verifying eligibility, processing enrollments and dis-enrollments, responding to Enrollee complaints and grievances, informing Enrollees of CalOptima Policies, providing Enrollees with membership cards and informational material, and informing Enrollees of Health Networks.

3.2 **Enrollment**. CalOptima agrees to process all enrollment applications and ensure that each Enrollee selects or is assigned to Health Networks in accordance with CalOptima Policies. CalOptima reserves the right to assign Enrollees to a Health Networks other than that selected by Enrollee.

3.3 **Model of Care and Health Risk Assessment**. CalOptima shall maintain a Model of Care, as required by CalOptima's Regulators. CalOptima shall ensure that, upon enrollment in the CalOptima MA Program, each Enrollee receives an initial HRA and an HRA annually thereafter in accordance with CalOptima Policies and that results of the HRA are shared with HMO in order to coordinate Enrollee care. HMO is responsible for interim updates to the HRA.

3.4 **Authorization Process**. CalOptima shall provide a written Authorization process for Covered Services pursuant to CalOptima Policies.

3.5 **Enrollee Grievance Process**. CalOptima will inform Enrollees that they may file a grievance through CalOptima or the CMS Ombudsman Program for complaints related to Medicare-covered benefits and services. Enrollees may also file a grievance through 1-800 Medicare.

3.6 **Enrollee Appeals**. Enrollees will be notified of all applicable MA Medicare Appeal rights through a single notice prior approved by CMS.

3.7 **CalOptima Formulary**. CalOptima shall publish and maintain the CalOptima Formulary pursuant to CalOptima Policies.

3.8 **Training and Education**. CalOptima agrees to provide Participating Provider education, training, and orientation in accordance with CMS requirements, including training regarding the CalOptima MA Program, Enrollee rights, clinical protocols, evidence-based practice guidelines, and CalOptima's cultural awareness and sensitivity instruction and cultural competency training, as applicable.

3.9 **Marketing**. HMO acknowledges that CalOptima will be responsible for marketing the CalOptima MA Program to Medicare beneficiaries. HMO acknowledges that it shall not conduct any marketing activities except as expressly approved in advance and in writing by CalOptima.

3.10 **Administration of Funds**. CalOptima will administer the funds and payments called for in this Contract to HMO in accordance with provisions outlined in Article VI.

3.11 **No Refusal to Pay or Contract Based on HMO Communications with Enrollees**. CalOptima will not refuse to contract or pay an otherwise eligible health care Provider for the provision of Covered Services solely because such Provider has, in good faith, communicated with or advocated on behalf of one or more of his or her prospective, current, or former patients regarding: (i) the provisions, terms or requirements of CalOptima's health care plans as they relate to the needs of such Provider's Enrollees; or (ii) the method by which such Provider is compensated by CalOptima for Covered Services rendered to the Enrollee.

3.12 **CalOptima Policies**. CalOptima will provide HMO with CalOptima Policies as necessary for Group to provide Covered Services to Enrollees. Those CalOptima Policies shall describe all

benefit plans, including copayments, limitations, and exclusions offered by CalOptima to Enrollees. The Provider Manual will be made available to HMO to disseminate to Physicians.

3.13 **Listing of CalOptima**. CalOptima agrees that HMO may list its name, address, telephone number, and a description of the CalOptima MA Program, along with CalOptima's name, in HMO's promotional materials and advertisements. The use of CalOptima's trademarks and logos by HMO is prohibited without CalOptima's prior written approval.

3.14 **CalOptima Oversight**. CalOptima shall monitor HMO's performance under this Contract on an ongoing basis. CalOptima may conduct regularly scheduled audits as well as an annual evaluation of the delegated functions to determine HMO's continued compliance with the Delegation Criteria. CalOptima may impose corrective action plans on HMO and/or its Downstream Entities, as necessary.

3.15 **CalOptima Accountability**. The delegation of the functions and responsibilities stated in this Contract and the Delegation Agreement does not relieve CalOptima of any of its accountability to CMS and obligations to its Enrollees under Laws. CalOptima is authorized to perform and remains liable for the performance of such obligations, notwithstanding any delegation of some or all of those obligations to HMO.

3.16 **COB Obligations of CalOptima**. CalOptima will cooperate in providing COB information to HMO by collecting appropriate data from the Enrollee at the point of enrollment and supplying such data to HMO.

3.17 **Enrollee Rights**. CalOptima shall ensure that Enrollee rights are fully respected and observed in accordance with Laws and CalOptima Policies. CalOptima shall notify Enrollees of their rights and protections at least annually and in a manner that accounts for cultural considerations, functional status, and language needs.

3.18 **Enrollee Grievances**. CalOptima retains responsibility for the Enrollee grievance process. HMO will comply with CalOptima Policies related to Enrollee grievances, including timely reporting to CalOptima and resolution of Enrollee grievances. Enrollees may file an internal Enrollee grievance at any time with CalOptima or HMO, including grievances related to reasonable accommodations and access to services under the ADA.

IV. QUALITY IMPROVEMENT PROGRAM AND CREDENTIALING

4.1 **CalOptima's Quality Improvement Program**. HMO shall comply with, and participate in, CalOptima's Quality Improvement Program ("**QIP**"). HMO shall immediately notify CalOptima of those Enrollees and cases that fall within the catastrophic and targeted case management guidelines and shall cooperate with CalOptima's case management program for catastrophic and targeted cases. HMO and its Downstream Entities shall fully cooperate with CalOptima with regard to the HEDIS measurements and HEDIS audits, guideline development, preventive services utilization, disease/risk management, clinical service monitoring, and quality improvement studies and initiatives. HMO shall comply with and accept as final the decisions of the CalOptima QIP and, pending resolution of any dispute through the dispute resolution process, comply with the decisions of the CalOptima Quality Improvement Committee.

4.2 **Quality Improvement Functions – Delegation to HMO**. HMO shall establish, maintain and operate a Quality Improvement ("**QI**") program, in accordance with the delineation of responsibilities in the Delegation Agreement, which shall include preparation of an annual QI

program plan, semi-annual work plan, and annual evaluation of effectiveness of the QI program, and report to CalOptima's QI department using the Health Industry Collaboration Effort Reporting Tool. All of the foregoing elements of the QI program shall be consistent with current industry standards, and meet CMS, National Committee for Quality Assurance ("**NCQA**"), The Joint Commission, and CalOptima QIP requirements.

4.2.1 HMO shall adopt a detailed written QI plan, which shall include: (i) well defined goals and objectives; (ii) a well-defined scope that considers all different types and levels of care and service provided to Enrollees; and (iii) clearly defined accountability and responsibility for the QI program.

4.2.2 The Board of Directors of the HMO or a multi-disciplinary QI committee designated by the Board of Directors of HMO shall oversee the QI program. This committee shall be separate from the utilization review committee (though members may be the same) and have a separate agenda. The QI committee shall meet at least on a quarterly basis. HMO shall maintain attendance records and meeting minutes related to the QI program. The QI committee shall have adequate representation from all categories of the HMO such as Physicians and non-Physician practitioners.

4.2.3 QI Program activities shall be reported in writing to HMO's Board of Directors at least on a quarterly basis. These reports shall be available to CalOptima upon request.

4.2.4 HMO's QI program shall include involvement and participation in network-wide studies/projects initiated by CalOptima. HMO shall facilitate quality studies and assist in collection of comparative data collected from all Participating Providers using objective parameters (e.g., the current version of HEDIS).

4.2.5 HMO shall develop an annual QI work plan, which includes the following: (i) goals, scope, and planned projects for the year; (ii) planned monitoring of identified issues and tracking these issues over time; (iii) planned studies/audits suggested by CalOptima or HMO; and (iv) an annual evaluation of the QI program/plan.

4.2.6 HMO shall have a written procedure for responding to the findings of QI activities, such as collecting data, analyzing results, implementing corrective action plans, and reassessing the same data for improvement.

4.2.7 Requirements for the HMO's QI program shall be established by the HMO's QI committee and requirements may change based on changes in industry standards. CalOptima's QI committee shall notify HMO of any additional changes in QI standards and requirements that shall be incorporated in HMO's QI program. HMO shall not be required to change QI program requirements more frequently than once per year.

4.2.8 HMO shall provide, upon CalOptima's request: (i) summaries of QI Committee meetings; (ii) findings following review of specific cases and other reviews; (iii) Medical Records; (iv) written responses to quality-of-care issues or Enrollee complaints; and/or (v) other information as required by CalOptima.

4.2.9 HMO shall comply with all measurement and improvement projects in the manner required by CMS, including the reporting of HEDIS, Health Outcomes Survey and Consumer Assessment of Healthcare Providers and Services measurement results consistent with

Medicare requirements. HMO shall contribute to all applicable CMS data quality assurance processes.

4.3 **Quality Improvement and Credentialing Program**. CalOptima delegates credentialing requirements to HMO as provided in the Delegation Agreement. HMO agrees to comply with CalOptima Policies regarding credentialing standards. In order to ascertain HMO's continuous compliance with CalOptima standards, CalOptima retains the right to oversee HMO's credentialing processes and to mandate changes thereto.

4.3.1 At least annually, HMO shall provide CalOptima with a written credentialing program for the purpose of review and approval by CalOptima. HMO shall also allow CalOptima, after reasonable prior notice, to conduct an on-site audit and review a sample of physician credentialing files to determine that delegation of the credentialing process is appropriate.

4.3.2 HMO's credentialing program shall comply with the requirements specified in 42 CFR Sections 422.504, 423.505 and 438.214, as applicable, which include requirements addressing selection and retention of providers, credentialing and re-credentialing requirements, and nondiscrimination. HMO's credentialing program shall include procedures used for credentialing and re-credentialing Participating Provider's according to current NCQA standards, in addition to procedures used for reducing, suspending or terminating Participating Provider's participation in the organization for reasons relating to quality of care, competence, professional conduct, or service-related issues; procedures for reporting to appropriate authorities serious quality deficiencies that could result in suspension or termination of a Participating Provider's participation; and procedures for provider appeal, as afforded by HMO's fair hearing plan and corrective actions.

4.3.3 HMO shall make best efforts to notify CalOptima within thirty (30) days of any changes involving the rules, regulations, authorities, and responsibilities of the credentialing program. In accordance with CMS requirements, CalOptima also retains the right, based on quality-of-care and service issues, to approve, suspend, or terminate arrangements with practitioners, providers, and sites. In the event that this occurs, CalOptima will notify the HMO of the quality-of-care and/or service issue, and HMO shall take appropriate action, report to appropriate authorities any serious quality deficiencies in accordance with Laws, and provide all due process as afforded by the HMO's fair hearing plan and Laws.

4.3.4 If CalOptima exercises its right to terminate a Provider's participation in the CalOptima MA program, CalOptima shall give the Provider a written statement of the reason or reasons for termination with cause and comply with the procedures required by Laws, if any.

4.4 **Release of Performance Information and Data**. HMO acknowledges that the CalOptima MA Program focuses on improving the coordination and quality of medical, Behavioral Health, LTSS, and other services for Enrollees, and, in that regard, CalOptima's Regulators will implement capitation withholds to ensure performance consistent with established quality thresholds. HMO acknowledges and agrees that CalOptima may release information and data related to the performance of HMO under this Contract to CalOptima Regulators, Providers, Enrollees, and others without further notice to HMO. The performance data will be used for purposes, including quality improvement activities, and public reporting to consumers, as identified in CalOptima Policies.

V. UTILIZATION MANAGEMENT PROGRAM

5.1 **CalOptima's Utilization Management Program**. CalOptima has implemented, and continuously updates, a UM program to ensure appropriate processes are used to review and approve the provision of Medically Necessary Covered Services to Enrollees in the timeframes required by CalOptima's Regulators. HMO and its Downstream Entities shall comply with and cooperate in CalOptima's UM program, as established in CalOptima Policies and the CalOptima UM plan, regardless of CalOptima's delegation to HMO under Section 5.2.

5.2 **UM Program Responsibility—Delegation to HMO**. CalOptima is hereby delegating to HMO the process of monitoring and evaluating on a prospective, concurrent, and retrospective basis, the utilization and Medical Necessity of Covered Services provided to HMO's Enrollees.

5.2.1 HMO's UM process shall include performing case management activities, referral management and discharge planning, and managing the denial sanction process, as well as conducting peer review for Medical Necessity and appropriateness. HMO (and its Downstream Entities) shall ensure that its UM program complies with all criteria as set forth in CalOptima Policies and required by CalOptima's Regulators.

5.2.2 In accordance with 42 CFR §§ 438.6(h) and 422.208, compensation to individuals or entities that conduct UM activities must not be structured so as to provide incentives for HMO (including HMO Physicians) or Downstream Entities to deny, limit, or discontinue Medically Necessary Covered Services to any Enrollee.

5.2.3 In the event HMO (or its Downstream Entities) fails to comply with CalOptima standards and Laws and fails to correct deficiencies within the stated time required by those provisions, CalOptima retains the right to revoke delegation of UM activities.

5.3 **Utilization Management Plan**. HMO will provide to CalOptima initially upon execution of this Contract, and annually thereafter, a written UM plan for review and approval by CalOptima.

5.3.1 HMO shall notify CalOptima within thirty (30) days of any changes involving the rules, regulations, authorities, and responsibilities for the UM plan, which shall be subject to reasonable approval by CalOptima. CalOptima approval will be assumed unless HMO is notified otherwise by CalOptima. HMO shall comply with and accept as final, the decisions of CalOptima's UM program and, pending resolution of any dispute through the dispute resolution process, comply with the decisions of CalOptima's UM program.

5.3.2 The UM plan shall include procedures approved by CalOptima to identify, assess, establish, and implement a treatment plan for Enrollees with complex or serious medical conditions. The UM plan shall also contain procedures for direct access of Enrollees to services as mandated by CMS regulations and instructions. All HMO denial letters shall provide Enrollees with timely notice and shall contain appropriate Enrollee appeals rights as approved by CMS and CalOptima. HMO agrees to cooperate with CalOptima in furnishing the required reports identified in CalOptima' Policies

5.4 **Utilization Management Committee**. HMO shall establish a UM committee that shall review and document the quality, appropriateness, level of care, and utilization of health care services provided to Enrollees. CalOptima's Medical Director and/or CalOptima staff may attend HMO UM committee meetings.

5.5 **Process and Timeframes for Authorization**. HMO (and its Downstream Entities) shall ensure that its process for initial and continuing Authorizations complies with CalOptima Policies, the UM plan and requirements established by CalOptima's Regulators, including timeframes for, and manner of, Authorization.

5.6 **No Prior Authorization**. HMO (and its Downstream Entities) shall not require prior Authorization for the following services: (i) any services for Emergency Medical Conditions (which include emergency Behavioral Health care); (ii) Urgent Care sought outside the Service Area: (iii) Urgent Care under unusual or extraordinary circumstances provided in the Service Area when the Participating Provider is unavailable or inaccessible; (iv) preventative services; (v) family planning services; (vi) Out-of-Area renal dialysis services; (vii) basic prenatal care; (viii) sexually transmitted disease services; and (ix) HIV testing.

5.7 **Second Opinions**. HMO (and Downstream Entities) shall ensure that Enrollees have the right to second opinions from qualified health professionals at no cost to the Enrollee.

5.8 **Physician Direct Referral**. HMO agrees that an Enrollee shall, without obtaining the prior Authorization of the PCP or HMO, refer him or herself directly to a specialist within said HMO per policy including any of the following conditions: an annual well woman exam by a Gynecologist, prenatal care and delivery by an Obstetrician, annual eye exam by an Optometrist, professional services related to audiology, and family planning services, including but not limited to vasectomy.

5.8.1 CalOptima will identify HMO as a provider that offers HMO Direct Referrals to Enrollees in CalOptima's provider directory and other marketing literature, if any. In the event CalOptima determines that HMO is non-compliant with the requirements of the Physician Direct Referral process, CalOptima reserves the right, at its sole discretion, to cease marketing HMO as a Physician Direct Referral provider to Enrollees.

5.8.2 HMO agrees to cooperate with CalOptima and, upon reasonable prior notice, provide CalOptima with all necessary Medical Records, policies and procedures, including utilization review, reports, and other pertinent information that may be necessary or required to enable CalOptima to ensure and verify that HMO has a Physician Direct Referral process acceptable to and in accordance with the requirements of CalOptima.

5.9 **Hospital Referrals**. HMO agrees to require HMO Physicians to admit Enrollees only to a Participating Provider Hospital with the concurrence of CalOptima, except for Emergency Services, Urgent Care, or when Authorization has been received in accordance with the UM Plan.

5.10 **Personal Care Coordinator Component to the Model of Care.**

5.10.1 "**PCC Profile**" is a monthly report generated by CalOptima that provides the compliance parameters required to receive PCC supplemental capitation.

5.10.2 HMO shall employ PCCs and participate in all PCC component requirements, as defined in the Model of Care Profile. PCCs shall assist Enrollees in the development of an ICP, ensure communication of the Enrollee's care plan with the Enrollee, physicians, HMO and health care team, and provide other related services as described in the job description, CalOptima Policy, and Model of Care Profile. HMO shall submit monthly reports and ICPs to demonstrate adherence to Model of Care requirements, including staffing of PCCs.

5.10.3 CalOptima may amend the Model of Care Profile at any time and, in such event, CalOptima shall provide HMO with thirty (30) days' written notice before the effective date of any such revisions. If HMO is unable to agree to the revisions and no resolution is reached in the thirty (30)-day period, HMO may proceed with the termination of the Contract under Article 11. In the event HMO terminates the Contract, it shall comply with all of its obligations required by this Contract and Laws including obligations related to transfer and coordination of Enrollee care following termination.

VI. COMPENSATION

6.1 **HMO Compensation**. CalOptima shall compensate HMO for Covered Services and Administrative Services delegated to HMO, as set forth in Attachment C. Such Capitation Payments shall be payment in full for Covered Services and Administrative Services, except for amounts recovered through collection of Enrollee's Share of Cost, COBs, and Stop Loss Program, if applicable. Capitation Payment shall be sent on a monthly basis by the twentieth (20th) calendar day of the month, or if such day falls on a weekend or national holiday, on the first business day thereafter, for all Enrollees eligible from the first (1st) of the month, and on whose behalf payment has been received by CalOptima from CMS by the nineteenth (19th) calendar day of the month. In the event CalOptima receives payment from CMS after the nineteenth (19th) calendar day of the month, capitation payment to HMO will be made within five (5) working days of receipt of the monthly payment by CalOptima.

6.2 **Disputes Regarding Payments or Enrollment**. Any and all disputes related to Capitation Payments and/or enrollments shall be reported to CalOptima within ninety (90) calendar days of payment, and each dispute shall be clearly defined and include supporting documentation. Failure to dispute within the established time frame indicates acceptance of the Capitation Payment by HMO.

6.3 **Capitation Rate Adjustments**. The Capitation Rates may be adjusted by CalOptima during the Contract period to reflect implementation of State or federal laws or regulations, changes in the CMS Contract or CMS policy, and/or changes in Covered Services. If CalOptima receives advance notice of adjustment from CalOptima's Regulators, CalOptima shall provide notice thereof to HMO as soon as practicable. Capitation Rates may also be adjusted in the event of de-delegation of any function delegated under this Contract.

6.4 **Enrollee Non-Liability and Hold Harmless Requirements.** HMO and its Downstream Entities shall accept CalOptima's payment as described in this Contract as payment in full. HMO and its Downstream Entities for all Covered Services and Administrative Services under this Contract and shall not hold Enrollees liable to the HMO or Providers for any sums owed to HMO by CalOptima or owed to Providers by HMO.

6.4.1 HMO and its Downstream Entities shall hold harmless CMS, CalOptima, and Enrollees in the event HMO and/or Downstream Entities cannot or will not pay for services performed by HMO or Downstream Entities pursuant to this Contract or subcontract, as applicable.

6.4.2 HMO and its Downstream Entities shall ensure that Enrollees will not be held liable for Medicare Part A and B cost sharing when the State is responsible for paying such amounts and that the HMO will (i) accept Capitation Payment as payment in full under the Contract, or (ii) bill the appropriate State source, as required at 42 CFR §422.504(g)(1)(iii). Such services must be provided at zero cost-sharing to Enrollees.

6.4.3 HMO shall not hold an Enrollee liable for the following: (i) debts of HMO, in the event of 'HMO's insolvency; (ii) Covered Services provided to the Enrollee in the event that CalOptima or HMO fails to receive payment from CMS for such services; or (iii) payments to a clinical FDR or Downstream Entity in excess of the amount that would be owed by the Enrollee if HMO had directly provided the services.

6.4.4 HMO and its Downstream Entities shall not charge Enrollees coinsurance, co-payments, deductibles, financial penalties, or any other amount in full or part, for any service provided under this Contract, except as otherwise permitted under this Contract.

6.4.5 HMO and its Downstream Entities shall not deny any service provided under this Contract to an Enrollee for Enrollee's (or any entity responsible for making payment on Enrollee's behalf) failure or inability to pay any applicable charge or shall not deny any service provided under this Contract to an Enrollee who, prior to becoming eligible, incurred a bill that has not been paid.

6.5 **Overpayments Discovered by Physician Group**. HMO shall disclose and return all overpayments to CalOptima within sixty (60) days of when HMO identified the overpayment or should have identified the overpayment through the exercise of reasonable diligence.

6.6 **Recoupment for Ineligibility; Conlan Reimbursements**. CalOptima shall recoup payments made to HMO when CMS has determined that an individual was not eligible for the MA Program and retroactively terminates the individual, including recouping any payments made for a deceased Enrollee. CalOptima may also recoup overpayments to HMO owed by HMO to Enrollees, including offsetting any such amounts owed against HMO's Capitation Payments or other amounts due from CalOptima to HMO under this Contract or any other agreement between the parties, if any. This Section 6.6 shall not be construed to limit CalOptima's right to recoup payment made to HMO on any other basis for which recoupment is appropriate.

6.7 **CalOptima Right to Recover**.

6.7.1 Overpayments. HMO acknowledges and agrees that, in the event that CalOptima determines that an amount has been overpaid or paid in duplicate, or that funds were paid which were not due under this Contract to HMO, CalOptima shall have the right to recover such amounts from HMO by recoupment or offset from current or future amounts due from CalOptima to HMO under this Contract or any other agreement between the parties, after giving HMO notice and an opportunity to return/pay such amounts.

6.7.2 Health Network Termination. In the event of termination of the Health Network or the transition of the Health Network to a different delegation model, CalOptima shall have the right to offset any unpaid claims that are the financial responsibility of Physician Group paid by CalOptima against any funds owed to Physician Group by CalOptima, including capitation payments, financial security withholds, pay-for-performance amounts, quality incentives, and shared risk pool surpluses.

6.7.3 Shared Risk Pool Payments Upon Termination. If this Contract terminates or expires for any reason and Physician Group is responsible for a deficit under any shared risk program under this Contract based on the final shared risk pool report results ("**Deficit**"), such Deficit shall be due to CalOptima as follows, as allowed by Laws: CalOptima may elect to recoup such Deficit by either (1) offsetting such Deficit amounts, upon notice to Physician Group, from any current or future amounts owed by CalOptima to Physician Group under the Contract or any other agreement

between the Parties, including capitation payments, financial security withholds, pay-for-performance amounts, quality incentives, and shared risk pool surpluses; or (2) sending an invoice to Physician Group that payment for such Deficits are due to CalOptima within thirty (30) days of Physician Group's receipt of the CalOptima invoice.

6.7.4 Regulator Recoupment Upon Termination. If following the termination or expiration of this Contract, CalOptima's Regulators find that Physician Group (or its Downstream Entities) has failed to comply with the requirements governing physician incentive plans and CalOptima's Regulators offset, recoup and/or otherwise seek recovery of FFP, as described in Section 1.33, CalOptima may elect to recoup such FFP amounts, as allowed by Laws, by either: (1) offsetting such FFP amounts, upon notice to Physician Group, from any current or future amounts owed by CalOptima to Physician Group under the Contract or any other agreement between the Parties, including capitation payments, financial security withholds, pay-for-performance amounts, quality incentives, or shared risk pool surpluses; or (2) sending an invoice to Physician Group that payment for such FFP amounts are due to CalOptima within thirty (30) days of Physician Group's receipt of the CalOptima invoice.

6.7.5 Dispute Resolution. Physician Group may use CalOptima's provider dispute resolution procedure, as described under CalOptima's Policies, and/or the dispute resolution procedures under this Contract to resolve any disputes related to the calculation or payment of such Deficits or FFP amounts.

6.7.6 Survival. This Section 6.7 shall survive the termination or expiration of the Contract.

6.8 **Retroactive Cancellation**. CalOptima will discourage retroactive cancellation of any Enrollee. However, CalOptima may make exceptions as required by CMS or due to legitimate administrative processing requirements of CMS. CalOptima may make retroactive additions or cancellations of Enrollees, as necessary for administrative or business reasons, and such retroactive additions or cancellations of Enrollees shall not exceed ninety (90) days.

VII. REPORTING REQUIREMENTS

7.1 **Data Reporting Requirements**. HMO shall comply with the data reporting requirements set forth in this Contract, including the requirements specified in Standard Reporting Requirements set forth in CalOptima Policies and guidelines (referred to as the Timely and Appropriate Submission requirements). HMO shall provide such additional data and modify the form, content, instructions, and timetables for the collection and reporting of data, as may be required by CalOptima Policies.

7.2 **Eligibility Reports**. CalOptima will maintain, update, and distribute monthly Enrollee eligibility reports for each month in which the persons included on such list are eligible for CalOptima MA Program. This report will identify the HMO, PCP selected by the Enrollee, and the Enrollee's coverage. The report will be sent to HMO and PCPs by the tenth (10th) of each month, identifying eligible Enrollees from the first (1st) of the month.

7.3 **Utilization Data**. HMO shall, upon request, provide CalOptima with information on the utilization and cost of Covered Services provided to Enrollees in such detail as to allow CalOptima to conduct analysis of costs as required by CMS, as dictated by sound business practices and for the conduct of quality management and UM activities by CalOptima. Such information to be provided by HMO will not include information beyond that customarily provided on a claim form (such as Form CMS-1500) and shall be provided in the form of a paper report, computer disc, computer tape, or

electronic file, as agreed by the parties. Required data will be delivered by HMO to CalOptima not later than forty-five (45) days following written request by CalOptima.

7.4 **Submission of Electronic Encounter Data**. HMO must meet any claims, diagnosis, and Encounter Data reporting requirements, as determined from time to time by CalOptima and CalOptima's Regulators.

7.4.1 HMO agrees to furnish CalOptima with complete, timely, reasonable, and accurate Encounter Data for Covered Services rendered to Enrollees. The Encounter Data will be furnished to CalOptima through Electronic Data Interchange (EDI) or a mutually acceptable format and shall be received by CalOptima per the Policy and Encounter Requirements Manual. HMO also agrees to furnish Medical Records that may be required to obtain any additional information or corroborate the Encounter Data. HMO further agrees to have its Chief Executive Officer (CEO) attest and certify the completeness and truthfulness of the Encounter Data submitted.

7.4.2 HMO shall be subject to financial penalties and/or sanctions if CalOptima determines that Physician is reporting to CalOptima less than all professional encounters in the CalOptima required format and timelines. Financial penalties or sanctions shall be assessed upon HMO should CalOptima determine that HMO is not meeting the standards defined in CalOptima Policies. This Section 7.4.2 shall survive the expiration or termination of this Contract, whether with or without cause, by rescission or otherwise, as to all Covered Services provided under this Contract prior to termination. Based on CalOptima's quarterly determinations and following thirty (30) days' prior notice to HMO, CalOptima may withhold three (3%) percent of Capitation Payment if CalOptima determines that the monthly Encounter Data that HMO must provide has not been received by CalOptima within the prior quarter. If at the quarterly determination following such withhold, CalOptima determines that HMO has satisfactorily delivered to CalOptima the previously non-delivered Encounter Data; such withheld Capitation Payment shall be paid to HMO, without interest. In the event that HMO does not deliver such Encounter Data to CalOptima prior to such quarterly determination, CalOptima shall be entitled to retain such withheld Capitation Payment and may withhold three (3%) percent from each quarter's Capitation Payment until CalOptima receives the Encounter Data.

7.5 **Financial Reporting**. HMO shall prepare financial information requested in accordance with Generally Accepted Accounting Principles ("**GAAP**"). Where financial statements and projections are requested by CalOptima and/or CalOptima's Regulators, these statements and projections should be prepared in accordance with the 1989 HMO Financial Report of Affairs and Conditions Format. Where appropriate, reference has been made to the Knox-Keene Act rules found under Title 28 CCR Section 1300.51 *et. seq*. Information submitted shall be based on HMO's current operations. HMO shall submit financial information consistent with filing requirements of the DMHC, unless otherwise specified by CMS.

7.6 **Financial Statements**. CalOptima, as a Knox-Keene Act health care service plan, is required by CalOptima's Regulators to monitor the financial viability of its contracted provider network on an on-going basis. HMO agrees to provide CalOptima annually with a copy of HMO's audited financial statements, including letters to management for the most recent fiscal year end along with an opinion letter on these statements from the accounting firm that completed an audit on these financial statements. Financial statements shall be presented in a form specified by CalOptima that clearly shows the financial position of HMO as related to Enrollees. HMO shall allow representatives of CalOptima, upon written request, to verify the financial reports. In the event

audited statements are unavailable, HMO agrees to provide CalOptima with the unaudited financial statements at HMO's fiscal year end. The unaudited financial statements will include: balance sheets, income statement and statement of cash flows, notes to the financial statement, name of the person preparing these statements, and representation letters from the senior financial executives of the HMO, attesting that these financial statements were prepared in accordance with GAAP and fairly present the financial condition of the HMO.

7.7 **Reports Regarding Disclosure of Confidential Enrollee Information**. If HMO, or any of its officers, employees, agents, or Downstream Entities, becomes aware of the unauthorized disclosure of confidential Enrollee information or of "personal information", within the meaning of California Civil Code Section 1798.3, HMO shall report said unauthorized disclosure to CalOptima's Privacy Officer immediately upon discovery of said disclosure, providing information on the information disclosed and how the disclosure occurred. For purposes of this section, "unauthorized disclosure" includes any unauthorized access, whether such access was through inadvertence, mistake, theft, or other means, and whether or not HMO had reasonable control to avoid the disclosure. Nothing herein is intended to limit or replace HMO's separate obligations under the Business Associate Agreement and Laws.

7.8 **Additional Information Required by CalOptima's Regulators**. HMO and Downstream Entities shall, at the request of CalOptima or CalOptima's Regulators, provide the following: (i) all information related to the performance of CalOptima's responsibilities, including non-medical information for the purposes of research and evaluation, to CalOptima's Regulators; (ii) any information required to comply with all Laws; and (iii) any information required for external rapid cycle evaluation, including program expenditures, service utilization rates, rebalancing from institutional to community settings, Enrollee satisfaction, Enrollee complaints and Appeals, and enrollment/disenrollment rates.

VIII. RECORD RETENTION, ACCESS AND CONFIDENTIALITY

8.1 **Disclosure of Records**. HMO and its Downstream Entities agree to maintain and make available contracts, books, documents, records, and electronic systems, including, Medical Records, (collectively, the "**Records**") to CalOptima, HHS, CMS, the Comptroller General, the U.S. Government Accountability Office, any Quality Improvement Organization, or accrediting organizations, including NCQA, their designees, and other representatives of regulatory or accrediting organizations, for inspection, evaluation, and auditing. For purposes of utilization management, quality improvement, and other CalOptima administrative purposes, CalOptima and CalOptima's Regulators shall have access to, and copies of, at reasonable time upon request, the Medical Records, books, charts, and papers relating to the provision of health care services to Enrollees, the cost of such services, and payments received by HMO or any of HMO Physicians from Enrollees (or from others on their behalf). Copies of the Medical Record shall be provided at no charge to CalOptima. Unless a longer time is required under applicable law, the records described herein shall be maintained for at least ten (10) years from the final date of the Contract or from the completion of any audit, whichever is later.

8.2 **Medical Records**. HMO will require that all HMO Physicians and Downstream Entities establish and maintain in an accurate and timely manner, for each Enrollee who has obtained Covered Services from a Group Provider or Downstream Entity, a legible Medical Record which shall be kept in detail consistent with good medical and professional practice in accordance with Laws and CalOptima Policies. Such Medical Records shall include a historical record of diagnostic and therapeutic services recommended or provided by, or under the direction of, the Provider. Such Medical Records shall be in such a form as to allow trained health professionals, other than the

Provider, to readily determine the nature and extent of the Enrollee's medical problem and the services provided and permit peer review of the care provided. HMO shall ensure that medical information is released in accordance with applicable Laws, or pursuant to valid court orders or subpoenas, subject to compliance with applicable privacy laws. HMO shall ensure than an individual is delegated the responsibility of securing and maintaining Medical Records at each HMO or Downstream Entity site.

8.3 **Right to Inspection**. Medical Records referred to in Section 8.2 above will be and remain the property of HMO or HMO Physicians and will not be removed or transferred from their offices except in accordance with Laws. CalOptima or its designated representatives will have the right, in accordance with this Article 8, to inspect, review, and make copies of such records at HMO's expense upon request to facilitate CalOptima's obligation to conduct quality management, utilization monitoring, and peer review activities.

8.4 **Records Related to Recovery for Litigation**. Upon request by CalOptima, HMO and its Downstream Entities shall timely gather, preserve, and provide to CalOptima, in the form and manner specified by CalOptima, any information specified by CalOptima, subject to any lawful privileges, in HMO's or its Downstream Entities' possession, relating to threatened or pending litigation by or against CalOptima, HHS, and CMS. If HMO asserts that any requested documents are covered by a privilege, HMO shall: (1) identify such privileged documents with sufficient particularity to reasonably identify the document while retaining the privilege; and (2) state the privilege being claimed that supports withholding production of the document. Such request shall include a response to a request for documents submitted by any party in any litigation by or against CalOptima. HMO acknowledges that time may be of the essence in responding to such request. HMO shall use all reasonable efforts to immediately notify CalOptima of any subpoenas, document production requests, or requests for records received by HMO or its Downstream Entities related to this Contract or subcontracts entered into under this Contract.

8.5 **State and Federal Site Visits**. HMO agrees to permit CalOptima, the DMHC, HHS, and/or CMS to conduct a site evaluation of HMO and its facilities in accordance with Laws and to comply with the agencies' recommendations, if any.

8.6 **Enrollee Access to Records**. HMO (including HMO Providers) and its Downstream Entities shall ensure that Enrollees have access to their Medical Records in accordance with the requirements of Laws. An Enrollee shall be provided a copy of his or her Medical Records, upon request, and shall have the right to request corrections or amendments to their Medical Records as specified in 45 CFR Part 164. HMO and Downstream Entities shall furnish a copy of the Enrollee's Medical Records to another treating or consulting Provider regardless of whether the requesting Provider is a Participating Provider, at no cost to CalOptima or the Enrollee when (i) such a transfer of Medical Records facilitates the continuity of that Enrollee's care; (ii) the Enrollee is transferring from one Provider to another for treatment; and (iii) an Enrollee seeks to obtain a second opinion on the diagnosis or treatment of a medical condition.

IX. INSURANCE AND LIABILITY

9.1 **Indemnification**. Each Party agrees to defend, indemnify, and the other Party and the State and CMS harmless, with respect to any and all claims, costs, damages, and expenses, including reasonable attorney's fees, that are related to or arise out of the negligent or willful performance or non-performance by the indemnifying Party, or any functions, duties, or obligations of such Party. Neither termination of the Contract nor completion of the acts to be performed under this Contract shall release either Party from its obligation to indemnify as to any claims or cause of action

asserted so long as the event(s) upon which such claims or cause of action is predicated shall have occurred prior to the effective date of termination or completion. CalOptima and HMO agree to promptly notify the other Party of any claims or demands that arise and for which indemnification hereunder is sought.

9.2 **Insurance Requirements**.

9.2.1 **HMO Liability Insurance**. HMO agrees to procure and maintain, at its own expense, the insurance policies required by this Section 9.2 and Laws and shall require its Downstream Entities to maintain similar policies of insurance where HMO's insurance does not cover its Downstream Entities. The coverage programs in this Section 9.2 above shall insure the HMO, HMO Physicians and their employees against any claim for damages arising by reason of personal injuries or death occasioned directly or indirectly in connection with the performance of, or the failure to perform any service provided by HMO Physicians, their employees or agents.

9.2.2 **Professional/Medical Malpractice**. Each HMO Physician and Participating Provider providing Covered Services to Enrollees shall maintain a professional liability (medical malpractice) insurance policy for the specialty or type of service that the HMO Physician provides with minimum limits of one million dollars ($1,000,000) per incident and three million dollars ($3,000,000) in the aggregate per Physician per year for all Physicians who are partners, associates or employees of HMO. HMO warrants that all Physicians that it contracts with for the provision of Covered Services will carry professional liability coverage in the same amount and that each Hospital providing Covered Services to Members shall maintain a professional liability insurance policy with a minimum of five million dollars ($5,000,000) per incident/five million dollars ($5,000,000) in the aggregate per year. If HMO, HMO Physicians, or its Downstream Entities have a claims-made malpractice insurance policy, they agree to keep the policy in effect for at least seven (7) years past any termination of the Contract or purchase "tail" coverage. Said "tail" coverage shall have the same policy limits as the primary professional liability policy.

9.2.3 **Commercial General Liability/Commercial Automobile Liability**. HMO and each Participating Provider who has entered into a contract with HMO to provide Covered Services under this Contract shall maintain a Commercial General Liability insurance policy and a Commercial Automobile Liability insurance policy with minimum limits as follows:

- Commercial General Liability: One million dollars ($1,000,000) per occurrence and three million dollars ($3,000,000) in the aggregate.

- Commercial Automobile Liability: One million, two hundred thousand dollars ($1,200,000) combined single limit for bodily injury or property damage covering any automobile, whether owned, leased, hired, or rented, on an ISO form CA 0001 or equivalent.

CalOptima must be named as an additional insured on Comprehensive General Liability and Commercial Automobile Liability insurance policies with respect to performance under this Contract.

9.2.4 **Workers' Compensation**. HMO Physician and each Participating Provider who has entered into a contract with HMO to provide Covered Services under this Contract shall

maintain a Workers' Compensation Insurance policy that provides statutory coverage with minimum limits as follows:

- Employers' Liability Insurance:
  - One million dollars ($1,000,000) Bodily Injury by Accident - each accident.
  - One million dollars ($1,000,000) Bodily Injury by Disease - policy limit
  - One million dollars ($1,000,000) Bodily Injury by Disease - each employee

9.2.5 **Managed Care Errors and Omissions**. Physician shall maintain a Managed Care Errors and Omissions Insurance policy with minimum limits as follows:

- Managed Care Errors and Omissions: Ten million dollars ($10,000,000) each claim/ten million dollars ($10,000,000) aggregate

9.2.6 **Electronic and Computer Crimes Insurance**. HMO and its Downstream Entities shall maintain electronic and computer crimes insurance and employee fidelity insurance with limits of at least one million dollars ($1,000,000) if HMO and/or its Downstream Entities will be paying claims or receiving funds on behalf of CalOptima, or will be storing, transmitting, and/or receiving personally identifiable and/or protected health information on a regular basis in carrying out its obligations under this Contract..

9.2.7 **Insurer Ratings**. Insurance required under this Article IX shall be provided by an insurer:

(a) Rated by A.M. Best with a rating of A V or better; and

(b) "Admitted" to do business in California or an insurer approved to do business in California by the California Department of Insurance and listed on the Surplus Lines Association of California List of Eligible Surplus Lines Insurers (LESLI); or

(c) An Unincorporated Interindemnity Trust Arrangement as authorized by the California Insurance Code 12180.7

9.2.8 **Captive Risk Retention Group/Self Insured**. Where any of the insurance(s) mentioned in this Article IX is provided by a captive risk retention group or self-insured, insurer ratings requirements above may be waived at the sole discretion of CalOptima, but only after review of the captive risk retention group's or self-insured's audited financial statements.

9.2.9 **Cancellation or Material Change**. HMO shall not of its own initiative cause such insurance as addressed in this Article IX to be cancelled or materially changed during the Term.

9.2.10 **Proof of Insurance**. Certificates of Insurance of the insurance policies and/or evidence of self-insurance required under this Article IX shall be provided to CalOptima prior to Effective Date, annually thereafter, and upon request.

X. COOPERATION

10.1 **Non-Interference**. HMO and Downstream Entities may not prohibit of otherwise restrict a health care professional, acting within the lawful scope of practice, from freely communicating with Enrollees about their treatment and the following, regardless of benefit coverage limitations:

10.1.1 The Enrollee's health status, medical care, or treatment options (including any alternative treatments that may be self-administered), including the provision of sufficient information to provide an opportunity for the Enrollee to decide among all relevant treatment options;

10.1.2 The risks, benefits, and consequences of treatment or non-treatment; or

10.1.3 The opportunity for the Enrollee to refuse treatment and to express preferences about future treatment decisions.

10.2 **No Counseling to Dis-enroll**. HMO and HMO Physicians agree that they will not, during the Term, provide advice to or counsel any Enrollee to dis-enroll from CalOptima, and HMO and HMO Physicians will not solicit such Enrollee to become enrolled with any other health maintenance organization, preferred provider organization, or any other similar hospitalization, medical payment plan or insurance program.

10.3 **Cooperation**. CalOptima and HMO agree that, to the extent compatible with the separate and independent management of each, they will at all times maintain an effective liaison and close cooperation with each other to provide maximum benefits to Enrollees at the most reasonable cost, consistent with quality standards of hospital and physician care.

10.4 **Signs**. HMO agrees that CalOptima may post notices, mutually acceptable as to size, content and form in a prominent place instructing Enrollees as to proper procedures and limitations on coverage.

10.5 **Free Exchange of Information**. No provision of this Contract shall be construed to prohibit, nor shall any provision in any contract between HMO and its employees or Downstream Entities, prohibit, the free, open, and unrestricted exchange of any and all information of any kind between Providers and Enrollees regarding the nature of the Enrollee's medical condition, the health care treatment options and alternatives available and their relative risks and benefits, whether or not covered or excluded under the Enrollee's Evidence of Coverage, and the Enrollee's right to appeal any adverse decision made by HMO or CalOptima regarding coverage of treatment which has been recommended or rendered. HMO and CalOptima agree not to penalize nor sanction any Provider in any way for engaging in such free, open, and unrestricted communication with an Enrollee nor for advocating for a particular service on an Enrollee's behalf.

XI. TERM AND TERMINATION

11.1 **Term of Contract**. The term of this Contract shall become effective on the Effective Date and continue in effect for five (5) years through _____ ("Initial Term") and five (5) additional one-year automatic extensions except as directed otherwise by the Board.

11.2 **Sanctions and Terminations for Cause**. If HMO fails to fulfill any of its duties and obligations under this Contract, including: (i) committing acts to discriminate against Enrollees; (ii) engaging in any practice that would reasonably be expected to have the effect of denying or discouraging enrollment with the HMO by Enrollees whose medical condition or history indicated a need for substantial future medical services; (iii) not providing Covered Services in the scope or manner required under this Contract; (iv) engaging in prohibited marketing activities; (v) failing to comply with CalOptima's compliance and fraud, waste and abuse programs; (vi) failing to meet financial

requirements in Article II; (vii) committing fraud, waste or abuse relating to Covered Services or any and all obligations, duties, and responsibilities under this Contract; (viii) failure to enforce claims payment prohibitions on HMO Physicians who are denied the right to submit claims and/or receive reimbursement for services furnished to Enrollees; (ix) failure of HMO Physicians to comply with pharmacy requirements as determined by CalOptima; (x) failure to submit Encounter Data or comply with other reporting requirements pursuant to this Contract and CalOptima Policies; and/or (xi) failure to take corrective action related to any such obligation or duty in the time or manner required by CalOptima, CalOptima may take any one or more of the actions described in this Article XI.

11.3 **Corrective Action Plans**. CalOptima may require a Corrective Action Plan ("**CAP**") in the event that any report, audit, survey, site review or investigation indicates that the HMO or any Downstream Entity is not in compliance with any provision of this Contract.

11.3.1 A CAP shall be required if CalOptima receives a substantiated complaint or grievance related to the standard of care provided by the HMO or any Downstream Entities. CalOptima shall issue a written notice of deficiency and shall require that a CAP to be submitted within thirty (30) calendar days following the date of notice unless otherwise stated. The CAP shall include the time and manner in which the deficiency shall be corrected. CAPs are subject to approval by CalOptima, which may be approved as submitted, accepted with specific modifications, or rejected. CalOptima may extend or reduce the time allowed for completion of the CAP depending upon the nature of the deficiency.

11.3.2 Notwithstanding any request for a CAP, CalOptima may impose monetary penalties, suspend enrollment, reduce maximum enrollment, or impose other sanctions when the HMO is not in compliance with the provisions of this Contract, CalOptima Policies, and minimum performance requirements as established by CalOptima. All monetary fines are payable to CalOptima within thirty (30) calendar days of receipt of written notice, unless otherwise stated in the notice. Failure to submit payment to CalOptima for any monetary fines within the thirty (30) calendar day period shall result in CalOptima deducting the penalty plus administrative fees from the HMO's Capitation Payment.

11.4 **CalOptima Termination for Cause**. Notwithstanding and in addition to any other provisions of this Contract, CalOptima may terminate this Contract for cause effective upon thirty (30) calendar days' written notice; cause shall include, but shall not be limited to, the actions set forth in Section 11.2. CalOptima's rights and remedies provided in this provision shall not be exclusive and are in addition to any other rights and remedies provided by law or this Contract.

11.5 **HMO Termination for Cause**. HMO may terminate this Contract for cause only upon thirty (30) calendar days' written notice and only in the event that CalOptima fails to make payments due under this Contract within fifteen (15) calendar days of when such amounts are due and payable.

11.6 **Immediate Terminations**. In addition to all other sanction and termination rights, CalOptima may terminate Contract immediately upon delivery of written notice to HMO if:

11.6.1 HMO (including HMO Physicians) and/or its Downstream Entities are unable to secure the necessary governmental licenses, approvals, and/or certificates required for the performance of their duties;

11.6.2 CalOptima determines that the health, safety, or welfare of Enrollees is jeopardized by continuation of this Contract;

11.6.3 HMO commits fraud, waste, or abuse; or

11.6.4 CMS fails to authorize or reauthorize CalOptima to operate a MA Program for a period that overlaps the Term.

11.7 **Without Cause Termination**. Following the Initial Term, either Party may terminate this Contract for convenience, without cause, by giving written notice to the other Party of at least one hundred and eighty (180) calendar days' prior to the effective date of such termination.

11.8 **Bankruptcy**. If during the Term there is filed by or against HMO in any court pursuant to any statute of the United States or any state, a petition in bankruptcy or insolvency or for reorganization or for the appointment of a receiver or trustee or conservator of all or a portion of HMO's assets, or if HMO makes an assignment for the benefit of creditors, or if HMO becomes unable, admits in writing its inability, or fails generally to pay its debts as they become due, this Contract may, at the option of CalOptima, be canceled and terminated. In the event of the filing of a petition for bankruptcy by or against HMO, HMO shall assure that all of HMO's functions and duties related to the Contract are performed in accordance with the terms of the Contract. CalOptima shall have the right to withhold any and all amounts otherwise due to HMO until HMO fully discharges its obligations under the Contract. CalOptima shall also have the immediate right of offset by permanently retaining any and all withheld amounts as necessary to ensure that all HMO obligations have been met.

11.9 **Termination of CMS Contract.** In the event the CMS Contract with CalOptima is terminated or not renewed, the provisions of this Contract shall automatically terminate unless otherwise specified by CalOptima and subject to any provisions that survive termination. Any term provided in the Contract is subject to CMS's continuing approval of CalOptima's MA Program. HMO agrees to assist CalOptima with such transfer of care requirements mandated by CMS in the event of termination of the CMS Contract.

11.10 **Continuation of Benefits**. HMO and its Participating Providers agree that, in the event of CalOptima's insolvency or cessation of operations, benefits to Enrollees will continue through the period for which capitation has been paid or until the discharge of Enrollee from an inpatient facility, whichever time is greater. Covered Services to an Enrollee confined in an inpatient facility on the date of insolvency or other cessation of operations will continue until their appropriate discharge.

11.11 **HMO Obligations Following Termination**. In the event of termination of this Contract, at CalOptima's sole option, HMO will continue to provide Covered Services, and CalOptima shall reimburse for such services per the Medicare fee schedule, to Enrollees until CalOptima has made arrangements with alternative Providers to render care to Enrollees. HMO shall cooperate and assist CalOptima in the transfer of Enrollee care in the event this Contract or any relevant Downstream Entity subcontract is terminated for any reason. HMO shall provide a plan for the orderly termination of services under this Contract, in form and substance acceptable to CalOptima.

11.12 **Prohibition on Use of Certain HMO Physicians**. HMO agrees that CalOptima reserves the right to require HMO, upon notification from CalOptima, to prohibit any HMO Physician or Downstream Entity from providing services, whether Covered Services or otherwise, to Enrollees

when CalOptima deems such prohibition to be in the best interests of the Enrollees, provided that imposition of the foregoing prohibition shall not terminate this Contract.

XII. GENERAL PROVISIONS

12.1 **Dispute Resolution**.

12.1.1 **Provider Appeals Process**. CalOptima maintains a Provider dispute resolution process. HMO may appeal any aspect of the CalOptima MA Program, including a decision to impose a sanction, terminate this Contract, or take other actions against HMO, by filing a complaint pursuant to CalOptima Policies. HMO shall exhaust all administrative remedies and any government claims requirements, as applicable, before commencing arbitration.

12.1.2 **Meet and Confer**. For any dispute not subject to or resolved by the provider appeals process, or if either Party has a dispute it seeks to address informally, the Parties shall use reasonable efforts to informally meet and confer to try and resolve the dispute. The Parties shall meet and confer within thirty (30) days of a written request submitted by either Party in an effort to settle any dispute. At each meet-and-confer meeting, each Party shall be represented by persons with final authority to settle the dispute. If either Party fails to meet within the thirty (30)-day period, that Party shall be deemed to have waived the meet-and-confer requirement, and at the other Party's option, the dispute may proceed immediately to arbitration under Section 12.1.3.

12.1.3 **Arbitration**. If the Parties are unable to resolve any dispute arising out of or relating to this Contract under Sections 12.1.1 and 12.1.2, either Party may submit the dispute for resolution exclusively through confidential, binding arbitration, instead of through trial by court or jury, in Orange County, California. The Parties may agree in writing prior to commencing the arbitration on the dispute resolution rules and arbitration service that will be used to resolve the dispute. If the Parties cannot reach such an agreement, the arbitration will be conducted by Judicial Arbitration and Mediation Services ("**JAMS**") in accordance with the commercial dispute rules then in effect for JAMS; provided, however, that this Contract shall control in instances where it conflicts with JAMS's (or the applicable arbitration service's) rules. The arbitration shall be conducted on an expedited basis by a single arbitrator. The Parties prefer that the arbitrator be a retired judge of the California Superior, Appellate, or Supreme Court or of a United States court sitting in California. If no such retired judge is available, the arbitrator may be an attorney with at least fifteen (15) years of experience, including at least five (5) years in managed health care. If the Parties are unable to agree on the arbitrator within thirty (30) days of the date that the arbitration service accepts the arbitration, the arbitrator shall be selected by the arbitration service from a list of four potential arbitrators (all of whom shall be on arbitration services' panel of arbitrators) submitted by the Parties, two from each side; provided, however, that nothing stated in this section shall prevent a Party from disqualifying an arbitrator based on a conflict of interest. In making decisions about discovery and case management, it is the Parties' express agreement and intent that the arbitrator at all times promote efficiency without denying either Party the ability to present relevant evidence. In reaching and issuing decisions, the arbitrator shall have no jurisdiction to make errors of law and/or legal reasoning. The Parties shall share the costs of arbitration equally, and each Party shall bear its own attorneys' fees and costs.

12.1.4 **Exclusive Remedy**. With the exception of any dispute that under Laws may not be settled through arbitration, arbitration under Section 12.1.3 is the exclusive method to resolve a

dispute between the Parties arising out of or relating to this Contract that is not resolved through the provider appeals or meet-and-confer processes.

12.1.5 **Waiver**. By agreeing to binding arbitration as set forth in Section 12.1.3, the Parties acknowledge that they are waiving certain substantial rights and protections which otherwise may be available if a dispute between them was determined by litigation in a court, including the right to a jury trial, attorneys' fees, and certain rights of appeal.

12.2 **Interpretation of Contract Language**. CalOptima has the right to final interpretation of the Contract language when disputes arise. HMO has the right to appeal disputes concerning Contract language to CalOptima.

12.3 **Waiver**. The waiver by either Party of a breach or violation of any provision of this Contract will not operate as or be construed to be a waiver of any subsequent breach thereof. To be effective, a waiver must in writing signed by the Parties.

12.4 **Assignment**. This Contract and the rights, interests, duties, and obligations hereunder shall not be assigned, transferred, pledged, or hypothecated in any way by HMO nor shall the duties and obligations imposed herein be subcontracted or delegated without the prior written consent of CalOptima, which consent may be withheld in CalOptima's sole and absolute discretion for any reason or no reason. HMO acknowledges and agrees that CalOptima's consent, if any, to assignment and/or delegation is subject to the approval of CMS. Therefore, any assignment and/or delegation of this Contract, including the rights, interests, duties, and obligations hereunder, shall be void unless prior written consent is obtained from CalOptima and CMS. HMO further acknowledges and agrees that CalOptima may require HMO and the proposed assignee/sub-delegate to cooperate in due diligence and sub-delegation assessment activities as part of its review of any request for consent to assignment of this Contract and the rights, interests, duties, and obligations hereunder. HMO agrees to cooperate and provide such information as requested by CalOptima. HMO acknowledges and agrees that (i) CalOptima's due diligence and/or assessment activities related to any proposed assignment may take one hundred eighty (180) days or more; (ii) in no event shall CalOptima's due diligence and/or delegation assessment activities be construed as CalOptima's consent to assignment; and (iii) any consent to assignment by CalOptima must be reflected in a separate writing executed by CalOptima and other relevant parties. CalOptima may, from time to time, establish policies and procedures regarding its processes for initiating review and approval of any proposed assignment of this Contract. For purposes hereof, the term "**assignment**" shall include any of the following: (i) the change of more than twenty-five percent (25%) of the ownership or equity interest in HMO (whether in a single transaction or in a series of transactions); (ii) the change of more than twenty-five percent (25%) of the directors or trustees of HMO; (iii) the merger, reorganization, or consolidation of HMO with another entity with respect to which Physician is not the surviving entity; and/or (iv) a change in the management of HMO from management by persons appointed, elected, or otherwise selected by the governing body of HMO (e.g., the Board of Directors) to a third-party management person, company, group, team or other entity.

12.5 **Independent Parties**. None of the provisions of this Contract are intended to create nor will be deemed or construed to create any relationship between the Parties other than that of independent contractors, solely for the purposes of effecting the provisions of the Contract. Neither of the Parties nor any of their respective officers, directors, or employees shall act as nor be construed to be the agent, the employee, or the representative of the other Party.

12.6 **Integration of Entire Contract**. This Contract contains all of the terms and conditions agreed upon by the Parties regarding the subject matter of this Contract. Any prior agreements, promises, negotiations or representations of or between the Parties, either oral or written, relating to the subject matter of this Contract that are not expressly set forth in this Contract are null and void and of no further force or effect.

12.7 **Invalidity or Unenforceability**. The invalidity or unenforceability of any terms or provisions hereof will in no way affect the validity or enforceability of any other term or provision.

12.8 **Amendment**. CalOptima may amend this Contract immediately upon written notice to HMO in the event such amendment is required in order to maintain compliance with Laws. CalOptima may deem all other amendments to the Contract effective after at least forty-five (45) business days' notice or earlier if agreed to by HMO. All amendments of this Contract are subject to CMS approval.

12.9 **No Waiver of Immunity or Privilege**. Any information delivered, exchanged, or otherwise provided hereunder shall be delivered, exchanged, or otherwise provided in a manner, which does not constitute a waiver of immunity or privilege under applicable law.

12.10 **Choice of Law; Jurisdiction and Venue**. This Contract shall be governed by and construed in accordance with all State and federal laws and regulations governing the CMS Contract. The Parties consent to the jurisdiction of the California Courts with venue in Orange County California.

12.11 **Force Majeure**. Either Party, upon prompt written notice to the other Party, shall be excused from performance hereunder for any period that it is prevented from meeting the terms of this Contract as a result of a catastrophic occurrence or natural disaster, including, but not limited to, an act of war and excluding labor disputes ("**Force Majeure Event**");

12.12 **No Liability of County of Orange**. As required under Ordinance No. 3896, as amended, of the County of Orange, State of California, CalOptima and the HMO hereby acknowledge and agree that the obligations of CalOptima under this Contract are solely the obligations of CalOptima, and the County of Orange, State of California, shall have no obligation or liability therefor.

12.13 **Confidential and Proprietary Information**. HMO agrees to maintain confidential the following information (the "**Confidential Information**"): (a) eligibility lists and any other information containing the names, addresses and telephone numbers of CalOptima Enrollees; (b) CalOptima's administrative service manuals and all forms related thereto; (c) the financial arrangements between CalOptima and any Participating Provider; and (d) any other information compiled or created by CalOptima that is proprietary to CalOptima and that CalOptima identifies as proprietary to HMO in writing. HMO shall not disclose or use the Confidential Information for its own benefit or gain either during the Term or after the date of termination of this Contract. HMO may use the Confidential Information to the extent necessary to perform its duties under this Contract or upon express prior written permission of CalOptima. Upon the effective date of termination of this Contract, HMO shall promptly return to CalOptima the Confidential Information in its possession, upon CalOptima's notice.

12.14 **Third Party Beneficiaries**. Nothing in this Contract, express or implied, is intended to or shall confer upon any other person or entity, any right, benefit or remedy of any nature whatsoever.

12.15 **Survival**. The terms set forth in the following sections shall survive the expiration or termination of this Contract, whether with or without cause, by rescission or otherwise, as to all Covered

Services provided under this Contract prior to termination: Sections 6.2, 6.5, 7.8, Article 8, 9.1, 11.10, 11.11, 12.1, 12.2, 12.3, 12.5, 12.6, 12.7, 12.9, 12.10, 12.12, 12.13, 12.14, and any other sections that, by their terms, are intended to survive termination of the Contract.

12.16 **Recitals and Exhibits**. The recitals and exhibits set forth in this Contract are made a part of the Contract by this reference.

12.1 **Without Limitation**. Any reference in the Contract to "include(s)" or "including" means inclusion without limitation, unless otherwise distinguished within the text.

12.2 **Notices**. All notices shall be in writing and shall be deemed to have been duly given on the date of service if personally served on the Party to whom notice is given, or seventy-two (72) hours after mailing by electronic mail transmission, United States priority mail, United States mail first class (Certified Mail or Registered Mail), addressed to the Party to whom notice is to be given and such party's address as set forth below or such other address provided by notice.

To: CalOptima

Attention: Chief Operating Officer
505 City Parkway West
Orange, California 92868

To: HMO

_____

_____

_____

XIII. CONDITIONS PRECEDENT TO CONTRACT COMMENCEMENT

13.1 **Contract Effectiveness**. The Contract is subject to CalOptima's determination, in its sole discretion, that the following conditions have been met prior to the Effective Date: (i) HMO has successfully met all criteria in CalOptima's readiness assessment, including financial viability and delegated function criteria; HMO has signed CalOptima's Business Associate Agreement; and (iii) HMO has furnished all required documentation and data requested by CalOptima (e.g., insurance documents, licenses).

13.2 **Additional CalOptima Regulator Requirements**. CalOptima, in its sole discretion, may condition this Contract upon HMO's ability to meet other criteria imposed by CalOptima Regulators.

XIV. SIGNATURES

SUBJECT TO (I) THE UNITED STATES GOVERNMENT PROVIDING FUNDS FOR THE TERM OF THIS CONTRACT AND FOR THE PURPOSES WITH RESPECT TO WHICH IT IS ENTERED INTO; AND (II) THE APPROVAL OF THIS CONTRACT BY DMHC AND CMS, THIS CONTRACT SHALL BECOME EFFECTIVE ON THE EFFECTIVE DATE AND SHALL TERMINATE ON AS PROVIDED IN THIS CONTRACT.

IN WITNESS WHEREOF, CalOptima and HMO have executed this Contract as indicated below.

FOR HMO:	FOR CALOPTIMA:
_____	_____
SIGNATURE	SIGNATURE
_____	Yunkyung Kim
PRINT NAME	PRINT NAME
_____	Chief Operations Officer
TITLE	TITLE
_____	_____
DATE	DATE

ATTACHMENT A
DEFINITIONS

1. "**Administrative Services**" means those non-clinical, administrative functions that are the responsibility of the HMO as set forth under the Contract and in CalOptima Policies.

2. "**Advance Directive**" means an individual's written directive or instruction, such as a power of attorney for health care or a living will, recognized under state law (whether statutory or as recognized by the courts of the state) for the provision of that individual's health care if the individual is unable to make his or her health care wishes known.

3. "**Appeals**" means an Enrollee's actions, both internal and external to CalOptima, requesting review of the denial, reduction, or termination of benefits or services from CalOptima.

4. "**Authorization/Authorized**" means the approval of CalOptima, or its delegate (which may include HMO), for the provision or referral of Covered Services, obtained in accordance with, and as further described in, the Provider Manual and this Contract.

5. "**Behavioral Health**" means the mental health services and substance use disorder services arranged for or provided to Enrollees by a separate Mental Health Plan, CalOptima, or their subcontractors.

6. "**CalOptima Formulary**" means the CalOptima Approved Drug List, the Disposable Medical Equipment/Supplies List, the CalOptima OneCare Formulary, and any additional formularies as may be designated by CalOptima and provided to CalOptima's designated pharmacy benefits manager "**PBM**". There is no applicable CalOptima Formulary for the PACE program.

7. "**CalOptima Policies**" means CalOptima policies and procedures, including CalOptima's Provider Manual, that are amended from time to time at the sole discretion of CalOptima and incorporated into this Agreement by this reference.

8. "**CalOptima's Regulators**" means those government agencies that regulate and oversee CalOptima's and its FDRs' activities and obligations under this Contract including the Department of Health and Human Services, CMS, and the DMHC and other government agencies that have authority to set standards and oversee the performance of the parties to this Contract, as well as their respective agents and contractors quality improvement organizations.

9. "**Capitation Payment**" means the monthly payment paid to HMO by CalOptima for delivery for Covered Services to Enrollees, which is determined by multiplying the applicable Capitation Rate by HMO's monthly enrollment.

10. "**Capitation Rate**" means the rate set by CalOptima for the delivery of Covered Services to an Enrollee.

11. "**Care Coordinator**" means a clinician or other trained individual employed by or contracted with HMO who is accountable for providing care coordination services for Enrollees, as required by CalOptima Policies and who services on one or more ICTs.

12. "**C.C.R.**" means the California Code of Regulations.

13. "**C.F.R.**" means the Code of Federal Regulations.

14. "**CMS**" means the Center for Medicare & Medicaid Services.

15. "**CMS Contract**" means the agreement between CMS and CalOptima under which CalOptima can establish its MA Program for Enrollees.

16. "**COB**" refers to the coordination of benefits and determination of order of financial responsibility that applies when two or more health benefit plans provide coverage of items and services for an individual.

17. "**Compliance Program**" means the program (including the compliance manual, code of conduct and CalOptima Policies) developed and adopted by CalOptima to promote, monitor, and ensure that CalOptima's operations and practices and the practices of its Board members, employees, contractors, and Providers comply with applicable law and ethical standards. The Compliance Program includes CalOptima's Fraud, Waste and Abuse ("**FWA**") plan.

18. "**Covered Services**" means those health care items, drugs, and services that an Enrollee is entitled to receive pursuant to a Program applicable to that Enrollee. Covered Services must generally be referred and Authorized in confirming with CalOptima's Policies, including its utilization management program."

19. "**Delegation**" means the process by which CalOptima expressly grants, by formal written agreement to another entity, the authority to carry out a function that would otherwise be required to be performed by CalOptima in order to meet its obligations under the CMS Contract.

20. "**Delegation Agreement**" means the formal written agreement by which CalOptima grants to another entity the authority to carry out a function that would otherwise be required to be performed by CalOptima to meet its obligations under the CMS Contract.

21. "**Delegation Criteria**" means those criteria adopted by CalOptima, for the delegation of activities in the areas of UM, medical records audits, the Office Site Review, 'Enrollee's rights and responsibilities, and credentialing, as set forth in CalOptima Policies.

22. "**DMHC**" means the California Department of Managed Health Care.

23. "**Downstream Entity**" means all Providers and other persons or entities with which HMO has entered into a written subcontract (acceptable to CMS) to perform administrative functions and/or health care services to satisfy HMO's obligations to CalOptima under this Contract, continuing down to the ultimate provider of services. The term "HMO" as used in the terms of this Contract shall also include its subcontractors when such subcontractors are Downstream Entities, even if not expressly referenced in the particular provision.

24. "**Emergency Medical Condition**" means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, with an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in: (i) placing the health of the individual (or with respect to a pregnant woman, the health of the woman and her unborn child) in serious jeopardy; or (ii) serious impairment to bodily functions; or (iii) serious dysfunction of any bodily organ or part.

25. "**Emergency Services**" means those covered inpatient and outpatient services that are (i) furnished by a Provider qualified to furnish Emergency Services; and (ii) needed to evaluate and/or stabilize an Enrollee's Emergency Medical Condition.

26. "**Encounter Data**" means the record of an Enrollee receiving any item(s) or service(s) provided through Medicaid or Medicare under a prepaid, capitated, or any other risk basis payment methodology submitted to CMS. The encounter data record shall incorporate HIPAA security, privacy, and transaction standards and be submitted in ASCX12N 837 or any successor format required by CalOptima's Regulators.

27. "**Enrollee**" means an eligible individual who is enrolled in the CalOptima MA Program.

28. "**Evidence of Coverage**" means the document approved by CalOptima's Regulators and issued by CalOptima to Enrollees that describes Enrollee's benefits under the CalOptima MA Program.

29. "**FDR**" means a party that enters into a written agreement (acceptable to CMS) to provide administrative or health care services to CalOptima and/or its Enrollees that are governed by the CMS Contract.

30. "**FQHC**" means an entity that meets all of the requirements for designation as a federally qualified health center under § 1861(aa)(3) of the Social Security Act and is approved for participation in the MA program.

31. "**Grievance**" means an oral or written expression of dissatisfaction, including any compliant, dispute, request for reconsideration, or appeal, made by an Enrollee.

32. "**Health Network**" means HMO, a physician-hospital consortium, or health care service plan (such as an HMO) that is contracted with CalOptima to provide items and services to Enrollees on a capitated basis.

33. "**HMO Physician**" means a Physician who is employed by or under contract with HMO to provide physician services.

34. "**HEDIS**" means the set of standardized performance measures sponsored and maintained by the NCQA.

35. "**HRA**" means the health risk assessment tool that identifies an Enrollee's primary, acute, LTSS, Behavioral Health, and functional needs.

36. "**HIPAA**" means the Health Insurance Portability and Accountability Act of 1996, Public Law 104-191, the Health Information Technology for Economic and Clinical Health Act, Public Law 111-005, and regulations promulgated thereunder by the U.S. Department of Health and Human Services, including Title 45 of the C.F.R, Parts 160 and 164.

37. "**Hospital(s)**" means licensed acute care hospital(s) that have entered into an agreement with CalOptima or HMO to provide services to Enrollees in the CalOptima program and where HMO customarily admits patients.

38. "**ICP**" means the plan of care developed by an Enrollee and/or his/her ICT or CalOptima.

39. "**Indian Enrollee**" means an Enrollee who is an Indian (as defined in the Indian Health Care Improvement Act of 1976 [25 U.S.C. §§ 1603(13), 1603 (13 and 23), or 1679(a)] or who has been determined as an Indian under 42 C.F.R. § 136.12.

40. "**Indian Health Care Provider**" means a health care program operated by the Indian Health Services or by an Indian Tribe, Tribal Organization, or Urban Indian Organization, as those terms are defined in Section 4 of the Indian Health Care Improvement Act (25 U.S.C. § 1603).

41. "**ICT**" means an interdisciplinary care team comprised of the primary care provider and Care Coordinator and other Providers at the discretion of the Enrollee that work with the Enrollee to develop, implement, and maintain the ICP.

42. "**Laws**" means any local, State, or federal statute, regulation, rule, or executive or agency order applicable to this Contract.

43. "**LTSS**" means the range of long-term services and supports that help Enrollees meet their daily needs for assistance and improve the quality of their lives and which include: (i) In-Home Supportive Services ("**IHSS**"); (ii) Community-Based Adult Services ("**CBAS**"); (iii) Multi-purpose Senior Services Program ("**MSSP**") services; and (iv) skilled nursing facility services and sub-acute care services.

44. "**Medically Necessary**" or "**Medical Necessity**" means when addressing Covered Services: (i) under Medicare, reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member, or otherwise medically necessary under 42 U.S.C. Section 1395y.

45. "**Medical Record**" means any record kept or required to be kept by any Provider that documents medical services received by the Enrollee, including inpatient, outpatient, emergency care, referral requests, and Authorizations in accordance with applicable laws including Title 28 C.C.R. § 1300.80(b), Title 42 U.S.C. § 1396a(w), 42 C.F.R. § 456.111 and 42 C.F.R. § 456.211 and CalOptima Policies.

46. "**Mental Health Plan**" means the entity that has contracted with DHCS to provide Specialty Mental Health Services to individuals, including Enrollees.

47. "**Model of Care**" means the component of CalOptima's quality improvement framework that is evidence-based, includes certain clinical and non-clinical elements, and is in addition to the comprehensive care coordination requirements specified in CalOptima Policies.

48. "**Non-Covered Services**" means those services that are not benefits under the CalOptima MA Program in accordance with CalOptima's Evidence of Coverage and applicable state and federal laws and regulations.

49. "**Non-Participating Provider**" means an institution, professional, or other Provider of health care services who has not entered into an agreement, either with CalOptima or HMO, to provide medical and other services to Enrollees.

50. "**Out-of-Area**" means that area that is outside the Service Area.

51. "**Outpatient Mental Health Services**" means outpatient services that are provided to Enrollees with mild to moderate mental health conditions including: (i) individual/group mental health evaluation and treatment (psychotherapy); (ii) psychological testing when clinically indicated to evaluate a mental health condition; (iii) outpatient services for the purpose of monitoring drug therapy; (iv) psychiatric consultation for mediation management; and (v) outpatient laboratory supplies and supplements.

52. "**Participating Provider**" means an institution, professional, or other provider of health care services who has entered into an agreement, either with CalOptima or HMO, to provide health care services to Enrollees.

53. "**PCC**" means the personal care coordinator(s) employed by HMO to comply with the CalOptima MOC Program.

54. "**PCC Component to the Model of Care Profile**" means the PCC Components identified in the Model of Care Profile.

55. **"Physician"** means a person with an unrestricted license to practice medicine or osteopathy in the state in which they practice.

56. "**Physician Direct Referral**" means the process whereby a PCP has the authority the decide whether a referral is deemed necessary for an Enrollee and if deemed necessary the PCP will directly refer that Enrollee within said HMO to any of the specialties or services specified in CalOptima Policies without requiring the prior Authorization of HMO.

57. "**Post-Stabilization Care Services**" means services related to an Emergency Medical Condition that are provided after an Enrollee is Stabilized in order to maintain the Stabilized condition, or under some circumstances, to improve or resolve the condition.

58. "**Preclusion List**" means the CMS-compiled list of providers and prescribers who are precluded from receiving payment for MA items and services or Part D drugs furnished or prescribed to Medicare beneficiaries.

59. "**PCP**" means a primary care physician responsible for supervising, coordinating, and providing initial and primary care to Enrollees; for serving as the medical home; for processing initial referrals for Specialist Physician care; and for maintaining the continuity of patient care.

60. "**Program**" is health care benefit program offered by CalOptima to Enrollees. Programs and their designs are subject to change periodically.

61. "**Provider**" means a physician, nurse, nurse mid-wife, nurse practitioner, medical technician, physician assistant, hospital, laboratory, health maintenance organization ("**HMO**"), or other person or institution who furnishes health care items or services.

62. "**Provider Manual**" means that comprehensive online document, as amended from time to time, and describes CalOptima's Policies and procedures affecting HMO Physicians' services under this Contract.

63. "**Referral**" means the process by which the Participating Provider Physician directs an Enrollee to seek and obtain Covered Services from a health professional or for care at a facility.

64. "**Rural Health Clinic (RHC)**" means an entity that meets all of the requirements for designation as a rural health clinic under § 1861(aa)(1) of the Social Security Act and is approved for participation in the MA program.

65. "**Service Area**" means the geographic area within Orange County, California.

66. "**Shared Risk Services**" will mean those Covered Services that are the financial responsibility under the Hospital Budget, as set forth in Attachment B.

67. "**Specialist Physician**" means any physician who is not a PCP, has the requisite training and education, and meets all other requirements set by CalOptima Policies for specialists.

68. "**Stabilize**" or "**Stabilized**" means, with respect to an Emergency Medical Condition, to provide such medical treatment of the condition to assure within reasonable medical probability that no material deterioration of the condition is likely to result or occur during the transfer of the individual from a facility, or in the case of a pregnant woman, that the woman has delivered the child and placenta.

69. "**Threshold Language"** means those languages as determined by CalOptima's Regulators from time to time and identified in guidance on translation requirements provided to CalOptima.

70. "**Urgent Care**" means services required to prevent serious deterioration of health following the onset of an unforeseen condition or injury and are medical services required promptly to prevent impairment of health due to symptoms that do not constitute an Emergency Medical Condition but that are the result of an unforeseen illness, injury or condition for which medical services are immediately required.

ATTACHMENT B
CALOPTIMA SENIOR PLAN
MATRIX OF FINANCIAL RESPONSIBILITY
January 1, 2023

HMO	RESPONSIBLE PARTY		
SERVICES	**GROUP**	**HOSPITAL**	**PLAN**
Medicare Part A Services – Not Otherwise Assigned Herein or in Any Agreement Incorporating This Exhibit:			
Inpatient		**X**	
Outpatient		**X**	
Medicare Part B Services Not Otherwise Assigned Herein or in Any Agreement Incorporating This Exhibit	**X**		
Some of the main services and those related to the Risk Sharing Program are listed below:			
Acupuncture (Medicare covered)	**X**		
Allergy			
Testing and Treatment	**X**		
Serum	**X**		
Ambulance – Air and Ground			
Emergency		**X**	
Inter-facility Transfers (all vehicle types)		**X**	
Amniocentesis			
Facility Component			
Outpatient (if not provided in physician office setting)		**X**	
Professional Component	**X**		
Audiologic			
Diagnostic	**X**		
Biofeedback	**X**		
Blood & Blood Products/Blood Transfusions (including professional component)			
Autologous Blood Donation		**X**	
From Blood Bank		**X**	
Cataract Surgery			
Professional Component	**X**		
Facility Component (Hospital Based Outpatient – Including Implanted Lenses)		**X**	
Facility Component (Ambulatory Surgery Center – Including Implanted Lenses)		**X**	

SERVICES	GROUP	HOSPITAL	PLAN
Chemical Dependency Rehabilitation and Detox (Medicare Covered)			
Professional Component	**X**		
Facility Component		**X**	
Methadone outpatient clinics			**X**
Chemotherapy			
Drugs – Outpatient (Part B)		**X**	
Drugs – Outpatient (Part D)			**Rx**
Professional Component	**X**		
Facility Component		**X**	
Chiropractic (Medicare covered)	**X**		
Dental Services (Medical)			
Professional Component	**X**		
Facility Component		**X**	
Facility Component (Non-Hospital) Based	**X**		
Diabetic Supplies			
Insulin and syringes (Rx Benefit)-see Medication-Outpatient Prescription Drug Benefit			**Rx**
Home Glucose Monitoring Equipment and Supplies)	**X**		
Diagnostic Testing			
Technical Component (Outpatient)	**X**		
Professional Component	**X**		
Durable Medical Equipment (DME)			
Outpatient	**X**		
Emergency Room			
Facility Component		**X**	
Professional Component (including interpretive reports)	**X**		
Endoscopy			
Facility Component		**X**	
Professional Component	**X**		
Family Planning			
Therapeutic Abortion Services, Tubal Ligation, Vasectomy, etc.			
Facility Component		**X**	
Professional Component	**X**		
Fetal Monitoring			
Facility Component		**X**	

SERVICES	GROUP	HOSPITAL	PLAN
Professional Component	X		
Genetic Testing/Counseling	X		
Health Education	X		
Hemodialysis/Dialysis			
Outpatient (Includes drugs per Medicare guidelines)		X	
Professional Component	X		
Home Health Care			
Medicare covered home health services (Including home IV therapy, excluding Part D drugs)		X	
Home Health Supplies (see medical supplies)		X	
Hospice	**Medicare FFS has primary responsibility**		
Hospitalization			
Facility Component (Including pre-admission diagnostic services)		X	
Interpretive Reports	X		
Professional Component (Including hospital-based physicians)	X		
Immunization and Inoculations (Part B)	X		
Immunization and Inoculations (Part D)			**Rx**
Infusion Therapy			
Professional Component	X		
Facility Component		X	
Part B drugs		X	
Part D drugs			**Rx**
Injectables -- (Outpatient) (see also Chemotherapy)			
Part B drugs		X	
Part D drugs			**Rx**
Lithotripsy			
Professional Component	X		
Facility Component		X	
Mammography	X		
Maternity/Obstetrics			
Facility Component		X	
Professional Component	X		
Medical supplies (includes catheters)			

SERVICES	GROUP	HOSPITAL	PLAN
Outpatient	X		
Medication			
Outpatient – Prescription Drug Benefit (Part D)			**Rx**
Outpatient medications (Part B)		X	
Mental Health			
Facility Component (includes Partial Hospitalization)		X	
Professional Component			X
Nuclear Medicine			
Inpatient, Facility Component (therapeutic)		X	
Outpatient, Facility Component	X		
Professional Component	X		
Nutrition			
Nutritional/Dietetic Counseling (Medicare Covered)	X		
Parenteral Nutrients, Supplies, Kits and Pumps			
Part B		X	
Part D			X
Enteral Nutrients, Supplies, Kits and Pumps			
Outpatient			X
Organ Transplants			
Pre Evaluation (All Inclusive)	X		
Organ Acquisition		X	**Medicare FFS for Kidney only**
Transplant Professional Component	X		
Transplant Facility Component (includes organ acquisition)		X	
Post Transplant (up to one year for transplant related services)			
Professional Component	X		
Post Transplant Facility Component (Inpatient)		X	
Post Transplant Facility Component (Outpatient – if provided in physician office setting)	X		
Orthotics and Prosthetics (Medicare Covered)			
Outpatient (Medicare defined coverage applies)		X	
Ostomy Supplies			
Outpatient	X		

SERVICES	GROUP	HOSPITAL	PLAN
Out of Area (Emergent and Urgently Needed Services)			
Facility Component		X	
Professional Component	X		
Outpatient Diagnostic Tests and Services (All Inclusive)	X		
Outpatient Surgery			
Facility Component (Hospital Based)		X	
Facility Component (Freestanding Ambulatory Surgery Center)		X	
Professional Component	X		
Cardiac catheterization and Angiograms (Professional)	X		
Cardiac catheterization and Angiograms (Facility)		X	
Physical Therapy (See Rehabilitation)			
Pain Management			
Professional	X		
Facility (if provided in other than physician office setting)		X	
Physician Visits/Consultations (inclusive of all settings)	X		
Podiatry Services (Medicare covered)	X		
Radiation Therapy			
Professional	X		
Facility, outpatient facility		X	
Radiology Services			
Outpatient, Preoperative, and Inpatient Professional Component	X		
Inpatient (facility component)		X	
Rehabilitation (Short Term e.g.: PT, OT, Speech, Cardiac)			
Outpatient Facility Component	X		
Professional Component	X		
Skilled Nursing Facility (SNF)			
Facility Component (All Inclusive)		X	
Professional Component	X		
Social Services – Medical	X		
Surgically Implanted Devices – All Categories		X	
Vision Care			
Annual routine exam			X
Glasses			X
Lenses and Frames incidental to cataract surgery (Medicare covered)	X		
Screening, Physician Office	X		

SERVICES	GROUP	HOSPITAL	PLAN
Notes:			
1. Financial responsibility is based on Medicare benefit interpretations and limitations.			
2. The symbol "Rx" denotes outpatient prescription drug services.			
Assignment of financial responsibility as outlined in this document is independent of the questions of medical necessity, coverage or benefits.			

ATTACHMENT C
CAPITATION RATES AND RISK SHARING

1. **Capitation Allocation**

1.1 **Allocation of Non-Part D CMS Revenue**. Each month, CalOptima shall allocate both the non-Part D related capitation that CalOptima receives from CMS for Enrollees affiliated with HMO and any applicable premiums that CalOptima charges Enrollees affiliated with HMO (collectively, the "**Total Revenues**") as follows:

Facility and Other Services ("**Hospital Budget**")	xx.x%
Physician Group Capitation Fees	xx.x%
Total paid to HMO	xx.x%

1.2 **MLR**. In accordance with Section 2.3, "Medical Loss Ratio", of the Contract, HMO shall maintain a minimum acceptable loss ratio of eighty-five percent (85%). Should HMO not meet the minimum eighty-five percent (85%) MLR, CalOptima reserves the right to require HMO to return to CalOptima the difference between eighty-five percent (85%) of Capitation Payments and the allowed medical expenses.

1.3 **Personal Care Coordinator**.

1.3.1 In addition to the amounts described above, and contingent on CalOptima Board of Directors' approval, CalOptima will pay HMO, ____dollars and ____cents ($xx.xx), a per Enrollee, per month amount for PCCs. The commencement date, amount, and duration of such PCC capitation payments, if any, will be established by the action of the CalOptima Board of Directors, and will be deemed incorporated herein by reference. Such payments, if any, may be adjusted in accordance with the PCC Reference Manual and are subject to recovery, termination, or offset as provided in this Contract and in the PCC Reference Manual.

1.3.2 HMO acknowledges and agrees that CalOptima may adjust and/or terminate the PCC Capitation Payments in the event HMO fails to comply with the requirements outlined in the PCC component of the model of care (MOC) profile. HMO acknowledges and agrees that CalOptima, in its sole and absolute discretion, may also offset HMO's future PCC Capitation Payments in the event CalOptima determines that HMO has not complied with the requirements set forth in the PCC component of the MOC Profile.

1.4 **Sequestration**. If CMS reduces payment to CalOptima under the CMS Contract by more than two percent (2%) at any time during the Term, CalOptima may, upon written notice to HMO, reduce payment to HMO under this Attachment C by the same percentage that CMS reduced payment to CalOptima. This provision applies each time CMS reduces payment to CalOptima by more than two percent (2%) during the Term.

1.5 **Pay-for-Performance Program**. CalOptima will develop a pay-for performance program to provide incentive payments to HMO. Payments will be calculated and paid quarterly and annually based on a per Enrollee, per month rate and reflect achievement of specified program goals, which are determined by CalOptima in its sole discretion.

ATTACHMENT D
CLAIMS PROCESSING AND COMPLIANCE OBLIGATIONS

XV. DEFINITIONS

15.1 "**Clean Claim**" means one that can be processed without obtaining additional information from the provider of the service or from a third party. Clean claim shall have the same meaning as "complete claim" as that term is defined in Title 28, CCR Section 1300.71(a)(2). Clean Claim does not include a claim from a Provider who is under investigation for fraud or abuse, or a claim under review for Medical Necessity.

15.2 "**Unclean Claim**" means any claim other than as defined in Section 1.1 of this attachment.

15.3 "**Denied Claim**" means a claim where (a) one or more services will not be paid by HMO and (b) payment is the responsibility of the Enrollee. Examples of claims that are not denials and should not be reported, submitted, or presented to CalOptima as Denied Claims include claims:

15.3.1 For patients who remain enrolled with CalOptima but have transferred to another HMO and HMO is forwarding the claim,

15.3.2 For which payment responsibility belongs to another contracting entity, and HMO is forwarding the claim,

15.3.3 That are duplicates,

15.3.4 That are encounter only/capitated claims and no patient liability is involved, and

15.3.5 That involve reduced payment amounts due to contract terms or allowed Medicare fee schedules.

XVI. GENERAL TERMS

16.1 **HMO Claims Processing**. HMO shall process claims for Provider services according to all CMS requirements and, as applicable, in accordance with the requirements of the Knox-Keene Act. This Attachment D is intended to comply with all DMHC and CMS standards and requirements. Should this Attachment D be out of compliance with any existing or newly enacted DMHC or CMS standard or requirement, the DMHC and/or CMS standard or requirement will supersede this Attachment D. CalOptima will communicate any changes in requirements to HMO in writing.

16.2 If HMO enters into a contract with a Downstream Entity whereby the responsibility for claims processing is delegated to that Downstream Entity, Attachment D provisions shall apply. HMO will have contractual provisions to ensure such Downstream Entity conforms to all DMHC and CMS requirements and oversight provisions as outlined herein and in CalOptima Policies.

16.3 HMO and any applicable Downstream Entity shall be required to have an oversight program for claims processing that includes written policies and procedures, a process for reporting fraudulent or unethical conduct, and an executive accountable for review of claims data and attesting to its accuracy. The oversight program shall include internal auditing of claims functions, and self-reporting as outlined in CalOptima Policies.

XVII. CLAIMS PROCESSING

17.1 **Timely Provider Payments**.

17.1.1 HMO and Downstream Entities, if, and as applicable, must make timely payments to Participating Providers consistent with 42 CFR § 447.45.

17.1.2 HMO shall reimburse Clean Claims, or any portion of any Clean Claim, for Covered Services, as soon as practical, but no later than thirty (30) calendar days after receipt of the claim by HMO, unless the claim or portion thereof is reasonably contested, in which case the claimant shall be notified in writing that the claim is contested or denied within forty-five (45) business days after receipt of the claim by HMO in accordance with CalOptima Policies.

17.1.3 HMO must ensure that ninety percent (90%) of claims from Providers who are in individual or group practice, which can be processed without obtaining additional information from the Provider or from a third party, will be paid within thirty (30) days of the date of receipt of the claim.

17.1.4 HMO must ensure that ninety-nine percent (99%) of all Clean Claims from Providers for Covered Services will be paid within ninety (90) days of the date of receipt of the claim.

17.1.5 Generally, the date of receipt is the date the HMO receives the claim, as indicated by its date stamp on the claim. The date of payment is the date of the check or other form of payment.

3.1.6 **"30-Day" Claim Timeliness**. HMO shall adjudicate nine-five percent (95%) of all Clean Claims from Non-Participating Providers or suppliers within thirty (30) calendar days of receiving the claim. Adjudicate a claim shall be deemed to mean to have processed the claim (paid or denied) and mailed the remittance advice by the thirtieth (30^{th}) calendar day since the earliest receipt by HMO or CalOptima's contracting Providers or Hospitals.

17.1.7 **"60-Day" Claim Timeliness**. HMO shall pay or deny Unclean Claims from Non-Participating Providers or suppliers, claims from Participating Providers or suppliers, and claims from Medicare fiscal intermediaries and carriers within sixty (60) calendar days of receipt of such claims. Processing shall be deemed to mean either to have paid or denied and mailed the remittance advice by the sixtieth (60^{th}) calendar day since the earliest receipt by HMO or CalOptima's contracting Providers or Hospitals, or to have denied the claim, and have mailed the denial letter to the Enrollee by the sixtieth (60^{th}) day. In accordance with federal law and CMS regulations, failure to process such claims within sixty (60) calendar days of receipt automatically constitutes an "adverse" initial determination, which the Enrollee may appeal; thus, a denial notice must be mailed to the Enrollee.

17.1.8 **Payment Accuracy**. When paying Non-Participating Providers, HMO shall employ only those Medicare fee schedules that MA plans are allowed to use by law and shall comply with 42 CFR § 422.214.

17.1.9 **Denied Claims**. Decisions to deny claims that result in liability for the Enrollee must be made in accordance with CMS guidelines. Whenever such decisions are made, the currently CMS approved Notice of Denial of Payment or Integrated Denial Notice must be used, including approved denial reasons. Under no circumstances shall HMO deny a claim for the second time as a consequence of responding to a request for reconsideration from an Enrollee; instead, HMO must direct the Enrollee to submit the request directly to

CalOptima as appropriate.

17.2 **Claims for Emergency and Post-Stabilization Services.**

17.2.1 HMO shall not retroactively deny a claim for Emergency Services because the condition, which appeared to be an Emergency Medical Condition, turned out to be non-emergency in nature. HMO shall ensure that its claims processing actions do not conflict with Hospital actions required to comply with the Emergency Medical Treatment and Active Labor Act ("**EMTALA**").

17.2.2 If there is a disagreement between HMO or any Participating Provider and any Non-Participating Provider regarding Medically Necessity of Covered Services in an emergency, the judgment of the attending physician(s) actually caring for the Enrollee at the treating facility shall prevail. HMO may establish relationships with treating facility whereby the HMO may send a Participating Provider with privileges to assume the attending physician's responsibilities to establish treatment or may arrange to have a Participating Provider under contract with HMO agree to accept the transfer of the Enrollee after the Enrollee has been Stabilized.

3.2.3 HMO shall ensure that an enrollee with an Emergency Medical Condition will be seen on an emergency basis and that Emergency Services will be available and accessible within the Service Area twenty-four (24) hours a day. HMO shall cover Emergency Services without prior Authorization pursuant to Title 28 CCR Section 1300.67(g), Title 22 CCR Section 53216, and Section 1932(b)(2) of the Social Security Act. HMO shall coordinate access to Emergency Services in accordance with 42 CFR § 438.114 and the HMO's emergency department protocol.

3.2.4 HMO may not refuse to cover Emergency Services based on the emergency room Provider, Hospital, or fiscal agent not notifying the Enrollee's PCP managed care organization, prepaid ambulatory health plan, prepaid inpatient health plan or applicable State entity of the Enrollee's screening and treatment within ten (10) calendar days of presentation for Emergency Services. An Enrollee who has an Emergency Medical Condition may not be held liable for payment of subsequent screening and treatment needed to diagnose the specific condition or Stabilize the Enrollee.

3.2.5 HMO may not deny payment for treatment obtained under either of the following circumstances: an Enrollee had an Emergency Medical Condition, including cases in which the absence of immediate medical attention would not have had the outcomes specified in the definition of an Emergency Medical Condition; or the HMO representative instructs the Enrollee to seek Emergency Services. The attending emergency Physician, or the Provider actually treating the Enrollee, is responsible for determining when the Enrollee is sufficiently Stabilized for transfer or discharge, and that determination is binding on the entities as responsible for coverage and payment.

3.2.6 HMO must cover and pay for Post-Stabilization Care Services. HMO is financially responsible for Post-Stabilization Care Services obtained within or outside the organization that are pre-approved by a HMO Provider or other HMO representative. HMO is financially responsible for Post-Stabilization Care Services obtained within or outside the HMO organization that are not pre-approved by a Participating Provider or other HMO representative, but are administered to maintain the Enrollee's Stabilized condition within one (1) hour of a request to the HMO for pre-approval of further Post-Stabilization Care

Services. HMO is financially responsible for Post-Stabilization Care Services obtained from within or outside the HMO that are not pre-approved by a Participating Provider or other HMO representative, but administered to maintain, improve, or resolve the Enrollee's Stabilized condition if the HMO: does not respond to a request for pre-approval within one (1) hour; cannot be contacted; or the HMO representative and the treating physician cannot reach an agreement concerning the Enrollee's care and a Participating Provider is not available for consultation. In this situation, the HMO must give the treating Physician the opportunity to consult with a Participating Provider and the treating Physician may continue with care of the Enrollee until a Participating Provider is reached or one criteria in 42 C.F.R. § 113(c)(3) is met. HMO must limit charges to Enrollees for Post-Stabilization Care Services to an amount no greater than what the HMO would charge the Enrollee if he or she had obtained the services through HMO. HMO financial responsibility for Post-Stabilization Care Services it has not pre-approved ends when: a Participating Provider with privileges at the treating Hospital assumes responsibility for the Enrollee's care; a Participating Provider assumes responsibility for the Enrollee's care through transfer; HMO representative and the treating Physician reach an agreement concerning the Enrollee's care; or; the Enrollee is discharged.

17.2.7 HMO shall reimburse those Physicians providing Emergency Services and Urgent Care services with whom HMO has a contract according to the terms of that contract.

17.2.8 HMO must reimburse a Non-Participating Provider for Emergency Services or Urgent Care services at the prevailing Medicare fee-for-service ("**FFS**") rate as applicable for that service. Where the Covered Service would traditionally be covered under Medicare FFS, the Medicare FFS rate applies. HMO shall ensure that Enrollees maintain balance billing protections as provided in Section 6.4 of this Contract.

3.2.9 In accordance with CalOptima Policies, HMO shall implement the CMS Quality Payment Program known as the Merit-based Incentive Payment System ("**MIPS**"). MIPS adjustments for Part B covered professional services furnished by MIPS-eligible Providers that are not contracted with HMO shall be administered in the same manner as any other changes in the applicable Medicare payment schedules. HMO shall make positive and negative payment adjustments as identified by CMS based on the CMS MIPS adjustment data files.

3.2.9.1 CalOptima or HMO may apply MIPS payment adjustments either at the time the payment is made during the applicable MIPS payment year or as a retrospective adjustment to paid claims.

3.2.9.2 CalOptima or HMO are required to demonstrate payment through reporting or attestation by the end of March on an annual basis.

17.3 **HMO Financial Responsibility**. If CalOptima receives a claim for Covered Services that are the financial responsibility of HMO, CalOptima shall forward such claim to HMO for payment, in accordance with the procedures set forth in Title 28 CCR Section 1300.71, "Claims Settlement Practices." CalOptima shall not pay for services that are HMO's financial responsibility unless HMO fails to make payment within the time allowed by State and federal laws and regulations, and CalOptima is required by law to make such payment. In such cases, CalOptima, after written notice to HMO and reasonable opportunity to cure, will make payment, and HMO shall reimburse CalOptima for such payments. If HMO fails to reimburse CalOptima, CalOptima may offset an

uncontested payment(s) against Capitation Payments or other amounts due from CalOptima to HMO, if any.

17.4 **Collection of Share of Cost**. HMO shall collect Medicare share of cost unless prohibited under this Contract.

17.5 **Capitation Payments**. HMO and/or Downstream Entities shall distribute monthly Capitation Payments to capitated Participating Providers within fifteen (15) calendar days following the date on which Physician receives payment from CalOptima.

17.6 **Claims Adjudication**. Except as provided in Section 3.1.1, HMO shall accept and adjudicate claims for Covered Services provided to Enrollees in accordance with the provisions of Sections 1371, 1371.1, 1371.2, 1371.22, 1371.35, 1371.36, 1371.37, 1371.38, 1371.4 and 1371.8 of the California Health & Safety Code, and Sections 1300.71, 1300.71.38, 1300.71.4, and 1300.77.4 of Title 28 of the CCR and CalOptima Policies. Waiver of any right or obligation specific to the Health and Safety Code and Title 28 related to claims processing and payment shall be prohibited.

17.7 **Dispute Resolution.** HMO shall establish and maintain a fair, fast and cost-effective dispute resolution mechanism to process and resolve provider disputes in accordance with the provisions of Sections 1371, 1371.1, 1371.2, 1371.22, 1371.35, 1371.36, 1371.37, 1371.38, 1371.4 and 1371.8 of the California Health & Safety Code, and Sections 1300.71, 1300.71.38, 1300.71.4, and 1300.77.4 of Title 28 of the CCR and CalOptima Policies.

17.8 **Right of Appeal**. HMO shall afford Providers an unconditional right of appeal and de novo review for claims disputes involving issues of Medical Necessity. Any Provider that submits a claim dispute to HMO's dispute resolution mechanism involving an issue of Medical Necessity or utilization review shall have an unconditional right of appeal for that claim dispute to CalOptima's dispute resolution process for a de novo review and resolution for a period of sixty (60) working days from Physician's Date of Determination.

17.9 **CalOptima Payment On Behalf Of Physician**. If CalOptima receives a copy of an unpaid Clean Claim as part of a Provider grievance that is thirty (30) working days old or more, CalOptima will follow all notification and acknowledgement procedures pursuant to CalOptima Policies. If HMO does not either notify CalOptima that the claim is reasonably contested, as set forth in CalOptima Policies, or pay the Clean Claim within the thirty (30) working day period, CalOptima shall pay the Claim on behalf of Physician, plus interest, as required by the Knox-Keene Act, and deduct the amounts reimbursed, plus processing costs, from the Capitation Payment, in accordance with CalOptima Policies.

17.10 **Quarterly Claims Payment Performance Report.**

17.10.1 HMO shall submit, in a format specified by CalOptima Policies, a quarterly claims payment performance report ("**Quarterly Claims Report**") to CalOptima within thirty (30) calendar days of the close of each calendar quarter. The Quarterly Claims Report shall, at a minimum, disclose HMO's compliance status with Sections 1371, 1371.1, 1371.2, 1371.22, 1371.35, 1371.36, 1371.37, 1371.4, and 1371.8 of the California Health and Safety Code and Sections 1300.71, 1300.71.38, 1300.71.4 and 1300.77.4 of Title 28 of the CCR.

17.10.2 HMO shall ensure that each Quarterly Claims Report is signed by, and includes the written verification of, a principal officer, as defined by Section 1300.45(o) of Title 28 of the CCR,

of HMO, stating that the report is true and correct to the best knowledge and belief of the principal officer.

17.10.3 HMO's Quarterly Claims Report shall include a tabulated record of each Provider dispute it received, categorized by date of receipt, and including the identification of the Provider, type of dispute, disposition and working days to resolution, as to each Provider dispute received. Each individual dispute contained in a Provider's bundled notice of Provider dispute shall be reported as a separate dispute to CalOptima.

17.11 **Forwarding of Misdirected Claims.**

17.11.1 HMO shall have the ability to receive a standard ANSI 837I and ANSI 837P claim file format for retrieving misrouted claims that are the financial responsibility of the HMO. HMO will receive and forward misdirected claims per CalOptima Policy.

17.11.2 HMO shall have the ability to create a standard ANSI 837I and ANSI 837P claim file for forwarding claims that are the financial responsibility of CalOptima within ten (10) working days of receipt of the claim. CalOptima shall receive these files per CalOptima policy and load them into its system to ensure timely claims processing. HMO shall forward any claims that are not its payment responsibility to CalOptima within eight (8) calendar days of receipt, so that a total of only ten (10) working days will elapse prior to the claims being in the proper hands.

17.12 **Assumption of Delegated Functions**. In the event that HMO fails to timely and accurately reimburse its claims (including the payment of interest and penalties), CalOptima may, at its sole discretion, revoke the delegation and assume responsibility from HMO for claims payment, or terminate this Contract as provided for in Article XI. CalOptima's assumption of responsibility for the processing and timely reimbursement of Provider claims may be altered to the extent that HMO has established an approved CAP consistent with Section 1375.4 (b)(4) of the Health and Safety Code and Section 11.3 of the Contract.

17.13 **Recoupment for Assumption of Claims Processing Obligations**. CalOptima, in its sole and absolute discretion, may reduce HMO's Capitation Payments to recoup additional administrative costs for the assumption of the claims processing obligations of HMO, as described in this Article III of Attachment D, as well as any amounts, including interest due, on claims unpaid at the assumption of such obligations by CalOptima.

XVIII. CLAIMS COMPLIANCE

18.1 **Claims Compliance Monitoring**. HMO understands that claims compliance programs are required by CalOptima's Regulators and agrees that delegation is contingent upon HMO's compliance with required monitoring and oversight activities, as outlined in CalOptima Policies. HMO agrees that CalOptima reserves the right to monitor HMO's claims compliance activities, notwithstanding any other audit, compliance, or contractual issue between HMO and CalOptima. In the event HMO demonstrates an inability to meet CalOptima's claims payment standards, CalOptima reserves the right to revoke and assume the delegated responsibilities described above.

18.2 **Claims Non-Compliance**. In the event that CalOptima determines that HMO is not in ninety-five percent (95%) compliance with any of the requirements of Attachment D the following actions will be applied:

18.2.1 Within thirty (30) days of an audit that documents non-compliance, CalOptima will issue a written warning to HMO that describes the non-compliance. HMO will respond within fifteen (15) working days of receiving the non-compliance notification with a written CAP to comply. Such CAP will describe the actions to be taken and the schedule by which those actions will be completed. CalOptima will review the CAP and advise HMO whether or not actions or time schedules are acceptable within fifteen (15) days of receiving it. CalOptima will conduct a follow-up audit of HMO's claims operation within ninety (90) days from the date of serving the non-compliance notification to verify compliance with Attachment D. If CalOptima does not receive a CAP within fifteen (15) calendar days, the consequences outlined in Subsection 4.2.2 of this attachment for continued non-compliance will apply.

18.2.2 If, as a result of CalOptima's follow-up audit, HMO is found to still be non-compliant with Attachment D within fifteen (15) calendar days of making that determination, CalOptima will notify HMO in writing of the continued non-compliance and may elect to provide consultative or other assistance to help establish, maintain and monitor continued administrative compliance or assume "joint administration" of HMO's claims operations, involving itself only with Enrollees' claims and allowing the operation to remain on HMO's premises. The Parties agree to meet and develop a mutually agreeable work plan for added staffing and work stations, the cost of which will be HMO's sole responsibility. CalOptima will develop a CAP with HMO's participation to assure maximum compatibility with HMO's ongoing operations. CalOptima will cooperate with HMO in implementing changes across all risk claims processed at that site, should HMO so request. Within fifteen (15) calendar days of receiving the second notice of non-compliance, HMO will provide a written response stating the specific action to be taken to establish compliance with the help of CalOptima. If CalOptima does not receive a CAP within fifteen (15) calendar days, the consequences outlined in Subsection 4.2.3 for continued non-compliance will apply. Within ninety (90) days from the date of serving the second notice of non-compliance, CalOptima will re-audit HMO's claims process and documents to determine final compliance or non-compliance.

18.2.3 If, as a result of its second follow-up audit, CalOptima reasonably determines that HMO is still non-compliant, CalOptima reserves the right to terminate this Contract for material breach upon ten (10) days' prior written notice and opportunity to cure.

18.2.4 HMO may resume sole administrative responsibility for claims processing if CalOptima determines that HMO has corrected the deficiencies that caused the non-compliance, and, as a result of resuming responsibility for claims processing, demonstrates compliance with the timely provider payments requirements set forth in Section 3.1 of this Attachment D.

18.2.5 With respect to the requirements of Attachment D, HMO will be subject to regular site-audits conducted by CalOptima to monitor all claims requirements.

V. CLAIMS FORWARDING

HMO shall forward any claims that are not its payment responsibility to CalOptima within ten (10) calendar days of receipt.

VI. SELF-MONITORING & REPORTING

HMO shall develop, implement and demonstrate upon request, a claims quality assurance process, including regular, scheduled, automated, or manual reports, self-testing procedures, and internal reporting to HMO's executive management of timeliness, payment accuracy, and denial accuracy (as required herein). Such self-monitoring and internal reporting shall involve use of industry standard tools and shall measure actual performance against the standards for DMHC and CMS compliance. CalOptima strongly recommends check issuance and mailing occur not less frequently than weekly and that HMO's internal reporting intervals match the intervals at which checks are issued, except that weekly reporting would be sufficient if checks are issued more often than weekly. At a point early in the beginning of operations under the Contract and in accordance with industry-wide CMS requirements, CalOptima will require that HMO submit monthly reports to CalOptima using the industry-standard Monthly Report of Claims Processing Timeliness and Overall Percent of Denial Accuracy format. Those reports must be received by CalOptima not later than the fifteenth (15th) calendar day of each month.

VII. AUDITS & AUDIT PREPARATION

Article IV, above, provides detailed, specific processes involving claims non-compliance. Even when HMO does meet compliance standards and successfully concludes any time periods where denials must be submitted to CalOptima for review, CalOptima will continue to schedule (1) periodic audits, (2) random, focused audits, and (3) focused reviews based on appeals and grievance results to monitor HMO's compliance with CMS regulations. Prior to the scheduled arrival of CalOptima's auditor, HMO shall retrieve claims and related documents in accordance with instructions provided to HMO by CalOptima in its letter confirming the appointment.

VIII. SPECIAL STUDIES

8.1 In the event DMHC and/or CMS requires that CalOptima conduct any special compliance study or effort, HMO shall support the study and will be subject to any DMHC and/or CMS specified time schedules or deadlines for corrective actions.

IX. FEDERALLY QUALIFIED HEALTH CENTERS AND RURAL HEALTH CLINICS

9.1 HMO shall meet federal requirements for access to FQHC services, including those in 42 U.S.C. § 1396 b(m). HMO shall reimburse FQHCs and RHCs in accordance with current Laws. If FQHC and RHCs services are not available in the Provider network, HMO shall authorize out-of-network services subject to the prevailing MA payment requirements for out-of-network services.

9.2 HMO shall ensure that its payments to FQHCs and RHCs for services to Enrollees are no less than the sum of the level and amount of payment that the Health Network or CalOptima would make for such services if the services had been furnished by an entity providing similar services that was not an FQHC and RHC. The intent of these provisions is to ensure that HMO pays FQHCs and RHCs amounts consistent with Medicare managed care policies while preserving the opportunity for FQHCs to separately claim supplemental payments under such policies.

X. INDIAN HEALTH CARE PROVIDERS

10.1 HMO shall pay non-network Indian Health Care Providers that are FQHCs for the provision of services to an Indian Enrollee at a rate equal to the rate that HMO would pay to a network FQHC that is not an Indian Health Care Provider, including any supplemental payment from the State to make up the difference between the contract amount and what the Indian Health Care Provider would have received FFS.

10.2 When the amount the Participating Provider Indian Health Care Provider receives from the HMO is less than the amount the Indian Health Care Providers would receive FFS, the State must make a supplemental payment to the Indian Health Care Provider that the Indian Health Care Provider would receive FFS or the applicable encounter rate.

10.3 HMO shall not impose enrollment fees, premiums, or similar charges on Indians served by an Indian Health Care Provider or through referral under contract health services. HMO must exempt from all cost-sharing any Indian who is currently receiving or has ever received an item or service furnished by an Indian Health Care Provider or through referral under contract health services.

10.4 HMO shall reimburse Indian Health Care Providers promptly who provide Covered Services to Indian Enrollees, who are eligible to receive Covered Services, at the most current and applicable outpatient per-visit rate published in the Federal Register by the Indian Health Service, and HMO shall ensure any retroactive outpatient per visit rates are appropriately reimbursed to the Indian Health Care Provider.

ATTACHMENT E
STATUTORY AND REGULATORY COMPLIANCE TERMS

1. **Compliance with State and Federal Laws**. HMO acknowledges that CalOptima is subject to certain State and federal laws, regulations, and instructions governing its MA Program. HMO shall comply with all Laws and DMHC and CMS administrative bulletins, plan letters and instructions. HMO understands that payments made by CalOptima are, in whole or in part, derived from federal funds, and therefore HMO and any Downstream Entities are subject to certain laws that are applicable to individuals and entities receiving federal funds, including the following: (i) Title VI of the Civil Rights Act of 1964; (ii) Sections 503 and 504 of the Rehabilitation Act of 1973; (iii) the Age Discrimination Act of 1975; (iv) the Americans with Disabilities Act of 1990; (v) the Vietnam Era Veteran's Readjustment Assistance Act; and (vi) Title IX of the Education Amendments of 1972. Any provision required to be in this Contract by the CMS Contract, the Knox-Keene Act, Title 28 of the California Code of Regulations, Medicare laws and regulations, DMHC or CMS instructions and reporting requirements and other applicable laws, shall bind CalOptima, HMO, and Downstream Entities, whether or not specifically set forth in this Contract.

2. **Compliance with CalOptima's Contractual Obligations**. All services and other activities furnished by HMO and Downstream Entities must be performed in accordance with CalOptima's contractual obligations to CMS.

3. **Compliance with FWA Requirements**. HMO, and its employees, agents and Downstream Entities performing services under this Contract, shall comply with CalOptima's Compliance Program including, its FWA plan. Prior to performing services under this Contract, HMO shall complete and submit to CalOptima, any CMS-required training and/or CalOptima-required attestations related to such training and other compliance obligations. HMO agrees to comply and will have any Downstream Entity agree to comply with CalOptima standards and policies.

4. **Fraud and Abuse Reporting**. HMO shall, in accordance with all Laws, report to CalOptima all cases of suspected fraud and/or abuse relating to the rendering of Covered Services within five (5) days of the date when HMO first becomes aware of or is on notice of such activity.

5. **CMS Participation Requirements**. HMO represents and warrants that: (i) neither HMO nor any of its HMO Physician, employees or agents furnishing services under this Contract are excluded from participating in any federal or state healthcare program as defined in 42 U.S.C. Section 1320a-7b(f) ("**Federal Health Care Program(s)**"); (ii) HMO has not arranged or contracted (by employment or otherwise) with any employee, contractor or agent that HMO knows or should know are excluded or precluded from participation in Federal Health Care Programs; (iii) no action is pending against HMO or any of its HMO Physicians, employees, or agents performing services under this Contract to suspend or exclude such persons or entities from participation in any Federal Health Care Program; and (iv) HMO will immediately notify CalOptima if it learns that it is or has employed or contracted with a person or entity that is excluded from participation in any Federal Health Care Program. If HMO fails to comply with this Section 5 of this attachment, CalOptima reserves the right to require HMO to pay immediately to CalOptima the amount of any sanctions or other penalties that may be imposed on CalOptima by CMS for violation of this prohibition, and HMO shall be responsible for any resulting overpayments. HMO shall not make payment for a healthcare item or service furnished by an individual or entity that is excluded by the Office of the Inspector General or is included on the Preclusion List. HMO shall provide written notice to the Enrollee who received the services and the excluded Provider or Provider listed on the Preclusion List that payment will not be made, in accordance with CMS requirements. HMO shall ensure that

all Participating Providers that provide Covered Services do not appear on the CMS Preclusion List in order to receive reimbursement for claims or otherwise participate in the Medicare program.

6. **Confidentiality of Enrollee Information**. HMO, its Downstream Entities, and their employees and agents shall comply with the specific confidentiality obligations set forth below.

6.1 HMO, Downstream Entities, and their employees and agents 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 them as a result of services performed under this Contract, except for statistical information not identifying any such person. HMO, Downstream Entities, and their employees and agents shall not use such identifying information for any purpose other than carrying out HMO's obligations under this Contract.

6.2 HMO, Downstream Entities, and their employees and agents shall promptly transmit to CalOptima all requests for disclosure of such identifying information not emanating from the Enrollee. HMO shall not disclose, except as otherwise specifically permitted by this Contract or authorized by the Enrollee, any such identifying information to anyone other than CMS, DMHC, 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.

6.3 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*., Welfare and Institutions Code Section 14100.2, and regulations adopted thereunder. For the purpose of this Contract, all information, records, data, and data elements collected and maintained for the operation of the Contract and pertaining to Enrollees shall be protected by HMO from unauthorized disclosure. HMO may release Medical Records in accordance with Laws pertaining to the release of this type of information. HMO is not required to report requests for Medical Records made in accordance with Laws.

6.4 With respect to any identifiable information concerning an Enrollee under this Contract that is obtained by HMO or its Downstream Entities from CalOptima's Regulators, HMO will, at the termination of this Contract, return all such information to CalOptima's Regulators if required by them, or maintain such information according to written procedures provided to HMO by CalOptima and/or CalOptima's Regulators for this purpose.

7. **Offshore Subcontracts**. HMO shall provide, and ensure that Downstream Entities provide, to CalOptima information and attestations related to the provision of any services under this Contract in a country other than the United States ("**Offshore Subcontractor**") to enable CalOptima to comply with CMS reporting obligations. Such information shall be submitted to CalOptima prior to engaging any Offshore Subcontractor for purposes of this Contract, and such Offshore Subcontractors are subject to approval by CalOptima.

8. **Required Disclosures**. In accordance with 42 CFR Section 1002.3, HMO shall immediately notify CalOptima in the event any sanctioned person (as defined in 42 CFR Section 1001.1001(a)(1)) owns or controls HMO.

9. **Equal Opportunity**. HMO and Downstream Entities shall comply with the following Equal Opportunity requirements set forth below.

9.1 HMO and its Downstream Entities 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. HMO and its Downstream Entities will take affirmative action to ensure that qualified applicants are employed, and that employees are treated during employment, without regard to their race, color, religion, sex, national origin, physical or mental handicap, disability, age, or status as a disabled veteran or veteran of the Vietnam era. Such action shall include the following: Employment, upgrading, demotion or transfer; recruitment or recruitment advertising; layoff or termination; rates of pay or other forms of compensation; and career development opportunities and selection for training, including apprenticeship. Physician and its Downstream Entities agree to post in conspicuous places, available to employees and applicants for employment, notices to be provided by the federal government, 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 HMO and its Downstream Entities' 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.

9.2 HMO and its Downstream Entities will, in all solicitations or advancements for employees placed by or on behalf of HMO and its Downstream Entities, 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.

9.3 HMO and its Downstream Entities will send to each labor union or representative of workers with which it has a collective bargaining agreement or other contract or understanding a notice, to be provided by the federal government or the State, advising the labor union or workers' representative of HMO and its Downstream Entities' commitments under the provisions herein and shall post copies of the notice in conspicuous places available to employees and applicants for employment.

9.4 HMO and its Downstream Entities 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.

9.5 HMO and its Downstream Entities 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 HMO 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.

9.6 In the event of HMO and its Downstream Entities' noncompliance with the requirements of the provisions herein or with any federal rules, regulations, or orders which are referenced in this Article IX, this Contract may be cancelled, terminated, or suspended in whole or in part, and HMO and its Downstream Entities may be declared ineligible for further State and Federal 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.

9.7 HMO and its Downstream Entities will include the provisions of Sections 10.1 through 10.7 of this attachment 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. Section 4212) of the Vietnam Era Veteran's Readjustment Assistance Act, so that such provisions will be binding upon each Downstream Entity. Physician and its Downstream Entities will take such action with respect to any subcontract or purchase order as the Director of the Office of Federal Contract Compliance Programs or CMS may direct as a means of enforcing such provisions, including sanctions for noncompliance; provided, however, that in the event HMO and/or its Downstream Entities become involved in, or are threatened with litigation by a other Downstream Entity or vendor as a result of such direction by CMS, HMO and its Downstream Entities may request in writing to CMS, 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.

10. **Non-Discrimination**. HMO and Downstream Entities shall comply with the non-discrimination requirements set forth below.

10.1 During the performance of this Contract, neither HMO nor any Downstream Entities shall unlawfully discriminate, harass, or allow harassment against any employee or applicant for employment because of sex, race, religion, color, national origin, ancestry, religious creed, physical disability, (including Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS), AIDS-Related Complex (ARC)), medical condition (including cancer), mental disability, marital status, age (over 40), or the use of family and medical care leave and pregnancy disability leave. HMO and Downstream Entities shall insure that the evaluation and treatment of their employees and applicants for employment are free of such discrimination and harassment. HMO and Downstream Entities shall comply with the provisions of the Fair Employment and Housing Act (Government Code, Section 12900, *et seq*.) and the applicable regulations promulgated thereunder (Title 2 CCR Section 7285.0, *et seq*.). The applicable regulations of the Fair

Employment and Housing Commission implementing Government Code, Section 12990, set forth in Chapter 5 of Division 4 of Title 2 of the CCR are incorporated into this Contract by reference and made a part hereof as if set forth in full. HMO and Downstream Entities shall give written notice of their obligations under this clause to labor organizations with which they have a collective bargaining or other agreement. HMO shall include the non-discrimination and compliance provisions of this Section 10.1 in all Downstream Entity subcontracts to perform work under this Contract.

10.2 HMO and all Downstream Entities shall abide by 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 1972 (regarding education programs and activities); Title 45 CFR Part 91 and the Age Discrimination Act of 1975 (discrimination based on age); and all other laws regarding privacy and confidentiality. Neither the Physician nor Downstream Entities shall discriminate against Enrollees because of race, color, creed, religion, ancestry, marital status, sexual orientation, national origin, age, sex, or physical or mental handicap in accordance with Title VI of the Civil Rights Act of 1964, 42 U.S.C., Section 2000d (race, color, national origin); 45 CFR Part 84 (physical or mental handicap); Government Code Section 11135 (ethnic group identification, religion, age, sex, color, physical or mental handicap); Civil Code Section 51 (all types of arbitrary discrimination); rules and regulations promulgated pursuant thereto, or as otherwise provided by Laws.

10.3 For the purpose of this Contract, if based on any of the foregoing criteria, the following constitute unlawful discriminations: (i) denying any Enrollee any Covered Services or availability of a facility; (ii) providing to an Enrollee any Covered Service that is different or is provided in a different manner or at a different time from that provided to other similarly situated Enrollees under this Contract, except where medically indicated; (iii) subjecting an Enrollee to segregation or separate treatment in any manner related to the receipt of any Covered Service; (iv) restricting an Enrollee in any way in the enjoyment of any advantage or privilege enjoyed by others receiving any Covered Service; or (v) treating an Enrollee differently from others similarly situated in determining compliance with admission, enrollment, quota, eligibility, or other requirements or conditions that individuals shall meet in order to be provided any Covered Service or assigning the times or places for the provision of Covered Services.

10.4 HMO shall take affirmative action to ensure that all Enrollees are provided Covered Services without unlawful discrimination, except where medically indicated. For the purposes of this Section 10.4, physical handicap includes the carrying of a gene that may, under some circumstances, be associated with disability in that person's offspring, but which causes no adverse effects on the carrier. Such genetic handicap shall include, but not be limited to, Tay-Sachs trait, sickle cell trait, thalassemia trait, and X-linked hemophilia.

10.5 Physician shall act upon all complaints alleging discrimination against Enrollees in accordance with CalOptima's Policies and shall forward copies of all such grievances to CalOptima within five (5) days of receipt of same.

11. **Smoke Free Workplace**. Public Law 103-227, also known as the Pro Children Act of 1994 ("**Pro Children Act**"), requires that smoking not be permitted in any portion of any indoor facility owned

or leased or contracted for by an entity and used routinely or regularly for the provision of health, day care, early childhood development services, education, or library services to children under the age of 18, if the services are funded by federal programs either directly or through state or local governments, by federal grant, contract, loan, or loan guarantee. The law also applies to children's services that are provided in indoor facilities that are constructed, operated, or maintained with such federal funds. The law does not apply to children's services provided in private residences; portions of facilities used for inpatient drug or alcohol treatment; service providers whose sole source of applicable federal funds is Medicare or Medicaid; or facilities where WIC coupons are redeemed. Failure to comply with the provisions of the law may result in the imposition of a civil monetary penalty of up to $1,000 for each violation and/or the imposition of an administrative compliance order on the responsible party. By signing this Contract, HMO certifies that it will comply with the requirements of the Pro Children Act and will not allow smoking within any portion of any indoor facility used for the provision of services for children as defined by the Pro Children Act. Physician further agrees that it will insert this certification into any subcontracts entered into that provide for children's services as described in the Pro Children Act.

12. **Air or Water Pollution Requirements**. Any federally funded agreement and/or subcontract in excess of $100,000 must comply with the following provisions unless said agreement is exempt under 40 CFR 15.5. HMO 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.

13. **Lobbying Restrictions and Disclosure Certification**. Any federally funded contracts in excess of $100,000 per Section 1352 of the 31, U.S.C. must comply with the following lobby restrictions and disclosures.

13.1 Each person (or recipient) who requests or receives a contract, subcontract, grant, or sub-grant, which is subject to 31 U.S.C. Section 1352 and which exceeds $100,000 at any tier, shall file a certification (in the form set forth in **Attachment E-1**, consisting of one page, entitled "Certification Regarding Lobbying") that the recipient has not made, and will not make, any payment prohibited by Subsection 13.6 of this attachment.

13.2 Each recipient shall file a disclosure (in the form set forth in **Attachment E-2**, entitled "Standard Form-LLL 'Disclosure of Lobbying Activities'") if such recipient has made or has agreed to make any payment using non-appropriated 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 Section 13.6 of this attachment if paid for with appropriated funds.

13.3 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 Section 13.2 of this attachment. An event that materially affects the accuracy of the information reported includes: (i) 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; (ii) a change in the person(s) or individuals(s) influencing or attempting to influence a covered federal action; or (iii) 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.

13.4 Each person (or recipient) who requests or receives, from a person referred to in Section 13.1 of this attachment, a contract, subcontract, grant or sub-grant 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.

13.5 All disclosure forms (but not certifications) shall be forwarded from tier to tier until received by the person referred to in Section 13.1 of this attachment.

13.6 31 U.S.C. Section 1352 provides in part that no appropriated funds may be expended by the recipient of a federal contract, grant, loan, or cooperative agreement to pay any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with any of the following covered federal actions: the awarding of any federal contract, the making of any federal grant, the making of any federal loan, entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any federal contract, grant, loan, or cooperative agreement.

14. **Debarment Certification**. HMO agrees to comply with applicable Federal suspension and debarment regulations including 7 CFR § 3017, 45 CFR §76, 40 CFR § 32, or 34 CFR § 85.

14.1 HMO certifies to the best of its knowledge and belief, that it and its principals:

(i) Are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded by any Federal department or agency;

(ii) Have not within a three (3)-year period preceding this Contract have been convicted of or had a civil judgment rendered against them for commission of fraud or a criminal offense in connection with obtaining, attempting to obtain, or performing a public (Federal, State or local) transaction or contract under a public transaction; violation of Federal or State antitrust statutes or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, or receiving stolen property;

(iii) Are not presently indicted for or otherwise criminally or civilly charged by a governmental entity (federal, State or local) with commission of any of the offenses enumerated in sub-provision (ii) herein;

(iv) Have not within a three (3)-year period preceding this Contract had one or more public transactions (Federal, State or local) terminated for cause or default;

(v) Shall not knowingly enter into any lower tier covered transaction with a person who is proposed for debarment under Federal regulations (i.e., 48 CFR 9, subpart 9.4), debarred, suspended, declared ineligible, or voluntarily excluded from participation in such transaction, unless authorized by the State; and

(vi) Will include a clause entitled, "Debarment and Suspension Certification'' that essentially sets forth the provisions herein, in all lower tier covered transactions and in all solicitations for lower tier covered transactions.

14.2 If HMO is unable to certify to any of the statements in this certification, the Physician shall submit an explanation to CalOptima.

14.3 The terms and definitions in this Section 14 have the meanings set out in the Definitions and Coverage sections of the rules implementing Federal Executive Order 12549.

14.4 If HMO knowingly violates this certification, in addition to other remedies available to the federal government, CalOptima may terminate this Contract for cause or default.

15. **Downstream Entity Contracts**. If any services under this Contract are to be provided by a Downstream Entity subcontracted by HMO, HMO shall ensure that such subcontracts comply with 42 CFR Sections 422.504, 423.505 and 438.6(l). Such subcontracts shall include all language required by CMS as provided in Attachment F**.**

16. **Other Statutory and Compliance Terms**. HMO shall not contract with, or otherwise pay for any items or services (other than an emergency item or service, not including items or services furnished in an emergency room of a Hospital):

16.1 Furnished by HMO by any individual or entity during any period when the individual or entity is excluded from participation under Titles V, XVIII, or XX, or under Title XIX pursuant to sections 1128, 1128A, 1156 or 1842(j)(2);

16.2 Furnished at the medical direction or the prescription of a physician, during the period when such physician is excluded from participation under Titles V, XVIII, or XX, or under Title XIX pursuant to sections 1128, 1128A, 1156, or 1842(j)(2) and when the person furnishing such item or service knew, or had some reason to know, of the exclusion (after a reasonable time period and after reasonable notice has been furnished to the person);

16.3 Furnished by an individual or entity to whom the State has suspended payments to during any period when there is a pending investigation of a credible allegation of fraud against the individual or entity, unless the State determines there is good cause not to suspend such payments;

16.4 HMO may not pay for an item or service with respect to any amount expended for which funds may not be used under the Assisted Suicide Funding Restriction Act of 1997

ATTACHMENT E-1
CERTIFICATION REGARDING LOBBYING

STATE OF CALIFORNIA
DEPARTMENT OF HEALTH CARE SERVICES
CERTIFICATIN 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 HMO	Printed Name of Person Signing for HMO
Contract / Grant Number	Signature of Person Signing for HMO
Date	Title

After execution by or on behalf of HMO, please return to:

CalOptima
Attn: Regulatory Affairs
505 City Parkway West
Orange, California 92868

ATTACHMENT E-2

CERTIFICATION REGARDING LOBBYING

Approved by OMB

Complete this form to disclose lobbying activities pursuant to 31 U.S.C. 1352
0348-0046 (See reverse for public burden disclosure)

<table>
<tr><td>1. Type of Federal Action:
contract
grant
cooperative agreement loan
loan guarantee
loan insurance</td><td colspan="2">2. Status of Federal Action:
bid/offer/application initial
award post-award</td><td>3. Report Type:
initial filing
material change

For Material Change Only:
Year _____ quarter_____
date of last report</td></tr>
<tr><td colspan="2">4. Name and Address of Reporting Entity:
Prime Subawardee Tier, if known:</td><td colspan="2" rowspan="2">5. If Reporting Entity in No. 4 is Subawardee,
Enter Name and Address of Prime:

Congressional District, If known:</td></tr>
<tr><td colspan="2">Congressional District, If known:</td></tr>
<tr><td colspan="2">6. Federal Department/Agency:</td><td colspan="2">Federal Program Name/Description:
CDFA Number, if applicable:</td></tr>
<tr><td colspan="2">8. Federal Action Number, if known:</td><td colspan="2">9. Award Amount, if known:</td></tr>
<tr><td colspan="2">10. a. Name and Address of Lobbying Entity
(If individual, last name, first name, MI):
(attach Continuation Sheets(s)</td><td colspan="2">b. Name and Address of Lobbying Entity
(If individual, last name, first name, MI):
SF-LLL-A, If necessary)</td></tr>
<tr><td colspan="2">Amount of Payment (check all that apply):
$ actual planned</td><td colspan="2" rowspan="3">13. Type of Payment (check all that apply):
a. retainer
b. one-time fee
c. commission
d. contingent fee
e. deferred
f. other, specify:</td></tr>
<tr><td colspan="2">Form of Payment (check all that apply):
a. cash
b. in-kind, specify: Nature</td></tr>
<tr><td colspan="2">Value</td></tr>
</table>

14. Brief Description of Services Performed or to be Performed and Dates(s) of Service, including Officer(s), Employee(s), or Member(s) Contracted for Payment indicated in item 11: (Attach Continuation Sheet(s) SF-LLL-A, If necessary)	
15. Continuation Sheet(s) SF-LLL-A Attached: Yes No	
16. Information requested through this form is authorized by Title 31, U.S.C., Section 1352. This disclosure of lobbying activities is a material representation of fact upon which reliance was placed by the tier above when this transaction was made or entered into. This disclosure is required pursuant to Title 31, U.S.C., Section 1352. This information will be reported to the Congress semiannually and will be available for public inspection. Any person who fails to file the required disclosure shall be subject to a civil penalty of not less than $19,000 and not more than $100,000 for each such failure.	Signature: Print Name: Title: Telephone No.: Date:
Federal Use Only	

INSTRUCTIONS FOR COMPLETION OF SF-LLL, DISCLOSURE OF LOBBYING ACTIVITIES

This disclosure form shall be completed by the reporting entity, whether subawardee or prime federal recipients at the initiation or receipt of a covered federal action, or a material change to a previous filing, pursuant to Title 31, U.S.C., Section 1352. The filing of a form is required for each payment or agreement to make payment to any lobbying entity for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with a covered federal action. Use the SF-LLL-A Continuation Sheet for additional information if the space on the form is inadequate. Complete all items that apply for both the initial filing and material change report. Refer to the implementing guidance published by the Office of Management and Budget for additional information.

Identify the type of covered federal action for which lobbying activity is and/or has been secured to influence the outcome of a covered federal action.

Identify the status of the covered federal action.

Identify the appropriate classification of this report. If this is a follow-up report caused by a material change to the information previously reported, enter the year and quarter in which the change occurred. Enter the date of the last previously submitted report by this reporting entity for this covered federal action.

Enter the full name, address, city, state, and ZIP code of the reporting entity. Include Congressional District, if known. Check the appropriate classification of the reporting entity that designates if it is, or expects to be, a prime or subaward recipient. Identify the tier of the subawardee, e.g., the first subawardee of the prime is the 1st tier. Subawards include but are not limited to subcontracts, subgrants, and contract awards under grants.

If the organization filing the report in Item 4 checks "Subawardee," then enter the full name, address, city, state, and ZIP code of the prime federal recipient. Include Congressional District, if known.

Enter the name of the federal agency making the award or loan commitment. Include at least one organizational level below agency name, if known. For example, Department of Transportation United States Coast Guard.

Enter the federal program name or description for the covered federal action (Item 1). If known, enter the full Catalog of Federal Domestic Assistance (CDFA) number for grants, cooperative agreements, loans, and loan commitments.

Enter the most appropriate federal identifying number available for the federal action identified in Item 1 (e.g., Request for Proposal (RFP) number; Invitation for Bid (IFB) number; grant announcement number; the contract grant, or loan award number; the application/proposal control number assigned by the federal agency). Include prefixes, e.g., "RFP-DE-90401."

For a covered federal action where there has been an award or loan commitment by the federal agency, enter the federal amount of the award/loan commitment for the prime entity identified in Item 4 or 5.

10. (a) Enter the full name, address, city, state, and ZIP code of the lobbying entity engaged by the reporting entity identified in Item 4 to influence the covered federal action.

10. (b) Enter the full names of the Individual(s) performing services and include full address if different from 10.(a). Enter last name, first name, and middle initial (MI).

Enter the amount of compensation paid or reasonably expected to be paid by the reporting entity (Item 4) to the lobbying entity (Item 10). Indicate whether the payment has been made (actual) or will be made (planned). Check all boxes that apply. If this is a material change report, enter the cumulative amount of payment made or planned to be made.

Check the appropriate box(es). Check all boxes that apply. If payment is made through an in-kind contribution, specify the nature and value of the in-kind payment.

Check the appropriate box(es). Check all boxes that apply. If other, specify nature.

Provide a specific and detailed description of the services that the lobbyist has performed, or will be expected to perform, and the date(s) of any services rendered. Include all preparatory and related activity, not just time spent in actual contact with federal officials, identify the federal official(s) or employee(s) contacted or the officer(s), employee(s), or Member(s) of Congress that were contacted.

Check whether or not a SF-LLL-A Continuation Sheet(s) is attached.

The certifying official shall sign and date the form, print his/her name, title, and telephone number.

Public reporting burden for this collection of information is estimated to average 30 minutes per response, including time for reviewing instruction, searching existing data sources, gathering and maintaining the data needed, and completing and renewing the collection of information. Send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to the Office of Management and Budget, Paperwork Reduction Project, (0348-0046), Washington, DC 20503.

ATTACHMENT F
SUBCONTRACT REGULATORY TERMS

A. **General Terms**: Language addressing the following matters shall be included in Downstream subcontracts:

1. The right of CalOptima's Regulators to monitor, audit, evaluate, inspect and have access to books, records and other information as provided in this Contract.
2. CalOptima's Regulators' right to inspect, evaluate, and audit any pertinent information related to the Contract for a period of ten (10) years from the final date of the contract period or from the date of completion of any audit as provided in this Contract.
3. Prohibitions against holding Enrollees liable for payment of any fees that are the obligation of CalOptima or the HMO, as applicable.
4. The services are in accordance with CalOptima's obligations to CMS and applicable CalOptima Policies.
5. The obligations of Downstream Entities to protect Enrollee privacy and confidentiality including health records, as provided in this Contract.
6. The obligation to comply with all federal and state laws, regulations and CMS instructions, including those laws that must be incorporated into such Downstream subcontracts as indicated in this Contract.
7. Language related to the obligations to submit timely and accurate Encounter Data and other data and reports required by CalOptima and CalOptima's Regulators as provided in this Contract and in CalOptima's Policies.
8. All requirements included in Attachment E not expressly addressed herein.

B. **Delegation Terms**. If, and to the extent that sub-delegation is permitted by CalOptima and HMO obtains CalOptima's approval as provided in this Contract, Downstream Entity subcontracts must include:

1. Language that specifies (i) the delegated activities and reporting requirements; (ii) that provides for revocation of the delegated activities and other remedies in the event CalOptima or CalOptima's Regulators find that the delegated party as not performed satisfactorily; (iii) that the performance of the parties is monitored by CalOptima on an ongoing basis; and (iv) that CalOptima may impose corrective action as necessary.
2. If the subcontract relates to credentialing of medical providers, language that the credentials of medical professionals affiliated with the party or parties will either be reviewed by CalOptima or the credential process will be reviewed and approved by CalOptima and that CalOptima must audit the process on an ongoing basis.
3. If the subcontract delegates selection of providers it must include language that CalOptima retains the right to approve, suspend or terminate any such arrangement and that CalOptima shall provide a written statement to a provider of the reason or reasons for the termination with cause.

C. **Medical Provider Downstream Subcontract Terms**.

All subcontracts or arrangements with medical providers shall include provisions addressing:

1. The term of the contract, including the beginning and ending dates as well as methods of extension, renegotiation and termination and full disclosure of the method and amount of compensation or other consideration.

2. The obligation to pay contracted medical providers under the terms of the contract and prompt payment provision, the terms of which are developed and agreed to by the parties.

3. The obligations to provide services in a culturally competent manner to all Enrollees, including those with limited English proficiency or reading skills, and diverse culturally and ethnic background and provide interpreter services for Enrollees at all provider sites.

4. The obligation to (i) abide by all federal and state laws and regulations regarding confidentiality and disclosure of medical records, or other health and enrollment information; (ii) to ensure that medical information is released in accordance with applicable federal or state law, or pursuant to court orders or subpoenas; (iii) to maintain Enrollee records and information in an accurate and timely manner; and (iv) to ensure timely access by Enrollees to the records and information that pertain to them.

5. The obligation to hold CalOptima, CalOptima's Regulators and Enrollees harmless in the event that HMO cannot or will not pay for services performed by the Downstream Entity and for Medicare Part A and B cost sharing. Specifically, Medicare Parts A and B services must be provided at zero cost-sharing to Enrollees.

6. Medical providers' EMTALA obligations and that they must not create any conflicts with hospital actions required to comply with EMTALA.

7. Language prohibiting providers, including PCPs, from closing or otherwise limiting their acceptance of Enrollees as patients unless the same limitations apply to all commercially insured Enrollees.

8. Language that prohibits the Downstream Entity from refusing to contract or pay an otherwise eligible health care Provider for the provision of Covered Services solely because such Provider has in good faith: (a) Communicated with or advocated on behalf of one or more of his or her prospective, current or former patients regarding the provisions, terms or requirements of the 'Downstream Entity's health benefit plans as they relate to the needs of such Provider's patients; or (b) communicated with one or more of his or her prospective, current or former patients with respect to the method by which such Provider is compensated by the Downstream Entity for services provided to the patient.

9. Language that states the Provider is not required to indemnify the HMO for any expenses and liabilities, including judgments, settlements, attorneys' fees, court costs and any associated charges, incurred in connection with any claim or action brought against the HMO based on its management decisions, utilization review provisions or other policies, guidelines or actions.

10. The obligation of the medical provider to assist CalOptima in the transfer of care, including in the transfer of care in the event of sub-subcontract termination for any reason.

11. Acknowledgement that assignment or delegation of the subcontract will be void unless prior written approval is obtained from CMS and CalOptima.

12. 'The Provider's right to submit a grievance and a description of the formal process to resolve the Provider's grievances.

13. The obligation to participate and cooperate in HMO's Quality Improvement System.

14. Language addressing requirements related to payment of Non-Participating Provider emergency and post-stabilization services.

ATTACHMENT G
CMS SPECIFIC PROGRAM PERFORMANCE REQUIREMENTS

1. HCC Coding Requirements and Performance Improvement Activities

1.1 CMS pays CalOptima health-based capitation to compensate CalOptima for services rendered to Enrollees. CMS utilizes encounter data to assign Hierarchical Condition Categories ("**HCC**") to Enrollees. The Enrollee's HCC determines the payment amount received by CalOptima accounting for the variation in expenditures for Medicare Enrollees based on an Enrollee's health status.

1.2 HMO shall submit Enrollee-specific accurate encounter and service data. Encounters are to be submitted no less than monthly using the ANSI 837P and/or 837I format version 5010 as appropriate, or current format as required by CalOptima.

1.3 HMO shall support and aid CalOptima's review of encounters, including to production and/or access of supporting medical records.

1.4 To enhance encounter submission accuracy and completeness, CalOptima has initiated performance improvement activities ("**PIAs**"). These PIAs include Enrollee medical and behavioral health assessments provided in the home or a residential facility.

1.5 HMO has the option to perform these PIAs provided HMO can demonstrate that HMO's PIAs meet all CalOptima standards and guidelines. Should HMO not perform the PIAs or HMO's PIAs not meet CalOptima standards and guidelines as determined by CalOptima, CalOptima shall perform these activities on behalf of HMO and the cost for these PIAs shall be charged to or shared with HMO. CalOptima will provide sixty (60) days' notification prior to taking any such action.

2. ESRD Waiver Responsibilities

2.1 HMO shall demonstrate to CalOptima that HMO administers a CalOptima-approved complex case management program for all End Stage Renal Disease (ESRD) Enrollees, which is in accordance with CMS requirements and CalOptima Policies and standards.

2.2 CalOptima shall advise HMO if its ESRD complex case management program does not meet CMS requirements and CalOptima Policies and clinical standards. If HMO cannot meet requirements as provided by CalOptima, CalOptima shall have the option to de-delegate the HMO for the management of ESRD Enrollees and retain a portion of the Capitation Payment for ESRD Enrollees commensurate with the costs for providing or outsourcing such services.

2.3 CalOptima shall provide notification to HMO of the intent to de-delegate. HMO shall have the opportunity to submit a corrective action plan to CalOptima in accordance with CalOptima policy.

3. Appeals Rights

HMO may appeal CalOptima's decision to take the actions outlined above, by filing a complaint pursuant to CalOptima Policies. If HMO is dissatisfied with the result of any appeal; it shall proceed in accordance with CalOptima's legal claims and judicial review policy.

MEDICARE ADVANTAGE – PHYSICIAN GROUP SERVICES CONTRACT

BETWEEN

ORANGE COUNTY HEALTH AUTHORITY DBA CALOPTIMA

AND

_____

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MEDICARE ADVANTAGE PHYSICIAN GROUP SERVICES CONTRACT

This Medicare Advantage Physician Group Services Contract ("**Contract**") is January 1, 2023 ("**Effective Date**") by and between Orange County Health Authority, a public agency dba CalOptima ("**CalOptima**"), and _____ ("**Physician Group**"), a California professional medical corporation organized under the laws of the State of California. CalOptima and Physician Group may each be referred to herein as a "**Party**" and collectively as the "**Parties**".

RECITALS

A. CalOptima is a County Organized Health System ("**COHS**") organized under Welfare & Institutions Section 14087.54 and Orange County Ordinance No. 3896.

B. CalOptima is licensed as a health care service plan by the California Department of Managed Health Care ("**DMHC**") under the Knox-Keene Health Care Service Plan Act of 1975 and its implementing regulations (collectively the "**Knox-Keene Act**") and authorized to offer a Medicare Advantage ("**MA**") plan pursuant to Title 42 of the United States Code, Chapter 7, Subchapter XVIII, Part C and its implementing regulations for individuals covered under the federal Medicare program.

C. CalOptima, as a dual–eligible special needs plan ("**DSNP**"), may only enroll those dual eligible individuals who meet all applicable Medicare Advantage eligibility requirements, and who are eligible to be enrolled in CalOptima's Medi-Cal Managed Care plan, as described in the contract between CalOptima and the California Department of Health Care Services ("**DHCS**").

D. Physician Group is a duly licensed California professional medical corporation that employs or has entered into contracts with physicians who are licensed to practice medicine in the State of California ("**State**"), and other Providers who are appropriately licensed in the State.

E. CalOptima and Physician Group desire to enter into the Contract whereby Physician Group will perform delegated administrative services and furnish health care items and services as described herein to certain Enrollees enrolled in CalOptima's MA plan.

F. Unless defined elsewhere in the Contract, the defined terms used in this Contract shall have the meanings set forth in Attachment A.

NOW, THEREFORE, in consideration of the promises and the mutual covenants herein stated, it is agreed by and between the Parties as follows:

I. PHYSICIAN GROUP SERVICE OBLIGATIONS

1.1 **Covered Services**. Physician Group shall provide Covered Services to Enrollees selecting, and assigned to, Physician Group in accordance with all provisions of this Contract and CalOptima Policies. The Covered Services that are to be provided by and are the financial responsibility of Physician Group are described in Attachment B. Physician Group specifically agrees to accept financial risk and responsibility for injectables pursuant to Health & Safety Code Section 1375.8.

1.1.1 Physician Group shall provide Covered Services: (i) in the same manner, in accordance with the same standards, and within the same time availability as offered to non-CalOptima

patients; (ii) in accordance with professionally recognized standards of practice, (iii) in a culturally competent manner to all Enrollees, including those with limited English proficiency or reading skills and from diverse cultural and ethnic backgrounds; and (iv) not discriminate in the provision of such Covered Services because of an Enrollee's race, ethnicity, color, national origin, religion, sex, sexual orientation, age, medical or claims history, mental or physical disability, genetic information, or source of payment.

1.1.2 Physician Group is prohibited from closing or otherwise limiting its acceptance of Enrollees as patients unless the same limitations apply to all of its commercially insured patients.

1.1.3 Physician Group shall use its best efforts, where consistent with sound medical practice, to ensure that Covered Services are provided only by Group Physicians and/or other Participating Providers, except in cases of Emergency Services or Urgent Care Services, or if no such Group Physician or Participating Provider is available to perform the appropriate Covered Services.

1.1.4 Physician Group shall be liable for the provision and payment of all Covered Services notwithstanding a delay in payment of the Capitation Payment.

1.1.5 Physician Group acknowledges that the determination of whether a service or supply was/is a Covered Service delegated to Physician Group rests with CalOptima, subject to the Evidence of Coverage and Appeals procedures established by the DMHC and CMS.

1.1.6 CalOptima may incorporate any change in Covered Services mandated by Laws into the Contract effective the date the change goes into effect. Whenever possible, CalOptima shall give the Physician Group thirty (30) calendar days' prior notice of any such change to the Contract. CalOptima shall determine the effective date of the change in Covered Services. Attachment B shall not be amended during the current Term without mutual consent of the Parties, except as may be required for continued compliance with Laws.

1.1.7 Decisions concerning whether to provide or authorize Covered Services under this Contract shall be based solely on Medical Necessity. Physician Group shall not deny Authorization for a Covered Service that the Enrollee or the Provider demonstrates is Medically Necessary. The actual provision of any Covered Service is subject to the professional judgment of the PCP or other physicians and/or Providers participating with Physician Group as to the Medical Necessity of the Covered Service, except that each Physician shall provide assessment and evaluation services ordered by a court or legal mandate. Physician Group acknowledges that disputes between the Physician Group and Enrollees about Medical Necessity can be appealed pursuant to CalOptima Policies and Laws.

1.1.8 Physician Group may not arbitrarily deny or reduce the amount, duration, or scope of a required Covered Service solely because of the diagnosis, type of illness, or condition. Physician Group may place appropriate limits on a service on the basis of criteria such as Medical Necessity or for utilization control, provided the services furnished can reasonably be expected to achieve their purpose and such a limitation complies with Laws.

1.2 **Confidentiality**. Physician Group and CalOptima agree to safeguard the confidentiality of Enrollee information and comply with all Laws (including, but limited to, the Health Insurance Portability and Accountability Act ("HIPAA"), 42 CFR Section 431.300 *et seq*., California Welfare and Institutions Code Section 14100.2, California Civil Code Section 56 *et seq.*, and the California

Information Practices Act, Civil Code Section 1798) regarding the confidentiality and disclosure of Enrollee names, health, enrollment and personal information (including medical and Behavioral Health information contained in Medical Records). Physician Group shall provide counseling to Enrollees on their right to confidentiality and obtain Enrollee consent prior to releasing confidential information unless such consent is not required pursuant to Title 22 CCR Section 51009.

1.3 **Emergency Services and Urgent Care**. Physician Group shall insure that it provides and pays for all Emergency Services and Urgent Care, including those services provided by Non-Participating Providers, without prior Authorization, twenty-four (24) hours each day, seven (7) days a week, in accordance with Laws and CalOptima Policies. Physician Group shall coordinate access to Emergency Services in accordance with CalOptima's emergency department protocol. Physician Group shall ensure adequate follow-up care for those Enrollees who have been screened in the emergency room and require non-Emergency Services. Physician Group may not specify what constitutes an Emergency Medical Condition on the basis of lists of diagnoses or symptoms.

1.4 **Days to Appointment**. Physician Group shall ensure that appointments for non-Emergency Services and non-Urgent Care Covered Services are scheduled within ten (10) business days of the Enrollee's request for PCP and fifteen (15) business days of Enrollee's request for Specialist Physician; that health assessments and general physical examinations and all preventative Covered Services are scheduled within thirty (30) calendar days of Enrollee's request for an appointment, and that, if Physician Group supplies maternity Covered Services, Physician Group shall ensure that the most current standards and guidelines of the American College of Obstetricians and Gynecologists are utilized as the minimum measure of quality for perinatal services. Physician Group shall also have a process in place for follow-up on Enrollee missed appointments.

1.5 **Twenty-Four (24) Hour Physician Group Coverage**. Physician Group shall ensure that it has, at a minimum, two Group Physicians as follows: One (1) Group Physician who is available twenty-four (24) hours a day to authorize Medically Necessary, Post-Stabilization Care Services and coordinate transfer of stabilized Enrollees in an emergency department, if necessary, and one (1) Group Physician available twenty-four (24) hours a day, seven (7) days a week to resolve disputed requests for Authorizations.

1.6 **Clinical Laboratory Improvement Amendments**. Physician Group shall only use laboratories with a Clinical Laboratory Improvement Amendments ("**CLIA**") certificate of waiver or a certificate of registration along with a CLIA identification number.

1.7 **CalOptima Formulary Compliance**. Participating Providers shall comply with the CalOptima Formulary and its associated drug utilization and disease management guidelines and protocols. Requests for items not included in the CalOptima Formulary shall require prior Authorization by CalOptima. The prescribing Physician shall be responsible for obtaining Authorization through CalOptima and/or its designated pharmacy benefit management contractor ("**PBM**"), as appropriate. The prescribing Physician shall provide CalOptima and/or the PBM with all information necessary to process Authorization requests.

1.8 **Enrollee Access**. Physician Group and its Downstream Entities shall comply with all Laws and CalOptima Policies governing Enrollee access to Covered Services.

1.8.1 If Physician Group is unable to provide necessary Covered Services to a particular Enrollee, Physician Group must adequately and timely cover these services with Non-Participating Providers for the Enrollee, for as long as Physician Group is unable to provide them. Physician Group shall make prior arrangements with Non-Participating Providers

for the provision of such services, shall be fully responsible for arranging and paying for such services, and shall comply with all applicable CalOptima Policies with regard to the payment and Authorization of Non-Participating Providers.

1.8.2 Physician Group shall ensure that PCPs as well as Specialty Physicians are located so as to assure sufficient geographic and physical access of Enrollees to such providers as required by Laws and CalOptima Policies.

1.8.3 Physician Group shall ensure that each Enrollee has a PCP who is available and physically present at the service site for sufficient time to ensure access for the assigned Enrollee when medically required. This requirement does not preclude an appropriately licensed professional from being a substitute for the PCP in the event of the PCP's vacation, illness, or other unforeseen circumstances.

1.8.4 Physician Group shall ensure female Enrollees have direct access to a women's health specialist within the network to provide women's routine and preventative health care services. Such access may be in addition to the Enrollee's PCP.

1.8.5 Physician Group shall cover family planning services for all Enrollees whether they are provided by a Participating Provider or Non-Participating Provider.

1.8.6 Physician Group shall reasonably accommodate Enrollees and ensure programs and services are as accessible (including a sufficient number of Providers and geographic access) to an Enrollee with disabilities as they are to an Enrollee without disabilities in accordance with CalOptima Policies. Physician Group's facilities shall comply with the requirements of Title III of the Americans with Disabilities Act of 1990 ("**ADA**") and shall ensure access for the disabled, including, but not limited to, ramps, elevators, restrooms, designated parking spaces, and drinking water provisions. Physician Group shall have policies to ensure that physical, communication and programmatic barriers do not inhibit Enrollees with disabilities from obtaining all Covered Services, including addressing reasonable accommodations required by the CMS Contract and CalOptima Policies. Physician Group will comply with CalOptima Policies and work plan requirements related to ADA compliance relevant to services under this Contract.

1.9 **Provider Network Maintenance**. Physician Group agrees to employ or contract with a sufficient number of Physicians and other Providers representing the range of medical specialties necessary, in the determination of CalOptima, CMS, and the DMHC to ensure Enrollees of reasonable access to the full range of Covered Services.

1.9.1 During the Term, all Participating Providers of Covered Services must: (i) be and remain qualified in accordance with current applicable legal, professional, and technical standards; (ii) be and remain appropriately licensed, certified or registered; (iii) be and remain in good standing with Medicare and not be terminated or suspended from participation in the Medicare and/or Medi-Cal programs; and (v) have a valid NPI number, as applicable. Physician Group shall ensure that PCPs are located so as to assure sufficient geographic and physical access of Enrollees to such Physicians under Laws and CalOptima Policies.

1.9.2 Physician Group shall ensure that Participating Providers have the requisite training and experience in dealing with the medical problems frequently encountered in elderly, disabled, and special needs individuals.

1.9.3 Physician Group shall use primary source verification to confirm the board certification in each clinical specialty area for which the Physician is being credentialed if the Physician lists such board certification on credentialing applications.

1.9.4 Physician Group acknowledges that the requirements of this Section 1.9 apply to each individual Provider who is affiliated with and/or part of any medical group, independent physician associations ("**IPA**"), and/or other organization or entity that contracts with Physician Group to furnish Covered Services to Enrollees.

1.9.5 Physician Group will maintain accurate records, including records detailing the status, membership, and qualifications of the Participating Providers in the Physician Group's network.

1.9.6 If a Provider who seeks to become a Participating Provider is denied a contract with Physician Group or a Participating Provider is suspended or terminated for cause, Physician Group shall provide the Provider with written notice of the reason for the action, as required by Laws, including any standards and profiling data Physician Group used to evaluate the provider, the number and mix of similar health care Providers that Physician Group needs (if applicable), and notice of the Provider's right to appeal the action, including notice of the process and timing to request a hearing. In the event Physician Group terminates a contract with a Participating Provider for deficiencies in the quality of care provided, Physician Group shall give notice of the action to CalOptima, as provided by CalOptima Policies, and to the appropriate licensing and disciplinary bodies, as provided by law.

1.9.7 In the event that a Provider, including a PCP, is terminated or leaves the Physician Group for any reason, Physician Group shall give written notification of termination of such Provider to CalOptima within fifteen (15) days after receipt or issuance of the termination notice.

1.9.8 In the event that a Provider, including a PCP, is terminated or leaves the Physician Group for any reason, Physician Group shall ensure that there is no disruption in services provided to Enrollees who are receiving treatment for a chronic or ongoing medical condition in accordance with applicable Laws.

1.9.9 Physician Group shall notify CalOptima at least sixty (60) days before any significant change in Physician Group's provider network that renders Physician Group unable to provide one or more Covered Services within CalOptima's access to care standards. If such notice is not possible because the providers terminate their participation with less than sixty (60) days' notice or Physician Group terminates the providers without prior notice as a result of their endangering the health and safety of Enrollees, providers committed criminal or fraudulent acts, or providers engaged in grossly unprofessional conduct, then Physician Group shall notify CalOptima immediately upon receipt of notice of the termination, or sending notice to the providers of a Physician Group-initiated termination.

1.9.10 Physician Group shall ensure that no Provider who fails to meet the requirements of this section furnishes items and/or services to Enrollees, submits claims and/or receives reimbursement for any Covered Services.

1.9.11 Physician Group agrees that each Participating Provider with whom Physician Group contracts to provide Covered Services will be required to execute a contract with Physician Group. Such an agreement will require all Participating Providers to comply with those

aspects of this Contract relating to activities of Participating Providers and with Laws, including the standards of accrediting and regulatory agencies governing CalOptima's MA Program, and any and all provisions required by MA regulations. The Physician Group agreement with Participating Providers shall be made available to CalOptima and its regulatory agencies for inspection and copying upon request. Physician Group shall ensure that all contracts with Participating Providers allow for termination of the contract for failure to meet the requirements of this Section 1.9.

1.10 **Enrollment**. Physician Group shall accept as Enrollees all persons indicated as Enrollees by the CalOptima information system and transmitted to Physician Group and shall comply with requirements to provide notices to Enrollees in accordance with CalOptima Policies.

1.11 **Primary Care Physician**. Physician Group agrees that each Enrollee will select or be assigned a PCP. Enrollee must request a PCP assignment from CalOptima's Customer Service department. If the Enrollee has not selected a PCP, CalOptima shall assign the PCP per its policies. Physician Group agrees that it will ensure that the PCP shall be responsible for the provision, coordination, referral, and Authorization of Covered Services in accordance with the utilization management ("**UM**") program and prevailing standards of medical practice so that there is a Physician who has ultimate responsibility for the Enrollee's care management.

1.12 **Physician Group Medical Director**. Physician Group shall designate a Group Physician as Medical Director for purposes of this Contract. The Physician Group Medical Director will be a member of the Physician Group's quality management and UM committee(s) and will be the individual to whom CalOptima communicates regarding provision of professional medical care and quality and/or appropriate utilization of medical services. The Physician Group Medical Director will be the individual responsible for representing Physician Group in the resolution of any Grievances presented to CalOptima by Enrollees related to the provision of medical care.

1.13 **Care Coordination**. CalOptima shall retain the responsibility for the initial HRA and an HRA annually thereafter in accordance with CalOptima Policies, but any update during the course of the year due to change in Enrollee's condition/circumstance would be the responsibility of the Physician Group, per policy. Physician Group shall offer care coordination and case management services to all Enrollees, which shall: (i) include coordination of care across the full continuum of service providers as appropriate to Covered Services under this Contract; (ii) ensure that care coordination services reflect a person-centered, outcome-based approach, consistent with the Model of Care and CalOptima Policies; (iii) follow Enrollee direction about level of involvement of his or her caregivers or medical providers; (iv) include the assignment of a qualified Care Coordinator to each Enrollee needing or requesting one; and (v) reflect access to appropriate community resources with a focus on providing services in the least restrictive setting and transitions between the facilities and the community.

1.14 **Model of Care**. Physician Group shall furnish Covered Services in compliance with CalOptima's Model of Care, including the PCC component, HRA, ICP and ICT requirements.

1.14.1 CalOptima will complete and communicate the HRA to Physician Group. Physician Group shall, upon notification by CalOptima of the need to follow-up on the results of an HRA administered by CalOptima, perform and provide any follow-up required by CalOptima.

1.14.2 Physician Group shall develop an ICP for each Enrollee and engage Enrollees and/or their representative in the design of the ICP in accordance with CalOptima Policies.

1.14.3 Physician Group shall offer an ICT for each Enrollee, as necessary, which will be developed around the Enrollee and integrate medical and LTSS and the coordination of Behavioral Health services. Enrollees shall not be required to participate in the ICT and may opt-out at any time. Enrollees may not be dis-enrolled from the ICT for lack of participation on the ICT. The ICT shall comply with CalOptima Policies.

1.14.4 PCPs and/or the Care Coordinator, in collaboration with CalOptima, will provide basic case management services to Enrollees in accordance with CalOptima's Policies. If the Enrollee has been identified as potentially benefiting from complex case management services, Physician Group shall provide such services to the Enrollee.

1.14.5 Physician Group shall ensure the provision of discharge planning when an Enrollee is admitted to a Hospital or institution and continues into the post-discharge period. Discharge planning shall include ensuring that the necessary care, services, and supports are in place in the community for the Enrollee once he or she is discharged, including scheduling an outpatient appointment and/or conducting follow-up with the Enrollee or caregiver. Physician Group shall comply with CalOptima Policies addressing minimum criteria requirements for discharge planning.

1.15 **Behavioral Health Services Referrals**. Physician Group shall furnish and/or coordinate Behavioral Health services as specified in CalOptima Policies and this Contract.

1.15.1 For Specialty Mental Health Services, Physician Group shall refer Enrollees to CalOptima as the Administrative Service Organization contracted to provide assessment, referral and Authorization services.

1.15.2 For Outpatient Mental Health Services that are within a Physician Group' PCP's scope of practice, Physician Group shall manage according to current appropriate treatment guidelines. If the Outpatient Mental Health Services are outside its PCPs' scope of practice, Physician Group shall refer Enrollees to CalOptima's contracted behavioral health provider.

1.15.3 For Enrollees requiring alcohol or substance use disorder treatment, Physician Group shall manage according to the appropriate PCP treatment guidelines. If the alcohol or substance use disorder treatment are outside its PCPs' scope of practice, Physician Group shall refer Enrollees to CalOptima's contracted behavioral health provider. Coordination of care through the ICT will occur as is specified in CalOptima Policies and this Contract.

1.16 **LTSS Referrals**. Physician Group shall refer Enrollees to CalOptima for LTSS pursuant to CalOptima Policies.

1.17 **Facility Site and Medical Record Reviews**. Physician Group shall participate in, and comply with requirements for, PCP site and medical reviews, including facility site physical accessibility reviews, in accordance with CalOptima Policies and guidance issued by CalOptima's Regulators, including requirements, if any, related to collaborative programs.

1.18 **Transfers**. Physician Group agrees to assist CalOptima in facilitating the transfer of care of Enrollees if determined medically acceptable by attending Physicians and the CalOptima Medical Director. Physician Group will be responsible for the cost of Covered Services provided if Physician Group refuses to accept such transfer.

1.19 **Delegation by CalOptima to Physician Group**. Physician Group agrees to accept delegated responsibility for those activities listed in the Delegation Agreement and to perform the delegated activities in a manner consistent with the Delegation Criteria. Physician Group warrants that it meets CalOptima's Delegation Criteria and acknowledges that delegation to another entity does not alter Physician Group's ultimate obligations and responsibilities set forth in this Contract. Physician Group agrees to notify CalOptima of any change in its ability to meet the Delegation Criteria within twenty-four (24) hours from the date it fails to meet such Delegation Criteria. At CalOptima's request, Physician Group shall identify the Compliance Officer or other appropriate health network representative to be the liaison expressly responsible for oversight of delegated obligations.

1.19.1 Physician Group acknowledges that it is CalOptima's responsibility to oversee, monitor and evaluate Physician Group's ongoing eligibility for delegation according to the Delegation Criteria and performance of the delegated activities according to the Delegation Criteria. Physician Group agrees to cooperate with CalOptima's oversight, monitoring, and evaluation of Physician Group's eligibility and performance of delegated activities, including the provision of reasonable access during regular business hours to the Enrollee inquiry files, credentialing files, clinical and Medical Records of Enrollees, and all other information requested by CalOptima. Physician Group shall comply with corrective actions imposed by CalOptima and/or CalOptima's Regulators in the time and manner required by them.

1.19.2 Physician Group acknowledges and agrees that CalOptima retains final authority and responsibility for activities delegated under this Contract. Activities not expressly delegated herein and in the Delegation Agreement by CalOptima or for which delegation is terminated are the responsibility of CalOptima.

1.19.3 Physician Group agrees to provide CalOptima with periodic reports on delegated activities performed by Physician Group as provided in the Delegation Criteria or specified in CalOptima Policies.

1.19.4 In the event CalOptima, DMHC, or CMS is dissatisfied with the performance of delegated functions and activities by Physician Group or its Downstream Entities, CalOptima may, in its sole discretion, modify Physician Group's delegated status (in respect to all or a particular delegated activity), including from fully delegated to delegated with corrective action, or may immediately revoke all or part of the delegated activities. In the event Physician Group breaches its obligation to perform any delegated obligations, CalOptima shall have all remedies set forth in this Contract, including the right to revoke delegation of such function(s) and impose financial and other penalties. Moreover, CalOptima shall have the right to require Physician Group to terminate any Downstream Entity for good cause, including breach of its obligations to perform any delegated duties. Nothing herein is intended to limit CalOptima's remedies as provided for in this Contract or at law.

1.19.5 Physician Group acknowledges and agrees that CalOptima, in its sole and absolute discretion, may reduce Physician Group's Capitation Payments to recoup additional administrative costs where CalOptima revokes or modifies activities or functions delegated to Physician Group under this Contract.

1.20 **Delegation and Subcontracting of Administrative Services by Physician Group**. Except as otherwise limited by this Contract and/or CalOptima Policies, Physician Group may sub-delegate Administrative Services required of Physician Group to a management services organization

("**MSO**"), medical group and/or IPA. Delegation shall not absolve Physician Group of oversight responsibilities or its obligations under this Contract. All requests for delegation of Administrative Services (i) must be in writing; (ii) are subject to successful completion of CalOptima's readiness assessment requirements; and (iii) must be approved by CalOptima in advance of undertaking the Administrative Services. Physician Group shall obtain written approval of delegation from CalOptima pursuant to the process detailed in CalOptima Policies.

1.21 **Subcontracts**. Physician Group is required to inform CalOptima of the name and business addresses of all subcontracted Downstream Entities. Physician Group is required to ensure that all such subcontracts are in writing and include all provisions required by this Contract to be incorporated into subcontracts. Physician Group acknowledges that CalOptima's FDR subcontracts are subject to the review and approval of CMS.

1.22 **Payment to Providers**. CalOptima hereby delegates claims processing functions to Physician Group. Physician Group shall review, adjudicate, and pay (as appropriate) all claims in accordance with the benefits set forth in the Evidence of Coverage, the requirements established by Laws, and the terms of this Contract. In making payments to Providers, Physician Group shall comply with the provisions of Attachment D, including requirements related to payment of Non-Participating Provider Emergency Services and Urgent Care claims.

1.23 **Documentation and Data Submission Integrity**. Physician Group and its Downstream Entities shall not submit false claims or financial reports, encounter data, and other information to CalOptima, CMS or DMHC, whether by commission or omission. Physician Group and applicable Downstream Entities shall implement and maintain policies and procedures that address correct completion of claims, financial reports, encounter data, and other documentation requirements and penalties for falsifying such reports and other information that require all new and current employees and/or agents compiling or providing this information to sign a statement of attestation that will acknowledge understanding and compliance with said Physician Group policy.

1.24 **Advance Directives**. Physician Group shall maintain written policies and procedures related to Advanced Directives in compliance with Laws. Providers shall document Advance Directives in patient records in accordance with Laws. Physician Group shall not discriminate against any Enrollee on the basis of that Enrollee's Advance Directive status. Nothing in this Contract shall be interpreted to require an Enrollee to execute an Advance Directive or agree to orders regarding the provision of life-sustaining treatment as a condition of receipt of services.

1.25 **Enrollee Appeals**. Enrollees will be notified of all applicable MA and/or Medicare Appeal rights, the form and content of which is approved by CMS. . Medicare Appeal rights and protections will be maintained and enhanced for Medicare services. Physician Group agrees to cooperate with CalOptima in resolving Appeals related to Physician Group or Physician Group's Participating Providers and will comply with CalOptima Policies related to Appeals.

1.26 **Organization Determination Process**. Physician Group agrees to comply with CMS regulations and instructions and CalOptima Policies pertaining to timely organization determination by Physician Group with regard to the provision, denial, reduction, or suspension of a Covered Service to an Enrollee. "**Organization determination**" is defined as a decision to provide or deny service based on CMS and CalOptima criteria. Such determinations shall be made in accordance with procedures and instructions set forth in the CalOptima Policies and Laws. Physician Group shall immediately notify CalOptima of any request for an expedited initial organization determination and submit to CalOptima on a monthly basis a report which tracks the requests for standard and

expedited organization determinations and the timeframe within which Enrollees were informed of decisions made by Physician Group.

1.27 **Expedited Review Process**. Physician Group shall comply with CMS regulations and CalOptima Policies pertaining to expedited initial organization determinations of Enrollee's medical care and reconsideration (Appeals) thereof in the time sensitive situations. Time sensitive situations are those outlined by CMS which include medical conditions that require initial determinations to be made within seventy-two (72) hours upon Physician Group receiving a request for an expedited review from a Provider, Enrollee, or CalOptima.

1.28 **Linguistic and Cultural Sensitivity**. Physician Group shall comply with all requirements related to the provision of linguistic and culturally sensitive services in accordance to this Contract, CalOptima's Cultural and Linguistic Services Program, and CalOptima Policies. Physician Group shall address the special health needs of Enrollees who are of any minority, are homeless, are disabled (both congenital and acquired disabilities), or are part of other special populations served by the CalOptima MA Program, including the capacity to communicate with Enrollees in languages other than English, when necessary, as well as those Enrollees who are deaf, hard-of-hearing, and/or visually impaired. Physician shall, in policies, administration, and services, practice the values of: (a) honoring the Enrollees' beliefs, traditions and customs; (b) recognizing individual differences within a culture; (c) creating an open, supportive, and responsive organization in which differences are valued, respected and managed; (d) through cultural diversity training, foster in staff and Participating Providers attitudes and interpersonal communication styles that respect Enrollees' cultural backgrounds and are sensitive to their special needs; and (e) referring Enrollees to linguistically and culturally sensitive programs. Pursuant to CalOptima Policies, Physician Group shall provide translation of written materials in the Threshold Languages as provided by CalOptima Policies. Written materials to be translated include, but are not limited to, signage, the Enrollee services guide, Enrollee information, Explanation of Coverage, Enrollee forms, Enrollee notices, and Enrollee welcome packages.

1.29 **Provision of Interpreters**. Oral interpreters, signers, and bilingual Provider services shall be provided in all languages spoken by all MA Enrollees. Physician Group shall provide linguistic interpreter/translator services for Enrollees as necessary at all Physician Group sites to ensure the availability of effective communication regarding treatment, diagnosis, medical history, and health education to Enrollees. Physician Group shall provide twenty-four (24)-hour access to interpreter services for all Enrollees. Upon an Enrollee or Participating Provider request for interpreter services in a specific situation where care is needed, Physician Group shall make all reasonable efforts to provide an interpreter in time to assist adequately with all necessary Covered Services, including Urgent Care Services and Emergency Services, as required by Laws. Physician Group shall routinely document all such efforts and make this documentation available to CalOptima at its request. Interpreters shall be used where needed where technical, medical, or treatment information is to be discussed. Physician Group shall not require an Enrollee to use friends or family as interpreters. However, a family member or friend may be used when the use of the family member or friend: (i) is requested by the Enrollee; (ii) will not compromise the effectiveness of service; (iii) will not violate Enrollee's confidentiality; and (iv) the Enrollee is advised that an interpreter is available at no cost to the Enrollee. Physician Group shall maintain a contract with an interpreter service agency that is on "on call" status to provide interpreter services.

1.30 **Identification of Physician Group and Group Physicians**. Physician Group agrees that CalOptima may list the Physician Group's name, address, and telephone number and that of its Group Physicians and Downstream Entities in CalOptima's roster of Participating Providers that is given to Enrollees and prospective Enrollees, and CalOptima may use such names for

advertising/marketing purposes. However, CalOptima is not obligated to list the name of any particular Group Physician in the roster of Participating Providers. The use of Physician Group's trademarks or logos by CalOptima is prohibited without Physician Group's prior written approval.

1.31 **Liaisons**. Physician Group shall designate an individual(s) who will assume the day-to-day responsibilities with regard to Physician Group's obligations under this Contract and to serve as liaison with CalOptima. Physician Group will also designate an individual(s) to be responsible for answering Enrollee inquiries and responding promptly to any Enrollee grievance in accordance with CalOptima's grievance procedures and Laws.

1.32 **Provider Private Contract**. Physician Group understands that CalOptima is prohibited by CMS from paying capitation to, or including in its provider network, any provider that has entered into a private contract with a Medicare beneficiary for the provision of Covered Services. Physician Group shall notify CalOptima immediately in the event that any Group Physician has a private contract with a Medicare beneficiary. In such an event, CalOptima reserves the right to exclude any such Group Physician from its provider network. In addition, Physician Group agrees that CalOptima shall have the right to offset the amount of any reimbursement that was paid either directly or indirectly to such Provider(s) against Capitation Payments or other amounts due from CalOptima to Physician Group, if any.

1.33 **Disclosure of Physician Group PIPs**. In the event that Physician Group implements and maintains a physician incentive plan ("**PIP**"), Physician Group and its Downstream Entities must comply with all applicable requirements governing PIPs, including such requirements appearing at 42 CFR Parts 417, 422, 434, 438.6(h), and 1003.

1.33.1 Physician Group shall ensure that no specific payment is made directly or indirectly under a PIP to a Physician or Physician Group as an inducement to reduce or limit Medically Necessary services furnished to an Enrollee.

1.33.2 On an annual basis, Physician Group and its Downstream Entities must submit to CalOptima all information required to be disclosed to CMS and the DMHC in the manner and format specified by them.

1.33.3 Physician Group must provide information on its PIP to any Enrollee upon request as provided in 42 CFR Section 422.208.

1.33.4 In the event that CalOptima's Regulators find that Physician Group (or its Downstream Entities) has failed to comply with the requirements governing physician incentive plans and CalOptima's Regulators offset, recoup and/or otherwise seek recovery of federal financial participation ("**FFP**") amounts from CalOptima, Physician Group agrees that CalOptima may recover such FFP amounts attributable to Physician Group from Physician Group, including through recoupment or offset to future Capitation Payments or other amounts due from CalOptima to Physician Group, if any.

1.34 **Provider Grievance Process**. Physician Group shall establish and maintain a Provider dispute resolution process that at all times complies with the requirements of Laws. Physician Group shall provide CalOptima with all necessary information and reports regarding the provider dispute resolution process as required by CalOptima to meet its obligations under the CMS Contract and Laws. If Physician Group fails to maintain a process that complies with the requirements stated in Laws and CalOptima Policies, then following written notice of such deficiency from CalOptima to

Physician Group, CalOptima may revoke the delegation and assume responsibility for the administration of Physician Group's Provider dispute resolution process.

1.35 **Provider Education**. Physician Group acknowledges that CMS requires that CalOptima furnish to Participating Providers certain training, education, and orientation related to the MA Program in order to operate in full compliance with this Contract and Laws. Such training and education may address the MA Program, Enrollee rights, cultural competency and clinical protocols, evidence-based guidelines and cultural awareness and sensitivity instruction. Physician Group and its Participating Providers shall participate in such training, education, and orientation programs, as required by CalOptima, and shall attest to compliance with training requirements as required by CalOptima.

1.36 **State Licensure**. If Physician Group is licensed by the DMHC as a heath care service plan for purposes of the MA Program, it shall maintain such licensure in accordance with the Knox-Keene Act, as amended, and have no adverse actions with regard to enforcement or quality management.

1.37 **CalOptima's Regulator Requirements**. The MA Program is subject to oversight by CalOptima's Regulators, which mandate that CalOptima and its FDRs comply with certain terms and conditions in rendering services to Enrollees and that certain terms be incorporated in FDR subcontracts. Physician Group acknowledges that it will comply with CalOptima's Regulators' requirements set forth in Attachment E.

1.38 **COB Obligations of Physician Group**. Physician Group agrees to coordinate with CalOptima for proper determination of COB and to bill and collect from other payers and third-party liens such charges for which the other payer is responsible pursuant to CalOptima Policies. Physician Group agrees to establish procedures to effectively identify, at the time of service and as part of its claims payment procedures, individuals and services for which there may be a financially responsible party other than the CalOptima MA Program.

1.39 **CMS Lien Rights.** Physician Group shall coordinate benefits either operating a cost avoidance method of paying claims, when the existence of private health coverage is known at the time the claim is processed, or using the method of post-payment recovery of the cost of services, if the coverage is identified retroactively, as set forth in CalOptima Policies. Nothing herein shall be interpreted to, in any manner, impair any lien rights retained by the U.S. Department of Health and Human Services ("**HHS**") through CMS. Physician Group shall make no claim for the recovery of the value of Covered Services rendered to an Enrollee when such recovery would result from an action involving tort liability of a third party, recovery from the estate of deceased Enrollee, Workers' Compensation, or casualty liability insurance awards and uninsured motorist coverage. Physician Group shall identify and notify CalOptima, within five (5) calendar days of discovery of potential third-party liability ("**TPL**") claims, and provide information relative to potential TPL claims, in accordance with CalOptima Policies.

1.40 **Provider Training.** Physician Group shall ensure that all network Providers receive training regarding the MA Program in order to operate in full compliance with all Laws, including rights and responsibilities pertaining to grievance and appeals procedures and timelines under this Contract. Physician Group shall ensure that network Provider training relates to MA services, policies, procedures and any modifications to existing services, policies or procedures. Training shall include methods for sharing information among network Providers, Enrollees, and/or other healthcare professionals. Physician Group shall conduct training for all network Providers within thirty (30) working days after the Physician Group places a newly contracted Provider on active status. Physician Group shall ensure that network Provider training includes information on all

Enrollee rights, including the right to full disclosure of health care information and the right to actively participate in health care decisions. Physician Group will maintain policies and procedures on advance directives pursuant to 42 CFR §§ 422.128, 438.3(j), and 489.102, and will educate its network Providers concerning its policies and procedures on Advance Directives. Physician Group shall ensure that ongoing training is conducted when deemed necessary by either the Physician Group or CMS.

II. PHYSICIAN GROUP FINANCIAL OBLIGATIONS

2.1 **Financial Security Requirements**. Physician Group must establish and maintain during the Term financial security requirements as specified in Article 9 of Chapter 2 of Division 1 of Title 28 of the California Code of Regulations (SB 260 Regulations), and in compliance with CalOptima Policies. Physician Group must establish and maintain, throughout the Term, financial security reserves, in the form of time certificates of deposit, irrevocable standby letters of credit, surety bonds naming CalOptima as beneficiary, and/or other forms of financial instruments acceptable by CalOptima, as required in CalOptima Policies.

2.2 **Financial Viability Standards and Reporting**. Physician Group must establish and maintain a minimum reserve of twenty-five percent (25%) of one month's Capitation Payment. Physician shall have thirty (30) days upon receiving notice from CalOptima to cure any deficit. Physician Group shall maintain a cash-to-claims ratio of no less than 0.75 at all times during the Term. Physician Group shall substantiate compliance with this requirement by submitting all applicable reports to the DMHC that are required under Title 28 CCR Section 1300.75.4.2.

2.3 **Medical Loss Ratio**. Physician Group shall ensure that it maintains a minimum acceptable loss ratio (as defined by CalOptima Policies) of eight five percent (85%). Physician Group shall comply with CalOptima requirements related to limitations on administrative costs, as set forth in CalOptima Policies.

2.4 **Termination of Physician Group Health Network**. If this Contract terminates or expires for any reason, CalOptima may require that Physician Group take certain actions and/or CalOptima may take certain actions to ensure that all items and services for which Physician Group is delegated financial risk under this Contract are reimbursed by Physician Group, including the following: (i) require Physician Group to reserve sufficient funds to pay any claims run out; (ii) offset Physician Group's future Capitation Payments or other amounts due from CalOptima to Physician Group under this Contract or any other agreement, if any, in order to pay Physician Group's claims; and/or (iii) withhold or offset Physician Group's Capitation Payments or other amounts due from CalOptima to Physician Group, including to pay-for-performance, quality incentives, and shared risk pool surpluses, if any, in order to pay amounts owed by Physician Group to Providers.

2.5 **Conversion of Health Network Model**. If CalOptima approves a change in the delegated model of Physician Group at any time during the Term, CalOptima may require additional financial protections as a condition precedent to such approval, including: (i) require Physician Group to reserve sufficient funds to pay any claims run out related to claims which are the financial responsibility of Physician Group under the existing delegated relationship; (ii) require Physician Group to meet additional financial security requirements, including the maintenance of financial deposits; and/or (iii) withhold or offset Physician Group's Capitation Payments or other amounts due from CalOptima to Physician Group, including pay-for-performance, quality incentives and shared risk pool surpluses, if any, in order to pay amounts owed by Physician Group to Providers.

2.6 **Cooperation with DMHC**. Physician Group shall fully cooperate and comply with the DMHC's review and audit process and permit DMHC to obtain and evaluate supplemental financial information related to Physician Group, in accordance with Title 28 CCR Section 1300.75.4.7. Physician Group shall also fully cooperate and participate in DMHC's Corrective Action Plan process, in accordance with Title 28 CCR Section 1300.75.4.8.

III. CALOPTIMA OBLIGATIONS

3.1 **CalOptima Services**. CalOptima agrees to provide certain Enrollee and Administrative Services, including processing Enrollee applications, maintaining eligibility records and a system of verifying eligibility, processing enrollments and dis-enrollments, responding to Enrollee complaints and grievances, informing Enrollees of CalOptima Policies, providing Enrollees with membership cards and informational material, and informing Enrollees of Health Networks.

3.2 **Enrollment**. CalOptima agrees to process all enrollment applications and ensure that each Enrollee selects or is assigned to Health Networks in accordance with CalOptima Policies. CalOptima reserves the right to assign Enrollees to a Health Networks other than that selected by Enrollee.

3.3 **Model of Care and Health Risk Assessment**. CalOptima shall maintain a Model of Care, as required by CalOptima's Regulators. CalOptima shall ensure that, upon enrollment in the CalOptima MA Program, each Enrollee receives an initial HRA and an HRA annually thereafter in accordance with CalOptima Policies and that results of the HRA are shared with Physician Group in order to coordinate Enrollee care. Physician Group is responsible for interim updates to the HRA.

3.4 **Authorization Process**. CalOptima shall provide a written Authorization process for Covered Services pursuant to CalOptima Policies.

3.5 **Enrollee Grievance Process**. CalOptima will inform Enrollees that they may file a grievance through CalOptima or the CMS Ombudsman Program for complaints related to Medicare-covered benefits and services. Enrollees may also file a grievance through 1-800 Medicare.

3.6 **Enrollee Appeals**. Enrollees will be notified of all applicable MA Medicare Appeal rights through a single notice prior approved by CMS.

3.7 **CalOptima Formulary**. CalOptima shall publish and maintain the CalOptima Formulary pursuant to CalOptima Policies.

3.8 **Training and Education**. CalOptima agrees to provide Participating Provider education, training, and orientation in accordance with CMS requirements, including training regarding the CalOptima MA Program, Enrollee rights, clinical protocols, evidence-based practice guidelines, and CalOptima's cultural awareness and sensitivity instruction and cultural competency training, as applicable.

3.9 **Marketing**. Physician Group acknowledges that CalOptima will be responsible for marketing the CalOptima MA Program to Medicare beneficiaries. Physician Group acknowledges that it shall not conduct any marketing activities except as expressly approved in advance and in writing by CalOptima.

3.10 **Administration of Funds**. CalOptima will administer the funds and payments called for in this Contract to Physician Group in accordance with provisions outlined in Article VI.

3.11 **No Refusal to Pay or Contract Based on Physician Group Communications with Enrollees**. CalOptima will not refuse to contract or pay an otherwise eligible health care Provider for the provision of Covered Services solely because such Provider has, in good faith, communicated with or advocated on behalf of one or more of his or her prospective, current, or former patients regarding: (i) the provisions, terms or requirements of CalOptima's health care plans as they relate to the needs of such Provider's Enrollees; or (ii) the method by which such Provider is compensated by CalOptima for Covered Services rendered to the Enrollee.

3.12 **CalOptima Policies**. CalOptima will provide Physician Group with CalOptima Policies as necessary for Group to provide Covered Services to Enrollees. Those CalOptima Policies shall describe all benefit plans, including copayments, limitations, and exclusions offered by CalOptima to Enrollees. The Provider Manual will be made available to Physician Group to disseminate to Physicians.

3.13 **Listing of CalOptima**. CalOptima agrees that Physician Group may list its name, address, telephone number, and a description of the CalOptima MA Program, along with CalOptima's name, in Physician Group's promotional materials and advertisements. The use of CalOptima's trademarks and logos by Physician Group is prohibited without CalOptima's prior written approval.

3.14 **CalOptima Oversight**. CalOptima shall monitor Physician Group's performance under this Contract on an ongoing basis. CalOptima may conduct regularly scheduled audits as well as an annual evaluation of the delegated functions to determine Physician Group's continued compliance with the Delegation Criteria. CalOptima may impose corrective action plans on Physician Group and/or its Downstream Entities, as necessary.

3.15 **CalOptima Accountability**. The delegation of the functions and responsibilities stated in this Contract and the Delegation Agreement does not relieve CalOptima of any of its accountability to CMS and obligations to its Enrollees under Laws. CalOptima is authorized to perform and remains liable for the performance of such obligations, notwithstanding any delegation of some or all of those obligations to Physician Group.

3.16 **COB Obligations of CalOptima**. CalOptima will cooperate in providing COB information to Physician Group by collecting appropriate data from the Enrollee at the point of enrollment and supplying such data to Physician Group.

3.17 **Enrollee Rights**. CalOptima shall ensure that Enrollee rights are fully respected and observed in accordance with Laws and CalOptima Policies. CalOptima shall notify Enrollees of their rights and protections at least annually and in a manner that accounts for cultural considerations, functional status, and language needs.

3.18 **Enrollee Grievances**. CalOptima retains responsibility for the Enrollee grievance process. Physician Group will comply with CalOptima Policies related to Enrollee grievances, including timely reporting to CalOptima and resolution of Enrollee grievances. Enrollees may file an internal Enrollee grievance at any time with CalOptima or Physician Group, including grievances related to reasonable accommodations and access to services under the ADA.

IV. QUALITY IMPROVEMENT PROGRAM AND CREDENTIALING

4.1 **CalOptima's Quality Improvement Program**. Physician Group shall comply with, and participate in, CalOptima's Quality Improvement Program ("**QIP**"). Physician Group shall immediately notify CalOptima of those Enrollees and cases that fall within the catastrophic and

targeted case management guidelines and shall cooperate with CalOptima's case management program for catastrophic and targeted cases. Physician Group and its Downstream Entities shall fully cooperate with CalOptima with regard to the HEDIS measurements and HEDIS audits, guideline development, preventive services utilization, disease/risk management, clinical service monitoring, and quality improvement studies and initiatives. Physician Group shall comply with and accept as final the decisions of the CalOptima QIP and, pending resolution of any dispute through the dispute resolution process, comply with the decisions of the CalOptima Quality Improvement Committee.

4.2 **Quality Improvement Functions – Delegation to Physician Group**. Physician Group shall establish, maintain and operate a Quality Improvement ("**QI**") program, in accordance with the delineation of responsibilities in the Delegation Agreement, which shall include preparation of an annual QI program plan, semi-annual work plan, and annual evaluation of effectiveness of the QI program, and report to CalOptima's QI department using the Health Industry Collaboration Effort Reporting Tool. All of the foregoing elements of the QI program shall be consistent with current industry standards, and meet CMS, National Committee for Quality Assurance ("**NCQA**"), The Joint Commission, and CalOptima QIP requirements.

4.2.1 Physician Group shall adopt a detailed written QI plan, which shall include: (i) well defined goals and objectives; (ii) a well-defined scope that considers all different types and levels of care and service provided to Enrollees; and (iii) clearly defined accountability and responsibility for the QI program.

4.2.2 The Board of Directors of the Physician Group or a multi-disciplinary QI committee designated by the Board of Directors of Physician Group shall oversee the QI program. This committee shall be separate from the utilization review committee (though members may be the same) and have a separate agenda. The QI committee shall meet at least on a quarterly basis. Physician Group shall maintain attendance records and meeting minutes related to the QI program. The QI committee shall have adequate representation from all categories of the Physician Group such as Physicians and non-Physician practitioners.

4.2.3 QI Program activities shall be reported in writing to Physician Group's Board of Directors at least on a quarterly basis. These reports shall be available to CalOptima upon request.

4.2.4 Physician Group's QI program shall include involvement and participation in network-wide studies/projects initiated by CalOptima. Physician Group shall facilitate quality studies and assist in collection of comparative data collected from all Participating Providers using objective parameters (e.g., the current version of HEDIS).

4.2.5 Physician Group shall develop an annual QI work plan, which includes the following: (i) goals, scope, and planned projects for the year; (ii) planned monitoring of identified issues and tracking these issues over time; (iii) planned studies/audits suggested by CalOptima or Physician Group; and (iv) an annual evaluation of the QI program/plan.

4.2.6 Physician Group shall have a written procedure for responding to the findings of QI activities, such as collecting data, analyzing results, implementing corrective action plans, and reassessing the same data for improvement.

4.2.7 Requirements for the Physician Group's QI program shall be established by the Physician Group's QI committee and requirements may change based on changes in industry standards. CalOptima's QI committee shall notify Physician Group of any additional

changes in QI standards and requirements that shall be incorporated in Physician Group's QI program. Physician Group shall not be required to change QI program requirements more frequently than once per year.

4.2.8 Physician Group shall provide, upon CalOptima's request: (i) summaries of QI Committee meetings; (ii) findings following review of specific cases and other reviews; (iii) Medical Records; (iv) written responses to quality-of-care issues or Enrollee complaints; and/or (v) other information as required by CalOptima.

4.2.9 Physician Group shall comply with all measurement and improvement projects in the manner required by CMS, including the reporting of HEDIS, Health Outcomes Survey and Consumer Assessment of Healthcare Providers and Services measurement results consistent with Medicare requirements. Physician Group shall contribute to all applicable CMS data quality assurance processes.

4.3 **Quality Improvement and Credentialing Program**. CalOptima delegates credentialing requirements to Physician Group as provided in the Delegation Agreement. Physician Group agrees to comply with CalOptima Policies regarding credentialing standards. In order to ascertain Physician Group's continuous compliance with CalOptima standards, CalOptima retains the right to oversee Physician Group's credentialing processes and to mandate changes thereto.

4.3.1 At least annually, Physician Group shall provide CalOptima with a written credentialing program for the purpose of review and approval by CalOptima. Physician Group shall also allow CalOptima, after reasonable prior notice, to conduct an on-site audit and review a sample of physician credentialing files to determine that delegation of the credentialing process is appropriate.

4.3.2 Physician Group's credentialing program shall comply with the requirements specified in 42 CFR Sections 422.504, 423.505 and 438.214, as applicable, which include requirements addressing selection and retention of providers, credentialing and re-credentialing requirements, and nondiscrimination. Physician Group's credentialing program shall include procedures used for credentialing and re-credentialing Participating Provider's according to current NCQA standards, in addition to procedures used for reducing, suspending or terminating Participating Provider's participation in the organization for reasons relating to quality of care, competence, professional conduct, or service-related issues; procedures for reporting to appropriate authorities serious quality deficiencies that could result in suspension or termination of a Participating Provider's participation; and procedures for provider appeal, as afforded by Physician Group's fair hearing plan and corrective actions.

4.3.3 Physician Group shall make best efforts to notify CalOptima within thirty (30) days of any changes involving the rules, regulations, authorities, and responsibilities of the credentialing program. In accordance with CMS requirements, CalOptima also retains the right, based on quality-of-care and service issues, to approve, suspend, or terminate arrangements with practitioners, providers, and sites. In the event that this occurs, CalOptima will notify the Physician Group of the quality-of-care and/or service issue, and Physician Group shall take appropriate action, report to appropriate authorities any serious quality deficiencies in accordance with Laws, and provide all due process as afforded by the Physician Group's fair hearing plan and Laws.

4.3.4 If CalOptima exercises its right to terminate a Provider's participation in the CalOptima MA program, CalOptima shall give the Provider a written statement of the reason or reasons for termination with cause and comply with the procedures required by Laws, if any.

4.4 **Release of Performance Information and Data**. Physician Group acknowledges that the CalOptima MA Program focuses on improving the coordination and quality of medical, Behavioral Health, LTSS, and other services for Enrollees, and, in that regard, CalOptima's Regulators will implement capitation withholds to ensure performance consistent with established quality thresholds. Physician Group acknowledges and agrees that CalOptima may release information and data related to the performance of Physician Group under this Contract to CalOptima Regulators, Providers, Enrollees, and others without further notice to Physician Group. The performance data will be used for purposes, including quality improvement activities, and public reporting to consumers, as identified in CalOptima Policies.

V. UTILIZATION MANAGEMENT PROGRAM

5.1 **CalOptima's Utilization Management Program**. CalOptima has implemented, and continuously updates, a UM program to ensure appropriate processes are used to review and approve the provision of Medically Necessary Covered Services to Enrollees in the timeframes required by CalOptima's Regulators. Physician Group and its Downstream Entities shall comply with and cooperate in CalOptima's UM program, as established in CalOptima Policies and the CalOptima UM plan, regardless of CalOptima's delegation to Physician Group under Section 5.2.

5.2 **UM Program Responsibility—Delegation to Physician Group**. CalOptima is hereby delegating to Physician Group the process of monitoring and evaluating on a prospective, concurrent, and retrospective basis, the utilization and Medical Necessity of Covered Services provided to Physician Group's Enrollees.

5.2.1 Physician Group's UM process shall include performing case management activities, referral management and discharge planning, and managing the denial sanction process, as well as conducting peer review for Medical Necessity and appropriateness. Physician Group (and its Downstream Entities) shall ensure that its UM program complies with all criteria as set forth in CalOptima Policies and required by CalOptima's Regulators.

5.2.2 In accordance with 42 CFR §§ 438.6(h) and 422.208, compensation to individuals or entities that conduct UM activities must not be structured so as to provide incentives for Physician Group (including Group Physicians) or Downstream Entities to deny, limit, or discontinue Medically Necessary Covered Services to any Enrollee.

5.2.3 In the event Physician Group (or its Downstream Entities) fails to comply with CalOptima standards and Laws and fails to correct deficiencies within the stated time required by those provisions, CalOptima retains the right to revoke delegation of UM activities.

5.3 **Utilization Management Plan**. Physician Group will provide to CalOptima initially upon execution of this Contract, and annually thereafter, a written UM plan for review and approval by CalOptima.

5.3.1 Physician Group shall notify CalOptima within thirty (30) days of any changes involving the rules, regulations, authorities, and responsibilities for the UM plan, which shall be subject to reasonable approval by CalOptima. CalOptima approval will be assumed unless

Physician Group is notified otherwise by CalOptima. Physician Group shall comply with and accept as final, the decisions of CalOptima's UM program and, pending resolution of any dispute through the dispute resolution process, comply with the decisions of CalOptima's UM program.

5.3.2 The UM plan shall include procedures approved by CalOptima to identify, assess, establish, and implement a treatment plan for Enrollees with complex or serious medical conditions. The UM plan shall also contain procedures for direct access of Enrollees to services as mandated by CMS regulations and instructions. All Physician Group denial letters shall provide Enrollees with timely notice and shall contain appropriate Enrollee appeals rights as approved by CMS and CalOptima. Physician Group agrees to cooperate with CalOptima in furnishing the required reports identified in CalOptima' Policies

5.4 **Utilization Management Committee**. Physician Group shall establish a UM committee that shall review and document the quality, appropriateness, level of care, and utilization of health care services provided to Enrollees. CalOptima's Medical Director and/or CalOptima staff may attend Physician Group UM committee meetings.

5.5 **Process and Timeframes for Authorization**. Physician Group (and its Downstream Entities) shall ensure that its process for initial and continuing Authorizations complies with CalOptima Policies, the UM plan and requirements established by CalOptima's Regulators, including timeframes for, and manner of, Authorization.

5.6 **No Prior Authorization**. Physician Group (and its Downstream Entities) shall not require prior Authorization for the following services: (i) any services for Emergency Medical Conditions (which include emergency Behavioral Health care); (ii) Urgent Care sought outside the Service Area: (iii) Urgent Care under unusual or extraordinary circumstances provided in the Service Area when the Participating Provider is unavailable or inaccessible; (iv) preventative services; (v) family planning services; (vi) Out-of-Area renal dialysis services; (vii) basic prenatal care; (viii) sexually transmitted disease services; and (ix) HIV testing.

5.7 **Second Opinions**. Physician Group (and Downstream Entities) shall ensure that Enrollees have the right to second opinions from qualified health professionals at no cost to the Enrollee.

5.8 **Physician Direct Referral**. Physician Group agrees that an Enrollee shall, without obtaining the prior Authorization of the PCP or Physician Group, refer him or herself directly to a specialist within said Physician Group per policy including any of the following conditions: an annual well woman exam by a Gynecologist, prenatal care and delivery by an Obstetrician, annual eye exam by an Optometrist, professional services related to audiology, and family planning services, including but not limited to vasectomy.

5.8.1 CalOptima will identify Physician Group as a provider that offers Physician Group Direct Referrals to Enrollees in CalOptima's provider directory and other marketing literature, if any. In the event CalOptima determines that Physician Group is non-compliant with the requirements of the Physician Direct Referral process, CalOptima reserves the right, at its sole discretion, to cease marketing Physician Group as a Physician Direct Referral provider to Enrollees.

5.8.2 Physician Group agrees to cooperate with CalOptima and, upon reasonable prior notice, provide CalOptima with all necessary Medical Records, policies and procedures, including utilization review, reports, and other pertinent information that may be necessary or

required to enable CalOptima to ensure and verify that Physician Group has a Physician Direct Referral process acceptable to and in accordance with the requirements of CalOptima.

5.9 **Hospital Referrals**. Physician Group agrees to require Group Physicians to admit Enrollees only to a Participating Provider Hospital with the concurrence of CalOptima, except for Emergency Services, Urgent Care, or when Authorization has been received in accordance with the UM Plan.

5.10 **Personal Care Coordinator Component to the Model of Care.**

5.10.1 "**PCC Profile**" is a monthly report generated by CalOptima that provides the compliance parameters required to receive PCC supplemental capitation.

5.10.2 Physician Group shall employ PCCs and participate in all PCC component requirements, as defined in the Model of Care Profile. PCCs shall assist Enrollees in the development of an ICP, ensure communication of the Enrollee's care plan with the Enrollee, physicians, Physician Group and health care team, and provide other related services as described in the job description, CalOptima Policy, and Model of Care Profile. Physician Group shall submit monthly reports and ICPs to demonstrate adherence to Model of Care requirements, including staffing of PCCs.

5.10.3 CalOptima may amend the Model of Care Profile at any time and, in such event, CalOptima shall provide Physician Group with thirty (30) days' written notice before the effective date of any such revisions. If Physician Group is unable to agree to the revisions and no resolution is reached in the thirty (30)-day period, Physician Group may proceed with the termination of the Contract under Article 11. In the event Physician Group terminates the Contract, it shall comply with all of its obligations required by this Contract and Laws including obligations related to transfer and coordination of Enrollee care following termination.

VI. COMPENSATION

6.1 **Physician Group Compensation**. CalOptima shall compensate Physician Group for Covered Services and Administrative Services delegated to Physician Group, as set forth in Attachment C. Such Capitation Payments shall be payment in full for Covered Services and Administrative Services, except for amounts recovered through collection of Enrollee's Share of Cost, COBs, and Stop Loss Program, if applicable. Capitation Payment shall be sent on a monthly basis by the twentieth (20th) calendar day of the month, or if such day falls on a weekend or national holiday, on the first business day thereafter, for all Enrollees eligible from the first (1st) of the month, and on whose behalf payment has been received by CalOptima from CMS by the nineteenth (19th) calendar day of the month. In the event CalOptima receives payment from CMS after the nineteenth (19th) calendar day of the month, capitation payment to Physician Group will be made within five (5) working days of receipt of the monthly payment by CalOptima.

6.2 **Disputes Regarding Payments or Enrollment**. Any and all disputes related to Capitation Payments and/or enrollments shall be reported to CalOptima within ninety (90) calendar days of payment, and each dispute shall be clearly defined and include supporting documentation. Failure to dispute within the established time frame indicates acceptance of the Capitation Payment by Physician Group.

6.3 **Capitation Rate Adjustments**. The Capitation Rates may be adjusted by CalOptima during the Contract period to reflect implementation of State or federal laws or regulations, changes in the CMS Contract or CMS policy, and/or changes in Covered Services. If CalOptima receives advance notice of adjustment from CalOptima's Regulators, CalOptima shall provide notice thereof to Physician Group as soon as practicable. Capitation Rates may also be adjusted in the event of de-delegation of any function delegated under this Contract.

6.4 **Enrollee Non-Liability and Hold Harmless Requirements.** Physician Group and its Downstream Entities shall accept CalOptima's payment as described in this Contract as payment in full. Physician Group and its Downstream Entities for all Covered Services and Administrative Services under this Contract and shall not hold Enrollees liable to the Physician Group or Providers for any sums owed to Physician Group by CalOptima or owed to Providers by Physician Group.

6.4.1 Physician Group and its Downstream Entities shall hold harmless CMS, CalOptima, and Enrollees in the event Physician Group and/or Downstream Entities cannot or will not pay for services performed by Physician Group or Downstream Entities pursuant to this Contract or subcontract, as applicable.

6.4.2 Physician Group and its Downstream Entities shall ensure that Enrollees will not be held liable for Medicare Part A and B cost sharing when the State is responsible for paying such amounts and that the Physician Group will (i) accept Capitation Payment as payment in full under the Contract, or (ii) bill the appropriate State source, as required at 42 CFR §422.504(g)(1)(iii). Such services must be provided at zero cost-sharing to Enrollees.

6.4.3 Physician Group shall not hold an Enrollee liable for the following: (i) debts of Physician Group, in the event of 'Physician Group's insolvency; (ii) Covered Services provided to the Enrollee in the event that CalOptima or Physician Group fails to receive payment from CMS for such services; or (iii) payments to a clinical FDR or Downstream Entity in excess of the amount that would be owed by the Enrollee if Physician Group had directly provided the services.

6.4.4 Physician Group and its Downstream Entities shall not charge Enrollees coinsurance, co-payments, deductibles, financial penalties, or any other amount in full or part, for any service provided under this Contract, except as otherwise permitted under this Contract.

6.4.5 Physician Group and its Downstream Entities shall not deny any service provided under this Contract to an Enrollee for Enrollee's (or any entity responsible for making payment on Enrollee's behalf) failure or inability to pay any applicable charge or shall not deny any service provided under this Contract to an Enrollee who, prior to becoming eligible, incurred a bill that has not been paid.

6.5 **Overpayments Discovered by Physician Group**. Physician Group shall disclose and return all overpayments to CalOptima within sixty (60) days of when Physician Group identified the overpayment or should have identified the overpayment through the exercise of reasonable diligence.

6.6 **Recoupment for Ineligibility; Conlan Reimbursements**. CalOptima shall recoup payments made to Physician Group when CMS has determined that an individual was not eligible for the MA Program and retroactively terminates the individual, including recouping any payments made for a deceased Enrollee. CalOptima may also recoup overpayments to Physician Group owed by Physician Group to Enrollees, including offsetting any such amounts owed against Physician

Group's Capitation Payments or other amounts due from CalOptima to Physician Group under this Contract or any other agreement between the parties, if any. This Section 6.6 shall not be construed to limit CalOptima's right to recoup payment made to Physician Group on any other basis for which recoupment is appropriate.

6.7 **CalOptima Right to Recover**.

6.7.1 Overpayments. Physician Group acknowledges and agrees that, in the event that CalOptima determines that an amount has been overpaid or paid in duplicate, or that funds were paid which were not due under this Contract to Physician Group, CalOptima shall have the right to recover such amounts from Physician Group by recoupment or offset from current or future amounts due from CalOptima to Physician Group under this Contract or any other agreement between the parties, after giving Physician Group notice and an opportunity to return/pay such amounts.

6.7.2 Health Network Termination. In the event of termination of the Health Network or the transition of the Health Network to a different delegation model, CalOptima shall have the right to offset any unpaid claims that are the financial responsibility of Physician Group paid by CalOptima against any funds owed to Physician Group by CalOptima, including capitation payments, financial security withholds, pay-for-performance amounts, quality incentives, and shared risk pool surpluses.

6.7.3 Shared Risk Pool Payments Upon Termination. If this Contract terminates or expires for any reason and Physician Group is responsible for a deficit under any shared risk program under this Contract based on the final shared risk pool report results ("**Deficit**"), such Deficit shall be due to CalOptima as follows, as allowed by Laws: CalOptima may elect to recoup such Deficit by either (1) offsetting such Deficit amounts, upon notice to Physician Group, from any current or future amounts owed by CalOptima to Physician Group under the Contract or any other agreement between the Parties, including capitation payments, financial security withholds, pay-for-performance amounts, quality incentives, and shared risk pool surpluses; or (2) sending an invoice to Physician Group that payment for such Deficits are due to CalOptima within thirty (30) days of Physician Group's receipt of the CalOptima invoice.

6.7.4 Regulator Recoupment Upon Termination. If following the termination or expiration of this Contract, CalOptima's Regulators find that Physician Group (or its Downstream Entities) has failed to comply with the requirements governing physician incentive plans and CalOptima's Regulators offset, recoup and/or otherwise seek recovery of FFP, as described in Section 1.33, CalOptima may elect to recoup such FFP amounts, as allowed by Laws, by either: (1) offsetting such FFP amounts, upon notice to Physician Group, from any current or future amounts owed by CalOptima to Physician Group under the Contract or any other agreement between the Parties, including capitation payments, financial security withholds, pay-for-performance amounts, quality incentives, or shared risk pool surpluses; or (2) sending an invoice to Physician Group that payment for such FFP amounts are due to CalOptima within thirty (30) days of Physician Group's receipt of the CalOptima invoice.

6.7.5 Dispute Resolution. Physician Group may use CalOptima's provider dispute resolution procedure, as described under CalOptima's Policies, and/or the dispute resolution procedures under this Contract to resolve any disputes related to the calculation or payment of such Deficits or FFP amounts.

6.7.6 Survival. This Section 6.7 shall survive the termination or expiration of the Contract.

6.8 **Retroactive Cancellation**. CalOptima will discourage retroactive cancellation of any Enrollee. However, CalOptima may make exceptions as required by CMS or due to legitimate administrative processing requirements of CMS. CalOptima may make retroactive additions or cancellations of Enrollees, as necessary for administrative or business reasons, and such retroactive additions or cancellations of Enrollees shall not exceed ninety (90) days.

VII. REPORTING REQUIREMENTS

7.1 **Data Reporting Requirements**. Physician Group shall comply with the data reporting requirements set forth in this Contract, including the requirements specified in Standard Reporting Requirements set forth in CalOptima Policies and guidelines (referred to as the Timely and Appropriate Submission requirements). Physician Group shall provide such additional data and modify the form, content, instructions, and timetables for the collection and reporting of data, as may be required by CalOptima Policies.

7.2 **Eligibility Reports**. CalOptima will maintain, update, and distribute monthly Enrollee eligibility reports for each month in which the persons included on such list are eligible for CalOptima MA Program. This report will identify the Physician Group, PCP selected by the Enrollee, and the Enrollee's coverage. The report will be sent to Physician Group and PCPs by the tenth (10th) of each month, identifying eligible Enrollees from the first (1st) of the month.

7.3 **Utilization Data**. Physician Group shall, upon request, provide CalOptima with information on the utilization and cost of Covered Services provided to Enrollees in such detail as to allow CalOptima to conduct analysis of costs as required by CMS, as dictated by sound business practices and for the conduct of quality management and UM activities by CalOptima. Such information to be provided by Physician Group will not include information beyond that customarily provided on a claim form (such as Form CMS-1500) and shall be provided in the form of a paper report, computer disc, computer tape, or electronic file, as agreed by the parties. Required data will be delivered by Physician Group to CalOptima not later than forty-five (45) days following written request by CalOptima.

7.4 **Submission of Electronic Encounter Data**. Physician Group must meet any claims, diagnosis, and Encounter Data reporting requirements, as determined from time to time by CalOptima and CalOptima's Regulators.

7.4.1 Physician Group agrees to furnish CalOptima with complete, timely, reasonable, and accurate Encounter Data for Covered Services rendered to Enrollees. The Encounter Data will be furnished to CalOptima through Electronic Data Interchange (EDI) or a mutually acceptable format and shall be received by CalOptima per the Policy and Encounter Requirements Manual. Physician Group also agrees to furnish Medical Records that may be required to obtain any additional information or corroborate the Encounter Data. Physician Group further agrees to have its Chief Executive Officer (CEO) attest and certify the completeness and truthfulness of the Encounter Data submitted.

7.4.2 Physician Group shall be subject to financial penalties and/or sanctions if CalOptima determines that Physician is reporting to CalOptima less than all professional encounters in the CalOptima required format and timelines. Financial penalties or sanctions shall be assessed upon Physician Group should CalOptima determine that Physician Group is not meeting the standards defined in CalOptima Policies. This Section 7.4.2 shall survive the expiration or termination of this Contract, whether with or without cause, by rescission or otherwise, as to all Covered Services provided under this Contract prior to termination.

Based on CalOptima's quarterly determinations and following thirty (30) days' prior notice to Physician Group, CalOptima may withhold three (3%) percent of Capitation Payment if CalOptima determines that the monthly Encounter Data that Physician Group must provide has not been received by CalOptima within the prior quarter. If at the quarterly determination following such withhold, CalOptima determines that Physician Group has satisfactorily delivered to CalOptima the previously non-delivered Encounter Data; such withheld Capitation Payment shall be paid to Physician Group, without interest. In the event that Physician Group does not deliver such Encounter Data to CalOptima prior to such quarterly determination, CalOptima shall be entitled to retain such withheld Capitation Payment and may withhold three (3%) percent from each quarter's Capitation Payment until CalOptima receives the Encounter Data.

7.5 **Disclosure of Provider Profiling**. Physician Group shall, upon request from CalOptima, provide. CalOptima with information regarding any "economic profiling" of Group Physicians by Physician Group in order to permit CalOptima to comply with the provisions of Section 1367.02 of the Knox-Keene Act. Further, to the extent that Physician Group utilizes "economic profiling" as defined in Section 1367.02, Physician Group shall provide copies of economic profiling information to Providers in accordance with the requirements of Section 1367.02.

7.6 **Financial Reporting**. Physician Group shall prepare financial information requested in accordance with Generally Accepted Accounting Principles ("**GAAP**"). Where financial statements and projections are requested by CalOptima and/or CalOptima's Regulators, these statements and projections should be prepared in accordance with the 1989 HMO Financial Report of Affairs and Conditions Format. Where appropriate, reference has been made to the Knox-Keene Act rules found under Title 28 CCR Section 1300.51 *et. seq*. Information submitted shall be based on Physician Group's current operations. Physician Group shall submit financial information consistent with filing requirements of the DMHC, unless otherwise specified by CMS.

7.7 **Financial Statements**. CalOptima, as a Knox-Keene Act health care service plan, is required by CalOptima's Regulators to monitor the financial viability of its contracted provider network on an on-going basis. Physician Group agrees to provide CalOptima annually with a copy of Physician Group's audited financial statements, including letters to management for the most recent fiscal year end along with an opinion letter on these statements from the accounting firm that completed an audit on these financial statements. Financial statements shall be presented in a form specified by CalOptima that clearly shows the financial position of Physician Group as related to Enrollees. Physician Group shall allow representatives of CalOptima, upon written request, to verify the financial reports. In the event audited statements are unavailable, Physician Group agrees to provide CalOptima with the unaudited financial statements at Physician Group's fiscal year end. The unaudited financial statements will include: balance sheets, income statement and statement of cash flows, notes to the financial statement, name of the person preparing these statements, and representation letters from the senior financial executives of the Physician Group, attesting that these financial statements were prepared in accordance with GAAP and fairly present the financial condition of the Physician Group.

7.8 **Reports Regarding Disclosure of Confidential Enrollee Information**. If Physician Group, or any of its officers, employees, agents, or Downstream Entities, becomes aware of the unauthorized disclosure of confidential Enrollee information or of "personal information", within the meaning of California Civil Code Section 1798.3, Physician Group shall report said unauthorized disclosure to CalOptima's Privacy Officer immediately upon discovery of said disclosure, providing information on the information disclosed and how the disclosure occurred. For purposes of this section, "unauthorized disclosure" includes any unauthorized access, whether such access was

through inadvertence, mistake, theft, or other means, and whether or not Physician Group had reasonable control to avoid the disclosure. Nothing herein is intended to limit or replace Physician Group's separate obligations under the Business Associate Agreement and Laws.

7.9 **Additional Information Required by CalOptima's Regulators**. Physician Group and Downstream Entities shall, at the request of CalOptima or CalOptima's Regulators, provide the following: (i) all information related to the performance of CalOptima's responsibilities, including non-medical information for the purposes of research and evaluation, to CalOptima's Regulators; (ii) any information required to comply with all Laws; and (iii) any information required for external rapid cycle evaluation, including program expenditures, service utilization rates, rebalancing from institutional to community settings, Enrollee satisfaction, Enrollee complaints and Appeals, and enrollment/disenrollment rates.

VIII. RECORD RETENTION, ACCESS AND CONFIDENTIALITY

8.1 **Disclosure of Records**. Physician Group and its Downstream Entities agree to maintain and make available contracts, books, documents, records, and electronic systems, including, Medical Records, (collectively, the "**Records**") to CalOptima, HHS, CMS, the Comptroller General, the U.S. Government Accountability Office, any Quality Improvement Organization, or accrediting organizations, including NCQA, their designees, and other representatives of regulatory or accrediting organizations, for inspection, evaluation, and auditing. For purposes of utilization management, quality improvement, and other CalOptima administrative purposes, CalOptima and CalOptima's Regulators shall have access to, and copies of, at reasonable time upon request, the Medical Records, books, charts, and papers relating to the provision of health care services to Enrollees, the cost of such services, and payments received by Physician Group or any of Group Physicians from Enrollees (or from others on their behalf). Copies of the Medical Record shall be provided at no charge to CalOptima. Unless a longer time is required under applicable law, the records described herein shall be maintained for at least ten (10) years from the final date of the Contract or from the completion of any audit, whichever is later.

8.2 **Medical Records**. Physician Group will require that all Group Physicians and Downstream Entities establish and maintain in an accurate and timely manner, for each Enrollee who has obtained Covered Services from a Group Provider or Downstream Entity, a legible Medical Record which shall be kept in detail consistent with good medical and professional practice in accordance with Laws and CalOptima Policies. Such Medical Records shall include a historical record of diagnostic and therapeutic services recommended or provided by, or under the direction of, the Provider. Such Medical Records shall be in such a form as to allow trained health professionals, other than the Provider, to readily determine the nature and extent of the Enrollee's medical problem and the services provided and permit peer review of the care provided. Physician Group shall ensure that medical information is released in accordance with applicable Laws, or pursuant to valid court orders or subpoenas, subject to compliance with applicable privacy laws. Physician Group shall ensure than an individual is delegated the responsibility of securing and maintaining Medical Records at each Physician Group or Downstream Entity site.

8.3 **Right to Inspection**. Medical Records referred to in Section 8.2 above will be and remain the property of Physician Group or Group Physicians and will not be removed or transferred from their offices except in accordance with Laws. CalOptima or its designated representatives will have the right, in accordance with this Article 8, to inspect, review, and make copies of such records at Physician Group's expense upon request to facilitate CalOptima's obligation to conduct quality management, utilization monitoring, and peer review activities.

8.4 **Records Related to Recovery for Litigation**. Upon request by CalOptima, Physician Group and its Downstream Entities shall timely gather, preserve, and provide to CalOptima, in the form and manner specified by CalOptima, any information specified by CalOptima, subject to any lawful privileges, in Physician Group's or its Downstream Entities' possession, relating to threatened or pending litigation by or against CalOptima, HHS, and CMS. If Physician Group asserts that any requested documents are covered by a privilege, Physician Group shall: (1) identify such privileged documents with sufficient particularity to reasonably identify the document while retaining the privilege; and (2) state the privilege being claimed that supports withholding production of the document. Such request shall include a response to a request for documents submitted by any party in any litigation by or against CalOptima. Physician Group acknowledges that time may be of the essence in responding to such request. Physician Group shall use all reasonable efforts to immediately notify CalOptima of any subpoenas, document production requests, or requests for records received by Physician Group or its Downstream Entities related to this Contract or subcontracts entered into under this Contract.

8.5 **State and Federal Site Visits**. Physician Group agrees to permit CalOptima, the DMHC, HHS, and/or CMS to conduct a site evaluation of Physician Group and its facilities in accordance with Laws and to comply with the agencies' recommendations, if any.

8.6 **Enrollee Access to Records**. Physician Group (including Physician Group Providers) and its Downstream Entities shall ensure that Enrollees have access to their Medical Records in accordance with the requirements of Laws. An Enrollee shall be provided a copy of his or her Medical Records, upon request, and shall have the right to request corrections or amendments to their Medical Records as specified in 45 CFR Part 164. Physician Group and Downstream Entities shall furnish a copy of the Enrollee's Medical Records to another treating or consulting Provider regardless of whether the requesting Provider is a Participating Provider, at no cost to CalOptima or the Enrollee when (i) such a transfer of Medical Records facilitates the continuity of that Enrollee's care; (ii) the Enrollee is transferring from one Provider to another for treatment; and (iii) an Enrollee seeks to obtain a second opinion on the diagnosis or treatment of a medical condition.

IX. INSURANCE AND LIABILITY

9.1 **Indemnification**. Each Party agrees to defend, indemnify, and the other Party and the State and CMS harmless, with respect to any and all claims, costs, damages, and expenses, including reasonable attorney's fees, that are related to or arise out of the negligent or willful performance or non-performance by the indemnifying Party, or any functions, duties, or obligations of such Party. Neither termination of the Contract nor completion of the acts to be performed under this Contract shall release either Party from its obligation to indemnify as to any claims or cause of action asserted so long as the event(s) upon which such claims or cause of action is predicated shall have occurred prior to the effective date of termination or completion. CalOptima and Physician Group agree to promptly notify the other Party of any claims or demands that arise and for which indemnification hereunder is sought.

9.2 **Insurance Requirements**.

9.2.1 **Professional/Medical Malpractice**. Each Group Physician and Participating Provider providing Covered Services to Enrollees shall maintain a professional liability (medical malpractice) insurance policy for the specialty or type of service that the Group Physician provides with minimum limits of one million dollars ($1,000,000) per incident and three million dollars ($3,000,000) in the aggregate.

9.2.2 **Commercial General Liability**. Physician Group and each Participating Provider who has entered into a contract with Physician Group to provide Covered Services under this Contract shall maintain a Commercial General Liability insurance policy with minimum limits of one million dollars ($1,000,000) per occurrence and three million dollars ($3,000,000) in the aggregate. CalOptima must be named as an additional insured on Comprehensive General Liability insurance policy with respect to performance under this Contract.

9.2.3 **Workers' Compensation**. Group Physician and each Participating Provider who has entered into a contract with Physician Group to provide Covered Services under this Contract shall maintain a Workers' Compensation Insurance policy with minimum limits as follows:

- Employers' Liability Insurance:
  - One million dollars ($1,000,000) Bodily Injury by Accident - each accident.
  - One million dollars ($1,000,000) Bodily Injury by Disease - policy limit
  - One million dollars ($1,000,000) Bodily Injury by Disease - each employee

9.2.4 **Managed Care Errors and Omissions**. Physician shall maintain a Managed Care Errors and Omissions Insurance policy with minimum limits as follows:

- Managed Care Errors and Omissions: Ten million dollars ($10,000,000) each claim/ten million dollars ($10,000,000) aggregate

9.2.5 **Electronic and Computer Crimes Insurance**. HMO and its Downstream Entities shall maintain electronic and computer crimes insurance and employee fidelity insurance with limits of at least one million dollars ($1,000,000) if HMO and/or its Downstream Entities will be paying claims or receiving funds on behalf of CalOptima, or will be storing, transmitting, and/or receiving personally identifiable and/or protected health information on a regular basis in carrying out its obligations under this Contract.

9.2.6 **Insurer Ratings**. Insurance required under this Article IX shall be provided by an insurer:

(a) Rated by A.M. Best with a rating of A V or better; and

(b) "Admitted" to do business in California or an insurer approved to do business in California by the California Department of Insurance and listed on the Surplus Lines Association of California List of Eligible Surplus Lines Insurers (LESLI); or

(c) An Unincorporated Interindemnity Trust Arrangement as authorized by the California Insurance Code 12180.7

9.2.7 **Captive Risk Retention Group/Self Insured**. Where any of the insurance(s) mentioned in this Article IX is provided by a captive risk retention group or self-insured, insurer ratings requirements above may be waived at the sole discretion of CalOptima, but only after review of the captive risk retention group's or self-insured's audited financial statements.

9.2.8 **Cancellation or Material Change**. Physician Group shall not of its own initiative cause such insurance as addressed in this Article IX to be cancelled or materially changed during the Term.

9.2.9 **Proof of Insurance**. Certificates of Insurance of the insurance policies and/or evidence of self-insurance required under this Article IX shall be provided to CalOptima prior to Effective Date, annually thereafter, and upon request.

X. COOPERATION

10.1 **Non-Interference**. Physician Group and Downstream Entities may not prohibit of otherwise restrict a health care professional, acting within the lawful scope of practice, from freely communicating with Enrollees about their treatment and the following, regardless of benefit coverage limitations:

10.1.1 The Enrollee's health status, medical care, or treatment options (including any alternative treatments that may be self-administered), including the provision of sufficient information to provide an opportunity for the Enrollee to decide among all relevant treatment options;

10.1.2 The risks, benefits, and consequences of treatment or non-treatment; or

10.1.3 The opportunity for the Enrollee to refuse treatment and to express preferences about future treatment decisions.

10.2 **No Counseling to Dis-enroll**. Physician Group and Group Physicians agree that they will not, during the Term, provide advice to or counsel any Enrollee to dis-enroll from CalOptima, and Physician Group and Group Physicians will not solicit such Enrollee to become enrolled with any other health maintenance organization, preferred provider organization, or any other similar hospitalization, medical payment plan or insurance program.

10.3 **Cooperation**. CalOptima and Physician Group agree that, to the extent compatible with the separate and independent management of each, they will at all times maintain an effective liaison and close cooperation with each other to provide maximum benefits to Enrollees at the most reasonable cost, consistent with quality standards of hospital and physician care.

10.4 **Signs**. Physician Group agrees that CalOptima may post notices, mutually acceptable as to size, content and form in a prominent place instructing Enrollees as to proper procedures and limitations on coverage.

10.5 **Free Exchange of Information**. No provision of this Contract shall be construed to prohibit, nor shall any provision in any contract between Physician Group and its employees or Downstream Entities, prohibit, the free, open, and unrestricted exchange of any and all information of any kind between Providers and Enrollees regarding the nature of the Enrollee's medical condition, the health care treatment options and alternatives available and their relative risks and benefits, whether or not covered or excluded under the Enrollee's Evidence of Coverage, and the Enrollee's right to appeal any adverse decision made by Physician Group or CalOptima regarding coverage of treatment which has been recommended or rendered. Physician Group and CalOptima agree not to penalize nor sanction any Provider in any way for engaging in such free, open, and unrestricted communication with an Enrollee nor for advocating for a particular service on an Enrollee's behalf.

XI. TERM AND TERMINATION

11.1 **Term of Contract**. The term of this Contract shall become effective on the Effective Date and continue in effect for five (5) years through _____ ("Initial Term") and five (5) additional one-year automatic extensions except as directed otherwise by the Board.

11.2 **Sanctions and Terminations for Cause**. If Physician Group fails to fulfill any of its duties and obligations under this Contract, including: (i) committing acts to discriminate against Enrollees; (ii) engaging in any practice that would reasonably be expected to have the effect of denying or discouraging enrollment with the Physician Group by Enrollees whose medical condition or history indicated a need for substantial future medical services; (iii) not providing Covered Services in the scope or manner required under this Contract; (iv) engaging in prohibited marketing activities; (v) failing to comply with CalOptima's compliance and fraud, waste and abuse programs; (vi) failing to meet financial requirements in Article II; (vii) committing fraud, waste or abuse relating to Covered Services or any and all obligations, duties, and responsibilities under this Contract; (viii) failure to enforce claims payment prohibitions on Group Physicians who are denied the right to submit claims and/or receive reimbursement for services furnished to Enrollees; (ix) failure of Group Physicians to comply with pharmacy requirements as determined by CalOptima; (x) failure to submit Encounter Data or comply with other reporting requirements pursuant to this Contract and CalOptima Policies; and/or (xi) failure to take corrective action related to any such obligation or duty in the time or manner required by CalOptima, CalOptima may take any one or more of the actions described in this Article XI.

11.3 **Corrective Action Plans**. CalOptima may require a Corrective Action Plan ("**CAP**") in the event that any report, audit, survey, site review or investigation indicates that the Physician Group or any Downstream Entity is not in compliance with any provision of this Contract.

11.3.1 A CAP shall be required if CalOptima receives a substantiated complaint or grievance related to the standard of care provided by the Physician Group or any Downstream Entities. CalOptima shall issue a written notice of deficiency and shall require that a CAP to be submitted within thirty (30) calendar days following the date of notice unless otherwise stated. The CAP shall include the time and manner in which the deficiency shall be corrected. CAPs are subject to approval by CalOptima, which may be approved as submitted, accepted with specific modifications, or rejected. CalOptima may extend or reduce the time allowed for completion of the CAP depending upon the nature of the deficiency.

11.3.2 Notwithstanding any request for a CAP, CalOptima may impose monetary penalties, suspend enrollment, reduce maximum enrollment, or impose other sanctions when the Physician Group is not in compliance with the provisions of this Contract, CalOptima Policies, and minimum performance requirements as established by CalOptima. All monetary fines are payable to CalOptima within thirty (30) calendar days of receipt of written notice, unless otherwise stated in the notice. Failure to submit payment to CalOptima for any monetary fines within the thirty (30) calendar day period shall result in CalOptima deducting the penalty plus administrative fees from the Physician Group's Capitation Payment.

11.4 **CalOptima Termination for Cause**. Notwithstanding and in addition to any other provisions of this Contract, CalOptima may terminate this Contract for cause effective upon thirty (30) calendar days' written notice; cause shall include, but shall not be limited to, the actions set forth in Section 11.2. CalOptima's rights and remedies provided in this provision shall not be exclusive and are in addition to any other rights and remedies provided by law or this Contract.

11.5 **Physician Group Termination for Cause**. Physician Group may terminate this Contract for cause only upon thirty (30) calendar days' written notice and only in the event that CalOptima fails to make payments due under this Contract within fifteen (15) calendar days of when such amounts are due and payable.

11.6 **Immediate Terminations**. In addition to all other sanction and termination rights, CalOptima may terminate Contract immediately upon delivery of written notice to Physician Group if:

11.6.1 Physician Group (including Group Physicians) and/or its Downstream Entities are unable to secure the necessary governmental licenses, approvals, and/or certificates required for the performance of their duties;

11.6.2 CalOptima determines that the health, safety, or welfare of Enrollees is jeopardized by continuation of this Contract;

11.6.3 Physician Group commits fraud, waste, or abuse; or

11.6.4 CMS fails to authorize or reauthorize CalOptima to operate a MA Program for a period that overlaps the Term.

11.7 **Without Cause Termination**. Following the Initial Term, either Party may terminate this Contract for convenience, without cause, by giving written notice to the other Party of at least one hundred and eighty (180) calendar days' prior to the effective date of such termination.

11.8 **Bankruptcy**. If during the Term there is filed by or against Physician Group in any court pursuant to any statute of the United States or any state, a petition in bankruptcy or insolvency or for reorganization or for the appointment of a receiver or trustee or conservator of all or a portion of Physician Group's assets, or if Physician Group makes an assignment for the benefit of creditors, or if Physician Group becomes unable, admits in writing its inability, or fails generally to pay its debts as they become due, this Contract may, at the option of CalOptima, be canceled and terminated. In the event of the filing of a petition for bankruptcy by or against Physician Group, Physician Group shall assure that all of Physician Group's functions and duties related to the Contract are performed in accordance with the terms of the Contract. CalOptima shall have the right to withhold any and all amounts otherwise due to Physician Group until Physician Group fully discharges its obligations under the Contract. CalOptima shall also have the immediate right of offset by permanently retaining any and all withheld amounts as necessary to ensure that all Physician Group obligations have been met.

11.9 **Termination of CMS Contract.** In the event the CMS Contract with CalOptima is terminated or not renewed, the provisions of this Contract shall automatically terminate unless otherwise specified by CalOptima and subject to any provisions that survive termination. Any term provided in the Contract is subject to CMS's continuing approval of CalOptima's MA Program. Physician Group agrees to assist CalOptima with such transfer of care requirements mandated by CMS in the event of termination of the CMS Contract.

11.10 **Continuation of Benefits**. Physician Group and its Participating Providers agree that, in the event of CalOptima's insolvency or cessation of operations, benefits to Enrollees will continue through the period for which capitation has been paid or until the discharge of Enrollee from an inpatient facility, whichever time is greater. Covered Services to an Enrollee confined in an inpatient facility on the date of insolvency or other cessation of operations will continue until their appropriate discharge.

11.11 **Physician Group Obligations Following Termination**. In the event of termination of this Contract, at CalOptima's sole option, Physician Group will continue to provide Covered Services, and CalOptima shall reimburse for such services per the Medicare fee schedule, to Enrollees until CalOptima has made arrangements with alternative Providers to render care to Enrollees. Physician Group shall cooperate and assist CalOptima in the transfer of Enrollee care in the event this Contract or any relevant Downstream Entity subcontract is terminated for any reason. Physician Group shall provide a plan for the orderly termination of services under this Contract, in form and substance acceptable to CalOptima.

11.12 **Prohibition on Use of Certain Group Physicians**. Physician Group agrees that CalOptima reserves the right to require Physician Group, upon notification from CalOptima, to prohibit any Group Physician or Downstream Entity from providing services, whether Covered Services or otherwise, to Enrollees when CalOptima deems such prohibition to be in the best interests of the Enrollees, provided that imposition of the foregoing prohibition shall not terminate this Contract.

XII. GENERAL PROVISIONS

12.1 **Dispute Resolution**.

12.1.1 **Provider Appeals Process**. CalOptima maintains a Provider dispute resolution process. Physician Group may appeal any aspect of the CalOptima MA Program, including a decision to impose a sanction, terminate this Contract, or take other actions against Physician Group, by filing a complaint pursuant to CalOptima Policies. Physician Group shall exhaust all administrative remedies and any government claims requirements, as applicable, before commencing arbitration.

12.1.2 **Meet and Confer**. For any dispute not subject to or resolved by the provider appeals process, or if either Party has a dispute it seeks to address informally, the Parties shall use reasonable efforts to informally meet and confer to try and resolve the dispute. The Parties shall meet and confer within thirty (30) days of a written request submitted by either Party in an effort to settle any dispute. At each meet-and-confer meeting, each Party shall be represented by persons with final authority to settle the dispute. If either Party fails to meet within the thirty (30)-day period, that Party shall be deemed to have waived the meet-and-confer requirement, and at the other Party's option, the dispute may proceed immediately to arbitration under Section 12.1.3.

12.1.3 **Arbitration**. If the Parties are unable to resolve any dispute arising out of or relating to this Contract under Sections 12.1.1 and 12.1.2, either Party may submit the dispute for resolution exclusively through confidential, binding arbitration, instead of through trial by court or jury, in Orange County, California. The Parties may agree in writing prior to commencing the arbitration on the dispute resolution rules and arbitration service that will be used to resolve the dispute. If the Parties cannot reach such an agreement, the arbitration will be conducted by Judicial Arbitration and Mediation Services ("**JAMS**") in accordance with the commercial dispute rules then in effect for JAMS; provided, however, that this Contract shall control in instances where it conflicts with JAMS's (or the applicable arbitration service's) rules. The arbitration shall be conducted on an expedited basis by a single arbitrator. The Parties prefer that the arbitrator be a retired judge of the California Superior, Appellate, or Supreme Court or of a United States court sitting in California. If no such retired judge is available, the arbitrator may be an attorney with at least fifteen (15) years of experience, including at least five (5) years in managed health care. If the Parties are unable to agree on the arbitrator within thirty (30) days of the date that the arbitration

service accepts the arbitration, the arbitrator shall be selected by the arbitration service from a list of four potential arbitrators (all of whom shall be on arbitration services' panel of arbitrators) submitted by the Parties, two from each side; provided, however, that nothing stated in this section shall prevent a Party from disqualifying an arbitrator based on a conflict of interest. In making decisions about discovery and case management, it is the Parties' express agreement and intent that the arbitrator at all times promote efficiency without denying either Party the ability to present relevant evidence. In reaching and issuing decisions, the arbitrator shall have no jurisdiction to make errors of law and/or legal reasoning. The Parties shall share the costs of arbitration equally, and each Party shall bear its own attorneys' fees and costs.

12.1.4 **Exclusive Remedy**. With the exception of any dispute that under Laws may not be settled through arbitration, arbitration under Section 12.1.3 is the exclusive method to resolve a dispute between the Parties arising out of or relating to this Contract that is not resolved through the provider appeals or meet-and-confer processes.

12.1.5 **Waiver**. By agreeing to binding arbitration as set forth in Section 12.1.3, the Parties acknowledge that they are waiving certain substantial rights and protections which otherwise may be available if a dispute between them was determined by litigation in a court, including the right to a jury trial, attorneys' fees, and certain rights of appeal.

12.2 **Interpretation of Contract Language**. CalOptima has the right to final interpretation of the Contract language when disputes arise. Physician Group has the right to appeal disputes concerning Contract language to CalOptima.

12.3 **Waiver**. The waiver by either Party of a breach or violation of any provision of this Contract will not operate as or be construed to be a waiver of any subsequent breach thereof. To be effective, a waiver must in writing signed by the Parties.

12.4 **Assignment**. This Contract and the rights, interests, duties, and obligations hereunder shall not be assigned, transferred, pledged, or hypothecated in any way by Physician Group nor shall the duties and obligations imposed herein be subcontracted or delegated without the prior written consent of CalOptima, which consent may be withheld in CalOptima's sole and absolute discretion for any reason or no reason. Physician Group acknowledges and agrees that CalOptima's consent, if any, to assignment and/or delegation is subject to the approval of CMS. Therefore, any assignment and/or delegation of this Contract, including the rights, interests, duties, and obligations hereunder, shall be void unless prior written consent is obtained from CalOptima and CMS. Physician Group further acknowledges and agrees that CalOptima may require Physician Group and the proposed assignee/sub-delegate to cooperate in due diligence and sub-delegation assessment activities as part of its review of any request for consent to assignment of this Contract and the rights, interests, duties, and obligations hereunder. Physician Group agrees to cooperate and provide such information as requested by CalOptima. Physician Group acknowledges and agrees that (i) CalOptima's due diligence and/or assessment activities related to any proposed assignment may take one hundred eighty (180) days or more; (ii) in no event shall CalOptima's due diligence and/or delegation assessment activities be construed as CalOptima's consent to assignment; and (iii) any consent to assignment by CalOptima must be reflected in a separate writing executed by CalOptima and other relevant parties. CalOptima may, from time to time, establish policies and procedures regarding its processes for initiating review and approval of any proposed assignment of this Contract. For purposes hereof, the term "**assignment**" shall include any of the following: (i) the change of more than twenty-five percent (25%) of the ownership or equity interest in Physician Group (whether in a single transaction or in a series of transactions); (ii) the change of more than

twenty-five percent (25%) of the directors or trustees of Physician Group; (iii) the merger, reorganization, or consolidation of Physician Group with another entity with respect to which Physician is not the surviving entity; and/or (iv) a change in the management of Physician Group from management by persons appointed, elected, or otherwise selected by the governing body of Physician Group (e.g., the Board of Directors) to a third-party management person, company, group, team or other entity.

12.5 **Independent Parties**. None of the provisions of this Contract are intended to create nor will be deemed or construed to create any relationship between the Parties other than that of independent contractors, solely for the purposes of effecting the provisions of the Contract. Neither of the Parties nor any of their respective officers, directors, or employees shall act as nor be construed to be the agent, the employee, or the representative of the other Party.

12.6 **Integration of Entire Contract**. This Contract contains all of the terms and conditions agreed upon by the Parties regarding the subject matter of this Contract. Any prior agreements, promises, negotiations or representations of or between the Parties, either oral or written, relating to the subject matter of this Contract that are not expressly set forth in this Contract are null and void and of no further force or effect.

12.7 **Invalidity or Unenforceability**. The invalidity or unenforceability of any terms or provisions hereof will in no way affect the validity or enforceability of any other term or provision.

12.8 **Amendment**. CalOptima may amend this Contract immediately upon written notice to Physician Group in the event such amendment is required in order to maintain compliance with Laws. CalOptima may deem all other amendments to the Contract effective after at least forty-five (45) business days' notice or earlier if agreed to by Physician Group. All amendments of this Contract are subject to CMS approval.

12.9 **No Waiver of Immunity or Privilege**. Any information delivered, exchanged, or otherwise provided hereunder shall be delivered, exchanged, or otherwise provided in a manner, which does not constitute a waiver of immunity or privilege under applicable law.

12.10 **Choice of Law; Jurisdiction and Venue**. This Contract shall be governed by and construed in accordance with all State and federal laws and regulations governing the CMS Contract. The Parties consent to the jurisdiction of the California Courts with venue in Orange County California.

12.11 **Force Majeure**. Either Party, upon prompt written notice to the other Party, shall be excused from performance hereunder for any period that it is prevented from meeting the terms of this Contract as a result of a catastrophic occurrence or natural disaster, including, but not limited to, an act of war and excluding labor disputes ("**Force Majeure Event**");

12.12 **No Liability of County of Orange**. As required under Ordinance No. 3896, as amended, of the County of Orange, State of California, CalOptima and the Physician Group hereby acknowledge and agree that the obligations of CalOptima under this Contract are solely the obligations of CalOptima, and the County of Orange, State of California, shall have no obligation or liability therefor.

12.13 **Confidential and Proprietary Information**. Physician Group agrees to maintain confidential the following information (the "**Confidential Information**"): (a) eligibility lists and any other information containing the names, addresses and telephone numbers of CalOptima Enrollees; (b) CalOptima's administrative service manuals and all forms related thereto; (c) the financial

arrangements between CalOptima and any Participating Provider; and (d) any other information compiled or created by CalOptima that is proprietary to CalOptima and that CalOptima identifies as proprietary to Physician Group in writing. Physician Group shall not disclose or use the Confidential Information for its own benefit or gain either during the Term or after the date of termination of this Contract. Physician Group may use the Confidential Information to the extent necessary to perform its duties under this Contract or upon express prior written permission of CalOptima. Upon the effective date of termination of this Contract, Physician Group shall promptly return to CalOptima the Confidential Information in its possession, upon CalOptima's notice.

12.14 **Third Party Beneficiaries**. Nothing in this Contract, express or implied, is intended to or shall confer upon any other person or entity, any right, benefit or remedy of any nature whatsoever.

12.15 **Survival**. The terms set forth in the following sections shall survive the expiration or termination of this Contract, whether with or without cause, by rescission or otherwise, as to all Covered Services provided under this Contract prior to termination: Sections 6.2, 6.5, 7.8, Article 8, 9.1, 11.10, 11.11, 12.1, 12.2, 12.3, 12.5, 12.6, 12.7, 12.9, 12.10, 12.12, 12.13, 12.14, and any other sections that, by their terms, are intended to survive termination of the Contract.

12.16 **Recitals and Exhibits**. The recitals and exhibits set forth in this Contract are made a part of the Contract by this reference.

12.17 **Without Limitation**. Any reference in the Contract to "include(s)" or "including" means inclusion without limitation, unless otherwise distinguished within the text.

12.18 **Notices**. All notices shall be in writing and shall be deemed to have been duly given on the date of service if personally served on the Party to whom notice is given, or seventy-two (72) hours after mailing by electronic mail transmission, United States priority mail, United States mail first class (Certified Mail or Registered Mail), addressed to the Party to whom notice is to be given and such party's address as set forth below or such other address provided by notice.

To: CalOptima

Attention: Chief Operating Officer
505 City Parkway West
Orange, California 92868

To: Physician Group

_____

_____

_____

XIII. CONDITIONS PRECEDENT TO CONTRACT COMMENCEMENT

13.1 **Contract Effectiveness**. The Contract is subject to CalOptima's determination, in its sole discretion, that the following conditions have been met prior to the Effective Date: (i) Physician Group has successfully met all criteria in CalOptima's readiness assessment, including financial viability and delegated function criteria; Physician Group has signed CalOptima's Business Associate Agreement; and (iii) Physician Group has furnished all required documentation and data requested by CalOptima (e.g., insurance documents, licenses).

13.2 **Additional CalOptima Regulator Requirements**. CalOptima, in its sole discretion, may condition this Contract upon Physician Group's ability to meet other criteria imposed by CalOptima Regulators.

XIV. SIGNATURES

SUBJECT TO (I) THE UNITED STATES GOVERNMENT PROVIDING FUNDS FOR THE TERM OF THIS CONTRACT AND FOR THE PURPOSES WITH RESPECT TO WHICH IT IS ENTERED INTO; AND (II) THE APPROVAL OF THIS CONTRACT BY DMHC AND CMS, THIS CONTRACT SHALL BECOME EFFECTIVE ON THE EFFECTIVE DATE AND SHALL TERMINATE ON AS PROVIDED IN THIS CONTRACT.

IN WITNESS WHEREOF, CalOptima and Physician Group have executed this Contract as indicated below.

FOR Physician Group:	FOR CALOPTIMA:
_____	_____
SIGNATURE	SIGNATURE
_____	Yunkyung Kim
PRINT NAME	PRINT NAME
_____	Chief Operations Officer
TITLE	TITLE
_____	_____
DATE	DATE

ATTACHMENT A
DEFINITIONS

1. "**Administrative Services**" means those non-clinical, administrative functions that are the responsibility of the Physician Group as set forth under the Contract and in CalOptima Policies.

2. "**Advance Directive**" means an individual's written directive or instruction, such as a power of attorney for health care or a living will, recognized under state law (whether statutory or as recognized by the courts of the state) for the provision of that individual's health care if the individual is unable to make his or her health care wishes known.

3. "**Appeals**" means an Enrollee's actions, both internal and external to CalOptima, requesting review of the denial, reduction, or termination of benefits or services from CalOptima.

4. "**Authorization/Authorized**" means the approval of CalOptima, or its delegate (which may include Physician Group), for the provision or referral of Covered Services, obtained in accordance with, and as further described in, the Provider Manual and this Contract.

5. "**Behavioral Health**" means the mental health services and substance use disorder services arranged for or provided to Enrollees by a separate Mental Health Plan, CalOptima, or their subcontractors.

6. "**CalOptima Formulary**" means the CalOptima Approved Drug List, the Disposable Medical Equipment/Supplies List, the CalOptima OneCare Formulary, and any additional formularies as may be designated by CalOptima and provided to CalOptima's designated pharmacy benefits manager "**PBM**". There is no applicable CalOptima Formulary for the PACE program.

7. "**CalOptima Policies**" means CalOptima policies and procedures, including CalOptima's Provider Manual, that are amended from time to time at the sole discretion of CalOptima and incorporated into this Agreement by this reference.

8. "**CalOptima's Regulators**" means those government agencies that regulate and oversee CalOptima's and its FDRs' activities and obligations under this Contract including the Department of Health and Human Services, CMS, and the DMHC and other government agencies that have authority to set standards and oversee the performance of the parties to this Contract, as well as their respective agents and contractors quality improvement organizations.

9. "**Capitation Payment**" means the monthly payment paid to Physician Group by CalOptima for delivery for Covered Services to Enrollees, which is determined by multiplying the applicable Capitation Rate by Physician Group's monthly enrollment.

10. "**Capitation Rate**" means the rate set by CalOptima for the delivery of Covered Services to an Enrollee.

11. "**Care Coordinator**" means a clinician or other trained individual employed by or contracted with Physician Group who is accountable for providing care coordination services for Enrollees, as required by CalOptima Policies and who services on one or more ICTs.

12. "**C.C.R.**" means the California Code of Regulations.

13. "**C.F.R.**" means the Code of Federal Regulations.

14. "**CMS**" means the Center for Medicare & Medicaid Services.

15. "**CMS Contract**" means the agreement between CMS and CalOptima under which CalOptima can establish its MA Program for Enrollees.

16. "**COB**" refers to the coordination of benefits and determination of order of financial responsibility that applies when two or more health benefit plans provide coverage of items and services for an individual.

17. "**Compliance Program**" means the program (including the compliance manual, code of conduct and CalOptima Policies) developed and adopted by CalOptima to promote, monitor, and ensure that CalOptima's operations and practices and the practices of its Board members, employees, contractors, and Providers comply with applicable law and ethical standards. The Compliance Program includes CalOptima's Fraud, Waste and Abuse ("**FWA**") plan.

18. "**Covered Services**" means those health care items, drugs, and services that an Enrollee is entitled to receive pursuant to a Program applicable to that Enrollee. Covered Services must generally be referred and Authorized in confirming with CalOptima's Policies, including its utilization management program."

19. "**Delegation**" means the process by which CalOptima expressly grants, by formal written agreement to another entity, the authority to carry out a function that would otherwise be required to be performed by CalOptima in order to meet its obligations under the CMS Contract.

20. "**Delegation Agreement**" means the formal written agreement by which CalOptima grants to another entity the authority to carry out a function that would otherwise be required to be performed by CalOptima to meet its obligations under the CMS Contract.

21. "**Delegation Criteria**" means those criteria adopted by CalOptima, for the delegation of activities in the areas of UM, medical records audits, the Office Site Review, 'Enrollee's rights and responsibilities, and credentialing, as set forth in CalOptima Policies.

22. "**DMHC**" means the California Department of Managed Health Care.

23. "**Downstream Entity**" means all Providers and other persons or entities with which Physician Group has entered into a written subcontract (acceptable to CMS) to perform administrative functions and/or health care services to satisfy Physician Group's obligations to CalOptima under this Contract, continuing down to the ultimate provider of services. The term "Physician Group" as used in the terms of this Contract shall also include its subcontractors when such subcontractors are Downstream Entities, even if not expressly referenced in the particular provision.

24. "**Emergency Medical Condition**" means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, with an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in: (i) placing the health of the individual (or with respect to a pregnant woman, the health of the woman and her unborn child) in serious jeopardy; or (ii) serious impairment to bodily functions; or (iii) serious dysfunction of any bodily organ or part.

25. "**Emergency Services**" means those covered inpatient and outpatient services that are (i) furnished by a Provider qualified to furnish Emergency Services; and (ii) needed to evaluate and/or stabilize an Enrollee's Emergency Medical Condition.

26. "**Encounter Data**" means the record of an Enrollee receiving any item(s) or service(s) provided through Medicaid or Medicare under a prepaid, capitated, or any other risk basis payment methodology submitted to CMS. The encounter data record shall incorporate HIPAA security, privacy, and transaction standards and be submitted in ASCX12N 837 or any successor format required by CalOptima's Regulators.

27. "**Enrollee**" means an eligible individual who is enrolled in the CalOptima MA Program.

28. "**Evidence of Coverage**" means the document approved by CalOptima's Regulators and issued by CalOptima to Enrollees that describes Enrollee's benefits under the CalOptima MA Program.

29. "**FDR**" means a party that enters into a written agreement (acceptable to CMS) to provide administrative or health care services to CalOptima and/or its Enrollees that are governed by the CMS Contract.

30. "**FQHC**" means an entity that meets all of the requirements for designation as a federally qualified health center under § 1861(aa)(3) of the Social Security Act and is approved for participation in the MA program.

31. "**Grievance**" means an oral or written expression of dissatisfaction, including any compliant, dispute, request for reconsideration, or appeal, made by an Enrollee.

32. "**Group Physician**" means a Physician who is employed by or under contract with Physician Group to provide physician services.

33. "**Health Network**" means Physician Group, a physician-hospital consortium, or health care service plan (such as an HMO) that is contracted with CalOptima to provide items and services to Enrollees on a capitated basis.

34. "**HEDIS**" means the set of standardized performance measures sponsored and maintained by the NCQA.

35. "**HRA**" means the health risk assessment tool that identifies an Enrollee's primary, acute, LTSS, Behavioral Health, and functional needs.

36. "**HIPAA**" means the Health Insurance Portability and Accountability Act of 1996, Public Law 104-191, the Health Information Technology for Economic and Clinical Health Act, Public Law 111-005, and regulations promulgated thereunder by the U.S. Department of Health and Human Services, including Title 45 of the C.F.R, Parts 160 and 164.

37. "**Hospital(s)**" means licensed acute care hospital(s) that have entered into an agreement with CalOptima or Physician Group to provide services to Enrollees in the CalOptima program and where Physician Group customarily admits patients.

38. "**ICP**" means the plan of care developed by an Enrollee and/or his/her ICT or CalOptima.

39. "**Indian Enrollee**" means an Enrollee who is an Indian (as defined in the Indian Health Care Improvement Act of 1976 [25 U.S.C. §§ 1603(13), 1603 (13 and 23), or 1679(a)] or who has been determined as an Indian under 42 C.F.R. § 136.12.

40. "**Indian Health Care Provider**" means a health care program operated by the Indian Health Services or by an Indian Tribe, Tribal Organization, or Urban Indian Organization, as those terms are defined in Section 4 of the Indian Health Care Improvement Act (25 U.S.C. § 1603).

41. "**ICT**" means an interdisciplinary care team comprised of the primary care provider and Care Coordinator and other Providers at the discretion of the Enrollee that work with the Enrollee to develop, implement, and maintain the ICP.

42. "**Laws**" means any local, State, or federal statute, regulation, rule, or executive or agency order applicable to this Contract.

43. "**LTSS**" means the range of long-term services and supports that help Enrollees meet their daily needs for assistance and improve the quality of their lives and which include: (i) In-Home Supportive Services ("**IHSS**"); (ii) Community-Based Adult Services ("**CBAS**"); (iii) Multi-purpose Senior Services Program ("**MSSP**") services; and (iv) skilled nursing facility services and sub-acute care services.

44. "**Medically Necessary**" or "**Medical Necessity**" means when addressing Covered Services: (i) under Medicare, reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member, or otherwise medically necessary under 42 U.S.C. Section 1395y.

45. "**Medical Record**" means any record kept or required to be kept by any Provider that documents medical services received by the Enrollee, including inpatient, outpatient, emergency care, referral requests, and Authorizations in accordance with applicable laws including Title 28 C.C.R. § 1300.80(b), Title 42 U.S.C. § 1396a(w), 42 C.F.R. § 456.111 and 42 C.F.R. § 456.211 and CalOptima Policies.

46. "**Mental Health Plan**" means the entity that has contracted with DHCS to provide Specialty Mental Health Services to individuals, including Enrollees.

47. "**Model of Care**" means the component of CalOptima's quality improvement framework that is evidence-based, includes certain clinical and non-clinical elements, and is in addition to the comprehensive care coordination requirements specified in CalOptima Policies.

48. "**Non-Covered Services**" means those services that are not benefits under the CalOptima MA Program in accordance with CalOptima's Evidence of Coverage and applicable state and federal laws and regulations.

49. "**Non-Participating Provider**" means an institution, professional, or other Provider of health care services who has not entered into an agreement, either with CalOptima or Physician Group, to provide medical and other services to Enrollees.

50. "**Out-of-Area**" means that area that is outside the Service Area.

51. "**Outpatient Mental Health Services**" means outpatient services that are provided to Enrollees with mild to moderate mental health conditions including: (i) individual/group mental health evaluation and treatment (psychotherapy); (ii) psychological testing when clinically indicated to evaluate a mental health condition; (iii) outpatient services for the purpose of monitoring drug therapy; (iv) psychiatric consultation for mediation management; and (v) outpatient laboratory supplies and supplements.

52. "**Participating Provider**" means an institution, professional, or other provider of health care services who has entered into an agreement, either with CalOptima or Physician Group, to provide health care services to Enrollees.

53. "**PCC**" means the personal care coordinator(s) employed by Physician Group to comply with the CalOptima MOC Program.

54. "**PCC Component to the Model of Care Profile**" means the PCC Components identified in the Model of Care Profile.

55. **"Physician"** means a person with an unrestricted license to practice medicine or osteopathy in the state in which they practice.

56. "**Physician Direct Referral**" means the process whereby a PCP has the authority the decide whether a referral is deemed necessary for an Enrollee and if deemed necessary the PCP will directly refer that Enrollee within said Physician Group to any of the specialties or services specified in CalOptima Policies without requiring the prior Authorization of Physician Group.

57. "**Post-Stabilization Care Services**" means services related to an Emergency Medical Condition that are provided after an Enrollee is Stabilized in order to maintain the Stabilized condition, or under some circumstances, to improve or resolve the condition.

58. "**Preclusion List**" means the CMS-compiled list of providers and prescribers who are precluded from receiving payment for MA items and services or Part D drugs furnished or prescribed to Medicare beneficiaries.

59. "**PCP**" means a primary care physician responsible for supervising, coordinating, and providing initial and primary care to Enrollees; for serving as the medical home; for processing initial referrals for Specialist Physician care; and for maintaining the continuity of patient care.

60. "**Program**" is health care benefit program offered by CalOptima to Enrollees. Programs and their designs are subject to change periodically.

61. "**Provider**" means a physician, nurse, nurse mid-wife, nurse practitioner, medical technician, physician assistant, hospital, laboratory, health maintenance organization ("**HMO**"), or other person or institution who furnishes health care items or services.

62. "**Provider Manual**" means that comprehensive online document, as amended from time to time, and describes CalOptima's Policies and procedures affecting Physician Group Physicians' services under this Contract.

63. "**Referral**" means the process by which the Participating Provider Physician directs an Enrollee to seek and obtain Covered Services from a health professional or for care at a facility.

64. "**Rural Health Clinic (RHC)**" means an entity that meets all of the requirements for designation as a rural health clinic under § 1861(aa)(1) of the Social Security Act and is approved for participation in the MA program.

65. "**Service Area**" means the geographic area within Orange County, California.

66. "**Shared Risk Services**" will mean those Covered Services that are the financial responsibility under the Hospital Budget, as set forth in Attachment B.

67. "**Specialist Physician**" means any physician who is not a PCP, has the requisite training and education, and meets all other requirements set by CalOptima Policies for specialists.

68. "**Stabilize**" or "**Stabilized**" means, with respect to an Emergency Medical Condition, to provide such medical treatment of the condition to assure within reasonable medical probability that no material deterioration of the condition is likely to result or occur during the transfer of the individual from a facility, or in the case of a pregnant woman, that the woman has delivered the child and placenta.

69. "**Threshold Language"** means those languages as determined by CalOptima's Regulators from time to time and identified in guidance on translation requirements provided to CalOptima.

70. "**Urgent Care**" means services required to prevent serious deterioration of health following the onset of an unforeseen condition or injury and are medical services required promptly to prevent impairment of health due to symptoms that do not constitute an Emergency Medical Condition but that are the result of an unforeseen illness, injury or condition for which medical services are immediately required.

ATTACHMENT B
CALOPTIMA SENIOR PLAN
MATRIX OF FINANCIAL RESPONSIBILITY
January 1, 2023

	PHYSICIAN GROUP	RESPONSIBLE PARTY	
SERVICES	**GROUP**	**SHARED RISK SERVICES BUDGET (Between Group and Plan)**	**PLAN**
Medicare Part A Services – Not Otherwise Assigned Herein or in Any Agreement Incorporating This Exhibit:			
Inpatient		**X**	
Outpatient		**X**	
Medicare Part B Services Not Otherwise Assigned Herein or in Any Agreement Incorporating This Exhibit	**X**		
Some of the main services and those related to the Risk Sharing Program are listed below:			
Acupuncture (Medicare covered)	**X**		
Allergy			
Testing and Treatment	**X**		
Serum	**X**		
Ambulance – Air and Ground			
Emergency		**X**	
Inter-facility Transfers (all vehicle types)		**X**	
Amniocentesis			
Facility Component			
Outpatient (if not provided in physician office setting)		**X**	
Professional Component	**X**		
Audiologic			
Diagnostic	**X**		
Biofeedback	**X**		
Blood & Blood Products/Blood Transfusions (including professional component)			
Autologous Blood Donation		**X**	
From Blood Bank		**X**	
Cataract Surgery			

SERVICES	GROUP	SHARED RISK SERVICES BUDGET (Between Group and Plan)	PLAN
Professional Component	X		
Facility Component (Hospital Based Outpatient – Including Implanted Lenses)		X	
Facility Component (Ambulatory Surgery Center – Including Implanted Lenses)		X	
Chemical Dependency Rehabilitation and Detox (Medicare Covered)			
Professional Component	X		
Facility Component		X	
Methadone outpatient clinics			X
Chemotherapy			
Drugs – Outpatient (Part B)		X	
Drugs – Outpatient (Part D)			Rx
Professional Component	X		
Facility Component		X	
Chiropractic (Medicare covered)	X		
Dental Services (Medical)			
Professional Component	X		
Facility Component		X	
Facility Component (Non-Hospital) Based	X		
Diabetic Supplies			
Insulin and syringes (Rx Benefit)-see Medication-Outpatient Prescription Drug Benefit			Rx
Home Glucose Monitoring Equipment and Supplies)	X		
Diagnostic Testing			
Technical Component (Outpatient)	X		
Professional Component	X		
Durable Medical Equipment (DME)			
Outpatient	X		
Emergency Room			
Facility Component		X	
Professional Component (including interpretive reports)	X		

SERVICES	GROUP	SHARED RISK SERVICES BUDGET (Between Group and Plan)	PLAN
Endoscopy			
Facility Component		X	
Professional Component	X		
Family Planning			
Therapeutic Abortion Services, Tubal Ligation, Vasectomy, etc.			
Facility Component		X	
Professional Component	X		
Fetal Monitoring			
Facility Component		X	
Professional Component	X		
Genetic Testing/Counseling	X		
Health Education	X		
Hemodialysis/Dialysis			
Outpatient (Includes drugs per Medicare guidelines)		X	
Professional Component	X		
Home Health Care			
Medicare covered home health services (Including home IV therapy, excluding Part D drugs)		X	
Home Health Supplies (see medical supplies)		X	
Hospice	**Medicare FFS has primary responsibility**		
Hospitalization			
Facility Component (Including pre-admission diagnostic services)		X	
Interpretive Reports	X		
Professional Component (Including hospital-based physicians)	X		
Immunization and Inoculations (Part B)	X		
Immunization and Inoculations (Part D)			**Rx**
Infusion Therapy			
Professional Component	X		
Facility Component		X	

SERVICES	GROUP	SHARED RISK SERVICES BUDGET (Between Group and Plan)	PLAN
Part B drugs		X	
Part D drugs			Rx
Injectables -- (Outpatient) (see also Chemotherapy)			
Part B drugs		X	
Part D drugs			Rx
Lithotripsy			
Professional Component	X		
Facility Component		X	
Mammography	X		
Maternity/Obstetrics			
Facility Component		X	
Professional Component	X		
Medical supplies (includes catheters)			
Outpatient	X		
Medication			
Outpatient – Prescription Drug Benefit (Part D)			Rx
Outpatient medications (Part B)		X	
Mental Health			
Facility Component (includes Partial Hospitalization)		X	
Professional Component			X
Nuclear Medicine			
Inpatient, Facility Component (therapeutic)		X	
Outpatient, Facility Component	X		
Professional Component	X		
Nutrition			
Nutritional/Dietetic Counseling (Medicare Covered)	X		
Parenteral Nutrients, Supplies, Kits and Pumps			
Part B		X	
Part D			X
Enteral Nutrients, Supplies, Kits and Pumps			

SERVICES	GROUP	SHARED RISK SERVICES BUDGET (Between Group and Plan)	PLAN
Outpatient			**X**
Organ Transplants			
Pre Evaluation (All Inclusive)	**X**		
Organ Acquisition		**X**	**Medicare FFS for Kidney only**
Transplant Professional Component	**X**		
Transplant Facility Component (includes organ acquisition)		**X**	
Post Transplant (up to one year for transplant related services)			
Professional Component	**X**		
Post Transplant Facility Component (Inpatient)		**X**	
Post Transplant Facility Component (Outpatient – if provided in physician office setting)	**X**		
Orthotics and Prosthetics (Medicare Covered)			
Outpatient (Medicare defined coverage applies)		**X**	
Ostomy Supplies			
Outpatient	**X**		
Out of Area (Emergent and Urgently Needed Services)			
Facility Component		**X**	
Professional Component	**X**		
Outpatient Diagnostic Tests and Services (All Inclusive)	**X**		
Outpatient Surgery			
Facility Component (Hospital Based)		**X**	
Facility Component (Freestanding Ambulatory Surgery Center)		**X**	
Professional Component	**X**		
Cardiac catheterization and Angiograms (Professional)	**X**		
Cardiac catheterization and Angiograms (Facility)		**X**	
Physical Therapy (See Rehabilitation)			
Pain Management			

SERVICES	GROUP	SHARED RISK SERVICES BUDGET (Between Group and Plan)	PLAN
Professional	X		
Facility (if provided in other than physician office setting)		X	
Physician Visits/Consultations (inclusive of all settings)	X		
Podiatry Services (Medicare covered)	X		
Radiation Therapy			
Professional	X		
Facility, outpatient facility		X	
Radiology Services			
Outpatient, Preoperative, and Inpatient Professional Component	X		
Inpatient (facility component)		X	
Rehabilitation (Short Term e.g.: PT, OT, Speech, Cardiac)			
Outpatient Facility Component	X		
Professional Component	X		
Skilled Nursing Facility (SNF)			
Facility Component (All Inclusive)		X	
Professional Component	X		
Social Services – Medical	X		
Surgically Implanted Devices – All Categories		X	
Vision Care			
Annual routine exam			X
Glasses			X
Lenses and Frames incidental to cataract surgery (Medicare covered)	X		
Screening, Physician Office	X		
Notes:			
1. Financial responsibility is based on Medicare benefit interpretations and limitations.			
2. The symbol "Rx" denotes outpatient prescription drug services.			
Assignment of financial responsibility as outlined in this document is independent of the questions of medical necessity, coverage or benefits.			

ATTACHMENT C
CAPITATION RATES AND RISK SHARING

1. **Capitation Allocation**

1.1 **Allocation of Non-Part D CMS Revenue**. Each month, CalOptima shall allocate both the non-Part D related capitation that CalOptima receives from CMS for Enrollees affiliated with Physician Group and any applicable premiums that CalOptima charges Enrollees affiliated with Physician Group (collectively, the "**Total Revenues**") as follows:

- Facility and Other Services ("**Hospital Budget**") xx.x%
- Physician Group Capitation Payment xx.xx%

1.2 **MLR**. In accordance with Section 2.3, "Medical Loss Ratio", of the Contract, Physician Group shall maintain a minimum acceptable loss ratio of eighty-five percent (85%). Should Physician Group not meet the minimum eighty-five percent (85%) MLR, CalOptima reserves the right to require Physician Group to return to CalOptima the difference between eighty-five percent (85%) of Capitation Payments and the allowed medical expenses.

1.3 **Personal Care Coordinator**.

1.3.1 In addition to the amounts described above, and contingent on CalOptima Board of Directors' approval, CalOptima will pay Physician Group, ____dollars and ____cents ($xx.xx), a per Enrollee, per month amount for PCCs. The commencement date, amount, and duration of such PCC capitation payments, if any, will be established by the action of the CalOptima Board of Directors, and will be deemed incorporated herein by reference. Such payments, if any, may be adjusted in accordance with the PCC Reference Manual and are subject to recovery, termination, or offset as provided in this Contract and in the PCC Reference Manual.

1.3.2 Physician Group acknowledges and agrees that CalOptima may adjust and/or terminate the PCC Capitation Payments in the event Physician Group fails to comply with the requirements outlined in the PCC component of the model of care (MOC) profile. Physician Group acknowledges and agrees that CalOptima, in its sole and absolute discretion, may also offset Physician Group's future PCC Capitation Payments in the event CalOptima determines that Physician Group has not complied with the requirements set forth in the PCC component of the MOC Profile.

1.4 **Sequestration**. If CMS reduces payment to CalOptima under the CMS Contract by more than two percent (2%) at any time during the Term, CalOptima may, upon written notice to Physician Group, reduce payment to Physician Group under this Attachment C by the same percentage that CMS reduced payment to CalOptima. This provision applies each time CMS reduces payment to CalOptima by more than two percent (2%) during the Term.

1.5 **Pay-for-Performance Program**. CalOptima will develop a pay-for performance program to provide incentive payments to Physician Group. Payments will be calculated and paid

quarterly and annually based on a per Enrollee, per month rate and reflect achievement of specified program goals, which are determined by CalOptima in its sole discretion.

1.6 **Hospital Shared Risk Program Between CalOptima and Physician Group**. As an incentive to control hospital service utilization, a Hospital Shared Risk Program covering Medicare shall be established and administered by CalOptima whereby both CalOptima and Physician Group shall be at risk for the utilization of Shared Risk Services.

1.7 **Shared Risk Services—Definition**. Shared Risk Services are defined as all Covered Services that are the financial responsibility under the Hospital Budget as set forth in Attachment B.

1.8 **Shared Risk Budget and Costs**. A Shared Risk budget shall be established. The Shared Risk budget shall be the Medicare Hospital Budget percentage. Shared Risk costs shall be the actual amounts paid for Shared Risk Services less any recoveries, including overpayments and reinsurance.

1.9 **Copayments and Coordination of Benefits**. Any applicable copayments payable for Shared Risk Services shall be deducted from Shared Risk Costs. Amounts payable for COB or worker's compensation shall be deducted from Shared Risk costs for the particular service. Amounts actually received by facility and other services providers under the Hospital Budget through third-party liability recoveries for Shared Risk Services shall be deducted from Shared Risk costs in the period in which such payment is actually received, up to the amount of Shared Risk costs for the particular service.

1.10 **Shared Risk Program Settlement**. The program for Shared Risk Services shall be administered on a calendar year basis ("**Shared Risk Period**"). It shall be based on compensation earned and services rendered during the calendar year on an accrual basis, regardless of when paid, including adequate incurred but not reported ("**IBNR**") expenses, provided that only those expense items received up to and within ninety (90) days after the end of the current calendar year shall be included in the computation of the IBNR expense of the Shared Risk Services. Within one hundred twenty (120) days following the end of each calendar year of this Contract, CalOptima shall prepare a final report of the status of the Shared Risk Program. Over and under accrual of the IBNR in the current Shared Risk Period shall be adjusted in the subsequent Shared Risk Period.

1.10.1 **Deficit**. If Shared Risk Costs exceed the Shared Risk budget, fifty percent (50%) of such deficit, up to an amount not to exceed $5.00 per Enrollee, per month calculated on a calendar year basis shall be considered the responsibility of the Physician Group. Any and all deficits for which the Physician Group is responsible shall be carried forward and applied to any future Shared Risk program settlements. In the event of termination of this Contract, all deficits shall be forgiven.

1.10.2 **Surplus**. If Shared Risk costs are less than the Shared Risk budget, fifty percent (50%) of such surplus shall be paid to Physician Group by CalOptima. Any and all surplus payments shall be offset by any deficits in any other risk-sharing arrangements.

2. **Risk Pool Reports and Timely Settlement**.

2.1 **CalOptima Shared Risk Pool for Reports and Maintenance of Records related to the Risk Pool**. CalOptima shall be responsible for maintenance of records and development of reports required for administration of the Hospital Shared Risk programs. To ensure timely settlements on risk-sharing programs, CalOptima shall prepare final reports within one hundred and twenty (120) days following the end of each calendar year.

2.2 **Objections to Final Report**. Physician Group shall have thirty (30) days following receipt to review such reports produced by CalOptima. Absent objections in such thirty (30)-day period, the reports shall be considered acceptable, and all payments due pursuant to such reports shall be made.

2.3 **Settlement in the Event of Termination**. Notwithstanding anything else in the Agreement, in the event of termination of the Contract in accordance with the provisions of Article XI, the Hospital Shared Risk programs shall also terminate, once CMS has provided the annualized capitation adjustment (also known as HCC sweeps) for the period up to the termination date of this Contract.

ATTACHMENT D
CLAIMS PROCESSING AND COMPLIANCE OBLIGATIONS

I. DEFINITIONS

1.1 "**Clean Claim**" means one that can be processed without obtaining additional information from the provider of the service or from a third party. Clean claim shall have the same meaning as "complete claim" as that term is defined in Title 28, CCR Section 1300.71(a)(2). Clean Claim does not include a claim from a Provider who is under investigation for fraud or abuse, or a claim under review for Medical Necessity.

1.2 "**Unclean Claim**" means any claim other than as defined in Section 1.1 of this attachment.

1.3 "**Denied Claim**" means a claim where (a) one or more services will not be paid by Physician Group and (b) payment is the responsibility of the Enrollee. Examples of claims that are not denials and should not be reported, submitted, or presented to CalOptima as Denied Claims include claims:

1.3.1 For patients who remain enrolled with CalOptima but have transferred to another Physician Group and Physician Group is forwarding the claim,

1.3.2 For which payment responsibility belongs to another contracting entity, and Physician Group is forwarding the claim,

1.3.3 That are duplicates,

1.3.4 That are encounter only/capitated claims and no patient liability is involved, and

1.3.5 That involve reduced payment amounts due to contract terms or allowed Medicare fee schedules.

II. GENERAL TERMS

2.1 **Physician Group Claims Processing**. Physician Group shall process claims for Provider services according to all CMS requirements and, as applicable, in accordance with the requirements of the Knox-Keene Act. This Attachment D is intended to comply with all DMHC and CMS standards and requirements. Should this Attachment D be out of compliance with any existing or newly enacted DMHC or CMS standard or requirement, the DMHC and/or CMS standard or requirement will supersede this Attachment D. CalOptima will communicate any changes in requirements to Physician Group in writing.

2.2 If Physician Group enters into a contract with a Downstream Entity whereby the responsibility for claims processing is delegated to that Downstream Entity, Attachment D provisions shall apply. Physician Group will have contractual provisions to ensure such Downstream Entity conforms to all DMHC and CMS requirements and oversight provisions as outlined herein and in CalOptima Policies.

2.3 Physician Group and any applicable Downstream Entity shall be required to have an oversight program for claims processing that includes written policies and procedures, a process for reporting fraudulent or unethical conduct, and an executive accountable for review of claims data and attesting to its accuracy. The oversight program shall include internal auditing of claims functions, and self-reporting as outlined in CalOptima Policies.

III. CLAIMS PROCESSING

3.1 **Timely Provider Payments**.

3.1.1 Physician Group and Downstream Entities, if, and as applicable, must make timely payments to Participating Providers consistent with 42 CFR § 447.45.

3.1.2 Physician Group shall reimburse Clean Claims, or any portion of any Clean Claim, for Covered Services, as soon as practical, but no later than thirty (30) calendar days after receipt of the claim by Physician Group, unless the claim or portion thereof is reasonably contested, in which case the claimant shall be notified in writing that the claim is contested or denied within forty-five (45) business days after receipt of the claim by Physician Group in accordance with CalOptima Policies.

3.1.3 Physician Group must ensure that ninety percent (90%) of claims from Providers who are in individual or group practice, which can be processed without obtaining additional information from the Provider or from a third party, will be paid within thirty (30) days of the date of receipt of the claim.

3.1.4 Physician Group must ensure that ninety-nine percent (99%) of all Clean Claims from Providers for Covered Services will be paid within ninety (90) days of the date of receipt of the claim.

3.1.5 Generally, the date of receipt is the date the Physician Group receives the claim, as indicated by its date stamp on the claim. The date of payment is the date of the check or other form of payment.

3.1.6 **"30-Day" Claim Timeliness**. Physician Group shall adjudicate nine-five percent (95%) of all Clean Claims from Non-Participating Providers or suppliers within thirty (30) calendar days of receiving the claim. Adjudicate a claim shall be deemed to mean to have processed the claim (paid or denied) and mailed the remittance advice by the thirtieth (30^{th}) calendar day since the earliest receipt by Physician Group or CalOptima's contracting Providers or Hospitals.

3.1.7 **"60-Day" Claim Timeliness**. Physician Group shall pay or deny Unclean Claims from Non-Participating Providers or suppliers, claims from Participating Providers or suppliers, and claims from Medicare fiscal intermediaries and carriers within sixty (60) calendar days of receipt of such claims. Processing shall be deemed to mean either to have paid or denied and mailed the remittance advice by the sixtieth (60^{th}) calendar day since the earliest receipt by Physician Group or CalOptima's contracting Providers or Hospitals, or to have denied the claim, and have mailed the denial letter to the Enrollee by the sixtieth (60^{th}) day. In accordance with federal law and CMS regulations, failure to process such claims within sixty (60) calendar days of receipt automatically constitutes an "adverse" initial determination, which the Enrollee may appeal; thus, a denial notice must be mailed to the Enrollee.

3.1.8 **Payment Accuracy**. When paying Non-Participating Providers, Physician Group shall employ only those Medicare fee schedules that MA plans are allowed to use by law and shall comply with 42 CFR § 422.214.

3.1.9 **Denied Claims**. Decisions to deny claims that result in liability for the Enrollee must be

made in accordance with CMS guidelines. Whenever such decisions are made, the currently CMS approved Notice of Denial of Payment or Integrated Denial Notice must be used, including approved denial reasons. Under no circumstances shall Physician Group deny a claim for the second time as a consequence of responding to a request for reconsideration from an Enrollee; instead, Physician Group must direct the Enrollee to submit the request directly to CalOptima as appropriate.

3.2 **Claims for Emergency and Post-Stabilization Services.**

3.2.1 Physician Group shall not retroactively deny a claim for Emergency Services because the condition, which appeared to be an Emergency Medical Condition, turned out to be non-emergency in nature. Physician Group shall ensure that its claims processing actions do not conflict with Hospital actions required to comply with the Emergency Medical Treatment and Active Labor Act ("**EMTALA**").

3.2.2 If there is a disagreement between Physician Group or any Participating Provider and any Non-Participating Provider regarding Medically Necessity of Covered Services in an emergency, the judgment of the attending physician(s) actually caring for the Enrollee at the treating facility shall prevail. Physician Group may establish relationships with treating facility whereby the Physician Group may send a Participating Provider with privileges to assume the attending physician's responsibilities to establish treatment or may arrange to have a Participating Provider under contract with Physician Group agree to accept the transfer of the Enrollee after the Enrollee has been Stabilized.

3.2.3 Physician Group shall ensure that an enrollee with an Emergency Medical Condition will be seen on an emergency basis and that Emergency Services will be available and accessible within the Service Area twenty-four (24) hours a day. Physician Group shall cover Emergency Services without prior Authorization pursuant to Title 28 CCR Section 1300.67(g), Title 22 CCR Section 53216, and Section 1932(b)(2) of the Social Security Act. Physician Group shall coordinate access to Emergency Services in accordance with 42 CFR § 438.114 and the Physician Group's emergency department protocol.

3.2.4 Physician Group may not refuse to cover Emergency Services based on the emergency room Provider, Hospital, or fiscal agent not notifying the Enrollee's PCP managed care organization, prepaid ambulatory health plan, prepaid inpatient health plan or applicable State entity of the Enrollee's screening and treatment within ten (10) calendar days of presentation for Emergency Services. An Enrollee who has an Emergency Medical Condition may not be held liable for payment of subsequent screening and treatment needed to diagnose the specific condition or Stabilize the Enrollee.

3.2.5 Physician Group may not deny payment for treatment obtained under either of the following circumstances: an Enrollee had an Emergency Medical Condition, including cases in which the absence of immediate medical attention would not have had the outcomes specified in the definition of an Emergency Medical Condition; or the Physician Group representative instructs the Enrollee to seek Emergency Services. The attending emergency Physician, or the Provider actually treating the Enrollee, is responsible for determining when the Enrollee is sufficiently Stabilized for transfer or discharge, and that determination is binding on the entities as responsible for coverage and payment.

3.2.6 Physician Group must cover and pay for Post-Stabilization Care Services. Physician Group is financially responsible for Post-Stabilization Care Services obtained within or outside

the organization that are pre-approved by a Physician Group Provider or other Physician Group representative. Physician Group is financially responsible for Post-Stabilization Care Services obtained within or outside the Physician Group organization that are not pre-approved by a Participating Provider or other Physician Group representative, but are administered to maintain the Enrollee's Stabilized condition within one (1) hour of a request to the Physician Group for pre-approval of further Post-Stabilization Care Services. Physician Group is financially responsible for Post-Stabilization Care Services obtained from within or outside the Physician Group that are not pre-approved by a Participating Provider or other Physician Group representative, but administered to maintain, improve, or resolve the Enrollee's Stabilized condition if the Physician Group: does not respond to a request for pre-approval within one (1) hour; cannot be contacted; or the Physician Group representative and the treating physician cannot reach an agreement concerning the Enrollee's care and a Participating Provider is not available for consultation. In this situation, the Physician Group must give the treating Physician the opportunity to consult with a Participating Provider and the treating Physician may continue with care of the Enrollee until a Participating Provider is reached or one criteria in 42 C.F.R. § 113(c)(3) is met. Physician Group must limit charges to Enrollees for Post-Stabilization Care Services to an amount no greater than what the Physician Group would charge the Enrollee if he or she had obtained the services through Physician Group. Physician Group financial responsibility for Post-Stabilization Care Services it has not pre-approved ends when: a Participating Provider with privileges at the treating Hospital assumes responsibility for the Enrollee's care; a Participating Provider assumes responsibility for the Enrollee's care through transfer; Physician Group representative and the treating Physician reach an agreement concerning the Enrollee's care; or; the Enrollee is discharged.

3.2.7 Physician Group shall reimburse those Physicians providing Emergency Services and Urgent Care services with whom Physician Group has a contract according to the terms of that contract.

3.2.8 Physician Group must reimburse a Non-Participating Provider for Emergency Services or Urgent Care services at the prevailing Medicare fee-for-service ("**FFS**") rate as applicable for that service. Where the Covered Service would traditionally be covered under Medicare FFS, the Medicare FFS rate applies. Physician Group shall ensure that Enrollees maintain balance billing protections as provided in Section 6.4 of this Contract.

3.2.9 In accordance with CalOptima Policies, Physician Group shall implement the CMS Quality Payment Program known as the Merit-based Incentive Payment System ("**MIPS**"). MIPS adjustments for Part B covered professional services furnished by MIPS-eligible Providers that are not contracted with Physician Group shall be administered in the same manner as any other changes in the applicable Medicare payment schedules. Physician Group shall make positive and negative payment adjustments as identified by CMS based on the CMS MIPS adjustment data files.

3.2.9.1 CalOptima or Physician Group may apply MIPS payment adjustments either at the time the payment is made during the applicable MIPS payment year or as a retrospective adjustment to paid claims.

3.2.9.2 CalOptima or Physician Group are required to demonstrate payment through reporting or attestation by the end of March on an annual basis.

3.3 **Physician Group Financial Responsibility**. If CalOptima receives a claim for Covered Services that are the financial responsibility of Physician Group, CalOptima shall forward such claim to Physician Group for payment, in accordance with the procedures set forth in Title 28 CCR Section 1300.71, "Claims Settlement Practices." CalOptima shall not pay for services that are Physician Group's financial responsibility unless Physician Group fails to make payment within the time allowed by State and federal laws and regulations, and CalOptima is required by law to make such payment. In such cases, CalOptima, after written notice to Physician Group and reasonable opportunity to cure, will make payment, and Physician Group shall reimburse CalOptima for such payments. If Physician Group fails to reimburse CalOptima, CalOptima may offset an uncontested payment(s) against Capitation Payments or other amounts due from CalOptima to Physician Group, if any.

3.4 **Collection of Share of Cost**. Physician Group shall collect Medicare share of cost unless prohibited under this Contract.

3.5 **Capitation Payments**. Physician Group and/or Downstream Entities shall distribute monthly Capitation Payments to capitated Participating Providers within fifteen (15) calendar days following the date on which Physician receives payment from CalOptima.

3.6 **Claims Adjudication**. Except as provided in Section 3.1.1, Physician Group shall accept and adjudicate claims for Covered Services provided to Enrollees in accordance with the provisions of Sections 1371, 1371.1, 1371.2, 1371.22, 1371.35, 1371.36, 1371.37, 1371.38, 1371.4 and 1371.8 of the California Health & Safety Code, and Sections 1300.71, 1300.71.38, 1300.71.4, and 1300.77.4 of Title 28 of the CCR and CalOptima Policies. Waiver of any right or obligation specific to the Health and Safety Code and Title 28 related to claims processing and payment shall be prohibited.

3.7 **Dispute Resolution.** Physician Group shall establish and maintain a fair, fast and cost-effective dispute resolution mechanism to process and resolve provider disputes in accordance with the provisions of Sections 1371, 1371.1, 1371.2, 1371.22, 1371.35, 1371.36, 1371.37, 1371.38, 1371.4 and 1371.8 of the California Health & Safety Code, and Sections 1300.71, 1300.71.38, 1300.71.4, and 1300.77.4 of Title 28 of the CCR and CalOptima Policies.

3.8 **Right of Appeal**. Physician Group shall afford Providers an unconditional right of appeal and de novo review for claims disputes involving issues of Medical Necessity. Any Provider that submits a claim dispute to Physician Group's dispute resolution mechanism involving an issue of Medical Necessity or utilization review shall have an unconditional right of appeal for that claim dispute to CalOptima's dispute resolution process for a de novo review and resolution for a period of sixty (60) working days from Physician's Date of Determination.

3.9 **CalOptima Payment On Behalf Of Physician**. If CalOptima receives a copy of an unpaid Clean Claim as part of a Provider grievance that is thirty (30) working days old or more, CalOptima will follow all notification and acknowledgement procedures pursuant to CalOptima Policies. If Physician Group does not either notify CalOptima that the claim is reasonably contested, as set forth in CalOptima Policies, or pay the Clean Claim within the thirty (30) working day period, CalOptima shall pay the Claim on behalf of Physician, plus interest, as required by the Knox-Keene Act, and deduct the amounts reimbursed, plus processing costs, from the Capitation Payment, in accordance with CalOptima Policies.

3.10 **Quarterly Claims Payment Performance Report.**

3.10.1 Physician Group shall submit, in a format specified by CalOptima Policies, a quarterly claims payment performance report ("**Quarterly Claims Report**") to CalOptima within thirty (30) calendar days of the close of each calendar quarter. The Quarterly Claims Report shall, at a minimum, disclose Physician Group's compliance status with Sections 1371, 1371.1, 1371.2, 1371.22, 1371.35, 1371.36, 1371.37, 1371.4, and 1371.8 of the California Health and Safety Code and Sections 1300.71, 1300.71.38, 1300.71.4 and 1300.77.4 of Title 28 of the CCR.

3.10.2 Physician Group shall ensure that each Quarterly Claims Report is signed by, and includes the written verification of, a principal officer, as defined by Section 1300.45(o) of Title 28 of the CCR, of Physician Group, stating that the report is true and correct to the best knowledge and belief of the principal officer.

3.10.3 Physician Group's Quarterly Claims Report shall include a tabulated record of each Provider dispute it received, categorized by date of receipt, and including the identification of the Provider, type of dispute, disposition and working days to resolution, as to each Provider dispute received. Each individual dispute contained in a Provider's bundled notice of Provider dispute shall be reported as a separate dispute to CalOptima.

3.11 **Forwarding of Misdirected Claims.**

3.11.1 Physician Group shall have the ability to receive a standard ANSI 837I and ANSI 837P claim file format for retrieving misrouted claims that are the financial responsibility of the Physician Group. Physician Group will receive and forward misdirected claims per CalOptima Policy.

3.11.2 Physician Group shall have the ability to create a standard ANSI 837I and ANSI 837P claim file for forwarding claims that are the financial responsibility of CalOptima within ten (10) working days of receipt of the claim. CalOptima shall receive these files per CalOptima policy and load them into its system to ensure timely claims processing. Physician Group shall forward any claims that are not its payment responsibility to CalOptima within eight (8) calendar days of receipt, so that a total of only ten (10) working days will elapse prior to the claims being in the proper hands.

3.12 **Assumption of Delegated Functions**. In the event that Physician Group fails to timely and accurately reimburse its claims (including the payment of interest and penalties), CalOptima may, at its sole discretion, revoke the delegation and assume responsibility from Physician Group for claims payment, or terminate this Contract as provided for in Article XI. CalOptima's assumption of responsibility for the processing and timely reimbursement of Provider claims may be altered to the extent that Physician Group has established an approved CAP consistent with Section 1375.4 (b)(4) of the Health and Safety Code and Section 11.3 of the Contract.

3.13 **Recoupment for Assumption of Claims Processing Obligations**. CalOptima, in its sole and absolute discretion, may reduce Physician Group's Capitation Payments to recoup additional administrative costs for the assumption of the claims processing obligations of Physician Group, as described in this Article III of Attachment D, as well as any amounts, including interest due, on claims unpaid at the assumption of such obligations by CalOptima.

IV. CLAIMS COMPLIANCE

4.1 **Claims Compliance Monitoring**. Physician Group understands that claims compliance programs are required by CalOptima's Regulators and agrees that delegation is contingent upon Physician Group's compliance with required monitoring and oversight activities, as outlined in CalOptima Policies. Physician Group agrees that CalOptima reserves the right to monitor Physician Group's claims compliance activities, notwithstanding any other audit, compliance, or contractual issue between Physician Group and CalOptima. In the event Physician Group demonstrates an inability to meet CalOptima's claims payment standards, CalOptima reserves the right to revoke and assume the delegated responsibilities described above.

4.2 **Claims Non-Compliance**. In the event that CalOptima determines that Physician Group is not in ninety-five percent (95%) compliance with any of the requirements of Attachment D the following actions will be applied:

4.2.1 Within thirty (30) days of an audit that documents non-compliance, CalOptima will issue a written warning to Physician Group that describes the non-compliance. Physician Group will respond within fifteen (15) working days of receiving the non-compliance notification with a written CAP to comply. Such CAP will describe the actions to be taken and the schedule by which those actions will be completed. CalOptima will review the CAP and advise Physician Group whether or not actions or time schedules are acceptable within fifteen (15) days of receiving it. CalOptima will conduct a follow-up audit of Physician Group's claims operation within ninety (90) days from the date of serving the non-compliance notification to verify compliance with Attachment D. If CalOptima does not receive a CAP within fifteen (15) calendar days, the consequences outlined in Subsection 4.2.2 of this attachment for continued non-compliance will apply.

4.2.2 If, as a result of CalOptima's follow-up audit, Physician Group is found to still be non-compliant with Attachment D within fifteen (15) calendar days of making that determination, CalOptima will notify Physician Group in writing of the continued non-compliance and may elect to provide consultative or other assistance to help establish, maintain and monitor continued administrative compliance or assume "joint administration" of Physician Group's claims operations, involving itself only with Enrollees' claims and allowing the operation to remain on Physician Group's premises. The Parties agree to meet and develop a mutually agreeable work plan for added staffing and work stations, the cost of which will be Physician Group's sole responsibility. CalOptima will develop a CAP with Physician Group's participation to assure maximum compatibility with Physician Group's ongoing operations. CalOptima will cooperate with Physician Group in implementing changes across all risk claims processed at that site, should Physician Group so request. Within fifteen (15) calendar days of receiving the second notice of non-compliance, Physician Group will provide a written response stating the specific action to be taken to establish compliance with the help of CalOptima. If CalOptima does not receive a CAP within fifteen (15) calendar days, the consequences outlined in Subsection 4.2.3 for continued non-compliance will apply. Within ninety (90) days from the date of serving the second notice of non-compliance, CalOptima will re-audit Physician Group's claims process and documents to determine final compliance or non-compliance.

4.2.3 If, as a result of its second follow-up audit, CalOptima reasonably determines that Physician Group is still non-compliant, CalOptima reserves the right to terminate this

Contract for material breach upon ten (10) days' prior written notice and opportunity to cure.

4.2.4 Physician Group may resume sole administrative responsibility for claims processing if CalOptima determines that Physician Group has corrected the deficiencies that caused the non-compliance, and, as a result of resuming responsibility for claims processing, demonstrates compliance with the timely provider payments requirements set forth in Section 3.1 of this Attachment D.

4.2.5 With respect to the requirements of Attachment D, Physician Group will be subject to regular site-audits conducted by CalOptima to monitor all claims requirements.

V. CLAIMS FORWARDING

Physician Group shall forward any claims that are not its payment responsibility to CalOptima within ten (10) calendar days of receipt.

VI. SELF-MONITORING & REPORTING

Physician Group shall develop, implement and demonstrate upon request, a claims quality assurance process, including regular, scheduled, automated, or manual reports, self-testing procedures, and internal reporting to Physician Group's executive management of timeliness, payment accuracy, and denial accuracy (as required herein). Such self-monitoring and internal reporting shall involve use of industry standard tools and shall measure actual performance against the standards for DMHC and CMS compliance. CalOptima strongly recommends check issuance and mailing occur not less frequently than weekly and that Physician Group's internal reporting intervals match the intervals at which checks are issued, except that weekly reporting would be sufficient if checks are issued more often than weekly. At a point early in the beginning of operations under the Contract and in accordance with industry-wide CMS requirements, CalOptima will require that Physician Group submit monthly reports to CalOptima using the industry-standard Monthly Report of Claims Processing Timeliness and Overall Percent of Denial Accuracy format. Those reports must be received by CalOptima not later than the fifteenth (15th) calendar day of each month.

VII. AUDITS & AUDIT PREPARATION

Article IV, above, provides detailed, specific processes involving claims non-compliance. Even when Physician Group does meet compliance standards and successfully concludes any time periods where denials must be submitted to CalOptima for review, CalOptima will continue to schedule (1) periodic audits, (2) random, focused audits, and (3) focused reviews based on appeals and grievance results to monitor Physician Group's compliance with CMS regulations. Prior to the scheduled arrival of CalOptima's auditor, Physician Group shall retrieve claims and related documents in accordance with instructions provided to Physician Group by CalOptima in its letter confirming the appointment.

VIII. SPECIAL STUDIES

8.1 In the event DMHC and/or CMS requires that CalOptima conduct any special compliance study or effort, Physician Group shall support the study and will be subject to any DMHC and/or CMS specified time schedules or deadlines for corrective actions.

IX. FEDERALLY QUALIFIED HEALTH CENTERS AND RURAL HEALTH CLINICS

9.1 Physician Group shall meet federal requirements for access to FQHC services, including those in 42 U.S.C. § 1396 b(m). Physician Group shall reimburse FQHCs and RHCs in accordance with current Laws. If FQHC and RHCs services are not available in the Provider network, Physician Group shall authorize out-of-network services subject to the prevailing MA payment requirements for out-of-network services.

9.2 Physician Group shall ensure that its payments to FQHCs and RHCs for services to Enrollees are no less than the sum of the level and amount of payment that the Health Network or CalOptima would make for such services if the services had been furnished by an entity providing similar services that was not an FQHC and RHC. The intent of these provisions is to ensure that Physician Group pays FQHCs and RHCs amounts consistent with Medicare managed care policies while preserving the opportunity for FQHCs to separately claim supplemental payments under such policies.

X. INDIAN HEALTH CARE PROVIDERS

10.1 Physician Group shall pay non-network Indian Health Care Providers that are FQHCs for the provision of services to an Indian Enrollee at a rate equal to the rate that Physician Group would pay to a network FQHC that is not an Indian Health Care Provider, including any supplemental payment from the State to make up the difference between the contract amount and what the Indian Health Care Provider would have received FFS.

10.2 When the amount the Participating Provider Indian Health Care Provider receives from the Physician Group is less than the amount the Indian Health Care Providers would receive FFS, the State must make a supplemental payment to the Indian Health Care Provider that the Indian Health Care Provider would receive FFS or the applicable encounter rate.

10.3 Physician Group shall not impose enrollment fees, premiums, or similar charges on Indians served by an Indian Health Care Provider or through referral under contract health services. Physician Group must exempt from all cost-sharing any Indian who is currently receiving or has ever received an item or service furnished by an Indian Health Care Provider or through referral under contract health services.

10.4 Physician Group shall reimburse Indian Health Care Providers promptly who provide Covered Services to Indian Enrollees, who are eligible to receive Covered Services, at the most current and applicable outpatient per-visit rate published in the Federal Register by the Indian Health Service, and Physician Group shall ensure any retroactive outpatient per visit rates are appropriately reimbursed to the Indian Health Care Provider.

ATTACHMENT E
STATUTORY AND REGULATORY COMPLIANCE TERMS

1. **Compliance with State and Federal Laws**. Physician Group acknowledges that CalOptima is subject to certain State and federal laws, regulations, and instructions governing its MA Program. Physician Group shall comply with all Laws and DMHC and CMS administrative bulletins, plan letters and instructions. Physician Group understands that payments made by CalOptima are, in whole or in part, derived from federal funds, and therefore Physician Group and any Downstream Entities are subject to certain laws that are applicable to individuals and entities receiving federal funds, including the following: (i) Title VI of the Civil Rights Act of 1964; (ii) Sections 503 and 504 of the Rehabilitation Act of 1973; (iii) the Age Discrimination Act of 1975; (iv) the Americans with Disabilities Act of 1990; (v) the Vietnam Era Veteran's Readjustment Assistance Act; and (vi) Title IX of the Education Amendments of 1972. Any provision required to be in this Contract by the CMS Contract, the Knox-Keene Act, Title 28 of the California Code of Regulations, Medicare laws and regulations, DMHC or CMS instructions and reporting requirements and other applicable laws, shall bind CalOptima, Physician Group, and Downstream Entities, whether or not specifically set forth in this Contract.

2. **Compliance with CalOptima's Contractual Obligations**. All services and other activities furnished by Physician Group and Downstream Entities must be performed in accordance with CalOptima's contractual obligations to CMS.

3. **Compliance with FWA Requirements**. Physician Group, and its employees, agents and Downstream Entities performing services under this Contract, shall comply with CalOptima's Compliance Program including, its FWA plan. Prior to performing services under this Contract, Physician Group shall complete and submit to CalOptima, any CMS-required training and/or CalOptima-required attestations related to such training and other compliance obligations. Physician Group agrees to comply and will have any Downstream Entity agree to comply with CalOptima standards and policies.

4. **Fraud and Abuse Reporting**. Physician Group shall, in accordance with all Laws, report to CalOptima all cases of suspected fraud and/or abuse relating to the rendering of Covered Services within five (5) days of the date when Physician Group first becomes aware of or is on notice of such activity.

5. **CMS Participation Requirements**. Physician Group represents and warrants that: (i) neither Physician Group nor any of its Group Physician, employees or agents furnishing services under this Contract are excluded from participating in any federal or state healthcare program as defined in 42 U.S.C. Section 1320a-7b(f) ("**Federal Health Care Program(s)**"); (ii) Physician Group has not arranged or contracted (by employment or otherwise) with any employee, contractor or agent that Physician Group knows or should know are excluded or precluded from participation in Federal Health Care Programs; (iii) no action is pending against Physician Group or any of its Group Physicians, employees, or agents performing services under this Contract to suspend or exclude such persons or entities from participation in any Federal Health Care Program; and (iv) Physician Group will immediately notify CalOptima if it learns that it is or has employed or contracted with a person or entity that is excluded from participation in any Federal Health Care Program. If Physician Group fails to comply with this Section 5 of this attachment, CalOptima reserves the right to require Physician Group to pay immediately to CalOptima the amount of any sanctions or other penalties that may be imposed on CalOptima by CMS for violation of this prohibition, and Physician Group shall be responsible for any resulting overpayments. Physician Group shall not make payment for a healthcare item or service furnished by an individual or entity

that is excluded by the Office of the Inspector General or is included on the Preclusion List. Physician Group shall provide written notice to the Enrollee who received the services and the excluded Provider or Provider listed on the Preclusion List that payment will not be made, in accordance with CMS requirements. Physician Group shall ensure that all Participating Providers that provide Covered Services do not appear on the CMS Preclusion List in order to receive reimbursement for claims or otherwise participate in the Medicare program.

6. **Confidentiality of Enrollee Information**. Physician Group, its Downstream Entities, and their employees and agents shall comply with the specific confidentiality obligations set forth below.

6.1 Physician Group, Downstream Entities, and their employees and agents 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 them as a result of services performed under this Contract, except for statistical information not identifying any such person. Physician Group, Downstream Entities, and their employees and agents shall not use such identifying information for any purpose other than carrying out Physician Group's obligations under this Contract.

6.2 Physician Group, Downstream Entities, and their employees and agents shall promptly transmit to CalOptima all requests for disclosure of such identifying information not emanating from the Enrollee. Physician Group shall not disclose, except as otherwise specifically permitted by this Contract or authorized by the Enrollee, any such identifying information to anyone other than CMS, DMHC, 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.

6.3 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*., Welfare and Institutions Code Section 14100.2, and regulations adopted thereunder. For the purpose of this Contract, all information, records, data, and data elements collected and maintained for the operation of the Contract and pertaining to Enrollees shall be protected by Physician Group from unauthorized disclosure. Physician Group may release Medical Records in accordance with Laws pertaining to the release of this type of information. Physician Group is not required to report requests for Medical Records made in accordance with Laws.

6.4 With respect to any identifiable information concerning an Enrollee under this Contract that is obtained by Physician Group or its Downstream Entities from CalOptima's Regulators, Physician Group will, at the termination of this Contract, return all such information to CalOptima's Regulators if required by them, or maintain such information according to written procedures provided to Physician Group by CalOptima and/or CalOptima's Regulators for this purpose.

7. **Offshore Subcontracts**. Physician Group shall provide, and ensure that Downstream Entities provide, to CalOptima information and attestations related to the provision of any services under this Contract in a country other than the United States ("**Offshore Subcontractor**") to enable CalOptima to comply with CMS reporting obligations. Such information shall be submitted to CalOptima prior to engaging any Offshore Subcontractor for purposes of this Contract, and such Offshore Subcontractors are subject to approval by CalOptima.

8. **Required Disclosures**. In accordance with 42 CFR Section 1002.3, Physician Group shall immediately notify CalOptima in the event any sanctioned person (as defined in 42 CFR Section 1001.1001(a)(1)) owns or controls Physician Group.

9. **Equal Opportunity**. Physician Group and Downstream Entities shall comply with the following Equal Opportunity requirements set forth below.

9.1 Physician Group and its Downstream Entities 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. Physician Group and its Downstream Entities will take affirmative action to ensure that qualified applicants are employed, and that employees are treated during employment, without regard to their race, color, religion, sex, national origin, physical or mental handicap, disability, age, or status as a disabled veteran or veteran of the Vietnam era. Such action shall include the following: Employment, upgrading, demotion or transfer; recruitment or recruitment advertising; layoff or termination; rates of pay or other forms of compensation; and career development opportunities and selection for training, including apprenticeship. Physician and its Downstream Entities agree to post in conspicuous places, available to employees and applicants for employment, notices to be provided by the federal government, 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 Physician Group and its Downstream Entities' 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.

9.2 Physician Group and its Downstream Entities will, in all solicitations or advancements for employees placed by or on behalf of Physician Group and its Downstream Entities, 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.

9.3 Physician Group and its Downstream Entities will send to each labor union or representative of workers with which it has a collective bargaining agreement or other contract or understanding a notice, to be provided by the federal government or the State, advising the labor union or workers' representative of Physician Group and its Downstream Entities' commitments under the provisions herein and shall post copies of the notice in conspicuous places available to employees and applicants for employment.

9.4 Physician Group and its Downstream Entities 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.

9.5 Physician Group and its Downstream Entities 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 Physician Group 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.

9.6 In the event of Physician Group and its Downstream Entities' noncompliance with the requirements of the provisions herein or with any federal rules, regulations, or orders which are referenced in this Article IX, this Contract may be cancelled, terminated, or suspended in whole or in part, and Physician Group and its Downstream Entities may be declared ineligible for further State and Federal 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.

9.7 Physician Group and its Downstream Entities will include the provisions of Sections 10.1 through 10.7 of this attachment 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. Section 4212) of the Vietnam Era Veteran's Readjustment Assistance Act, so that such provisions will be binding upon each Downstream Entity. Physician and its Downstream Entities will take such action with respect to any subcontract or purchase order as the Director of the Office of Federal Contract Compliance Programs or CMS may direct as a means of enforcing such provisions, including sanctions for noncompliance; provided, however, that in the event Physician Group and/or its Downstream Entities become involved in, or are threatened with litigation by a other Downstream Entity or vendor as a result of such direction by CMS, Physician Group and its Downstream Entities may request in writing to CMS, 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.

10. **Non-Discrimination**. Physician Group and Downstream Entities shall comply with the non-discrimination requirements set forth below.

10.1 During the performance of this Contract, neither Physician Group nor any Downstream Entities shall unlawfully discriminate, harass, or allow harassment against any employee or applicant for employment because of sex, race, religion, color, national origin, ancestry, religious creed, physical disability, (including Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS), AIDS-Related Complex (ARC)), medical condition (including cancer), mental disability, marital status, age (over 40), or the

use of family and medical care leave and pregnancy disability leave. Physician Group and Downstream Entities shall insure that the evaluation and treatment of their employees and applicants for employment are free of such discrimination and harassment. Physician Group and Downstream Entities shall comply with the provisions of the Fair Employment and Housing Act (Government Code, Section 12900, *et seq*.) and the applicable regulations promulgated thereunder (Title 2 CCR Section 7285.0, *et seq*.). The applicable regulations of the Fair Employment and Housing Commission implementing Government Code, Section 12990, set forth in Chapter 5 of Division 4 of Title 2 of the CCR are incorporated into this Contract by reference and made a part hereof as if set forth in full. Physician Group and Downstream Entities shall give written notice of their obligations under this clause to labor organizations with which they have a collective bargaining or other agreement. Physician Group shall include the non-discrimination and compliance provisions of this Section 10.1 in all Downstream Entity subcontracts to perform work under this Contract.

10.2 Physician Group and all Downstream Entities shall abide by 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 1972 (regarding education programs and activities); Title 45 CFR Part 91 and the Age Discrimination Act of 1975 (discrimination based on age); and all other laws regarding privacy and confidentiality. Neither the Physician nor Downstream Entities shall discriminate against Enrollees because of race, color, creed, religion, ancestry, marital status, sexual orientation, national origin, age, sex, or physical or mental handicap in accordance with Title VI of the Civil Rights Act of 1964, 42 U.S.C., Section 2000d (race, color, national origin); 45 CFR Part 84 (physical or mental handicap); Government Code Section 11135 (ethnic group identification, religion, age, sex, color, physical or mental handicap); Civil Code Section 51 (all types of arbitrary discrimination); rules and regulations promulgated pursuant thereto, or as otherwise provided by Laws.

10.3 For the purpose of this Contract, if based on any of the foregoing criteria, the following constitute unlawful discriminations: (i) denying any Enrollee any Covered Services or availability of a facility; (ii) providing to an Enrollee any Covered Service that is different or is provided in a different manner or at a different time from that provided to other similarly situated Enrollees under this Contract, except where medically indicated; (iii) subjecting an Enrollee to segregation or separate treatment in any manner related to the receipt of any Covered Service; (iv) restricting an Enrollee in any way in the enjoyment of any advantage or privilege enjoyed by others receiving any Covered Service; or (v) treating an Enrollee differently from others similarly situated in determining compliance with admission, enrollment, quota, eligibility, or other requirements or conditions that individuals shall meet in order to be provided any Covered Service or assigning the times or places for the provision of Covered Services.

10.4 Physician Group shall take affirmative action to ensure that all Enrollees are provided Covered Services without unlawful discrimination, except where medically indicated. For the purposes of this Section 10.4, physical handicap includes the carrying of a gene that may, under some circumstances, be associated with disability in that person's offspring, but which causes no adverse effects on the carrier. Such genetic handicap shall include,

but not be limited to, Tay-Sachs trait, sickle cell trait, thalassemia trait, and X-linked hemophilia.

10.5 Physician shall act upon all complaints alleging discrimination against Enrollees in accordance with CalOptima's Policies and shall forward copies of all such grievances to CalOptima within five (5) days of receipt of same.

11. **Smoke Free Workplace**. Public Law 103-227, also known as the Pro Children Act of 1994 ("**Pro Children Act**"), requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health, day care, early childhood development services, education, or library services to children under the age of 18, if the services are funded by federal programs either directly or through state or local governments, by federal grant, contract, loan, or loan guarantee. The law also applies to children's services that are provided in indoor facilities that are constructed, operated, or maintained with such federal funds. The law does not apply to children's services provided in private residences; portions of facilities used for inpatient drug or alcohol treatment; service providers whose sole source of applicable federal funds is Medicare or Medicaid; or facilities where WIC coupons are redeemed. Failure to comply with the provisions of the law may result in the imposition of a civil monetary penalty of up to $1,000 for each violation and/or the imposition of an administrative compliance order on the responsible party. By signing this Contract, Physician Group certifies that it will comply with the requirements of the Pro Children Act and will not allow smoking within any portion of any indoor facility used for the provision of services for children as defined by the Pro Children Act. Physician further agrees that it will insert this certification into any subcontracts entered into that provide for children's services as described in the Pro Children Act.

12. **Air or Water Pollution Requirements**. Any federally funded agreement and/or subcontract in excess of $100,000 must comply with the following provisions unless said agreement is exempt under 40 CFR 15.5. Physician Group 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.

13. **Lobbying Restrictions and Disclosure Certification**. Any federally funded contracts in excess of $100,000 per Section 1352 of the 31, U.S.C. must comply with the following lobby restrictions and disclosures.

13.1 Each person (or recipient) who requests or receives a contract, subcontract, grant, or sub-grant, which is subject to 31 U.S.C. Section 1352 and which exceeds $100,000 at any tier, shall file a certification (in the form set forth in **Attachment E-1**, consisting of one page, entitled "Certification Regarding Lobbying") that the recipient has not made, and will not make, any payment prohibited by Subsection 13.6 of this attachment.

13.2 Each recipient shall file a disclosure (in the form set forth in **Attachment E-2**, entitled "Standard Form-LLL 'Disclosure of Lobbying Activities'") if such recipient has made or has agreed to make any payment using non-appropriated 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 Section 13.6 of this attachment if paid for with appropriated funds.

13.3 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 Section

13.2 of this attachment. An event that materially affects the accuracy of the information reported includes: (i) 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; (ii) a change in the person(s) or individuals(s) influencing or attempting to influence a covered federal action; or (iii) 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.

13.4 Each person (or recipient) who requests or receives, from a person referred to in Section 13.1 of this attachment, a contract, subcontract, grant or sub-grant 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.

13.5 All disclosure forms (but not certifications) shall be forwarded from tier to tier until received by the person referred to in Section 13.1 of this attachment.

13.6 31 U.S.C. Section 1352 provides in part that no appropriated funds may be expended by the recipient of a federal contract, grant, loan, or cooperative agreement to pay any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with any of the following covered federal actions: the awarding of any federal contract, the making of any federal grant, the making of any federal loan, entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any federal contract, grant, loan, or cooperative agreement.

14. **Debarment Certification**. Physician Group agrees to comply with applicable Federal suspension and debarment regulations including 7 CFR § 3017, 45 CFR §76, 40 CFR § 32, or 34 CFR § 85.

14.1 Physician Group certifies to the best of its knowledge and belief, that it and its principals:

(i) Are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded by any Federal department or agency;

(ii) Have not within a three (3)-year period preceding this Contract have been convicted of or had a civil judgment rendered against them for commission of fraud or a criminal offense in connection with obtaining, attempting to obtain, or performing a public (Federal, State or local) transaction or contract under a public transaction; violation of Federal or State antitrust statutes or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, or receiving stolen property;

(iii) Are not presently indicted for or otherwise criminally or civilly charged by a governmental entity (federal, State or local) with commission of any of the offenses enumerated in sub-provision (ii) herein;

(iv) Have not within a three (3)-year period preceding this Contract had one or more public transactions (Federal, State or local) terminated for cause or default;

(v) Shall not knowingly enter into any lower tier covered transaction with a person who is proposed for debarment under Federal regulations (i.e., 48 CFR 9, subpart 9.4), debarred, suspended, declared ineligible, or voluntarily excluded from participation in such transaction, unless authorized by the State; and

(vi) Will include a clause entitled, "Debarment and Suspension Certification'' that essentially sets forth the provisions herein, in all lower tier covered transactions and in all solicitations for lower tier covered transactions.

14.2 If Physician Group is unable to certify to any of the statements in this certification, the Physician shall submit an explanation to CalOptima.

14.3 The terms and definitions in this Section 14 have the meanings set out in the Definitions and Coverage sections of the rules implementing Federal Executive Order 12549.

14.4 If Physician Group knowingly violates this certification, in addition to other remedies available to the federal government, CalOptima may terminate this Contract for cause or default.

15. **Downstream Entity Contracts**. If any services under this Contract are to be provided by a Downstream Entity subcontracted by Physician Group, Physician Group shall ensure that such subcontracts comply with 42 CFR Sections 422.504, 423.505 and 438.6(l). Such subcontracts shall include all language required by CMS as provided in Attachment F**.**

16. **Other Statutory and Compliance Terms**. Physician Group shall not contract with, or otherwise pay for any items or services (other than an emergency item or service, not including items or services furnished in an emergency room of a Hospital):

16.1 Furnished by Physician Group by any individual or entity during any period when the individual or entity is excluded from participation under Titles V, XVIII, or XX, or under Title XIX pursuant to sections 1128, 1128A, 1156 or 1842(j)(2);

16.2 Furnished at the medical direction or the prescription of a physician, during the period when such physician is excluded from participation under Titles V, XVIII, or XX, or under Title XIX pursuant to sections 1128, 1128A, 1156, or 1842(j)(2) and when the person furnishing such item or service knew, or had some reason to know, of the exclusion (after a reasonable time period and after reasonable notice has been furnished to the person);

16.3 Furnished by an individual or entity to whom the State has suspended payments to during any period when there is a pending investigation of a credible allegation of fraud against the individual or entity, unless the State determines there is good cause not to suspend such payments;

16.4 Physician Group may not pay for an item or service with respect to any amount expended for which funds may not be used under the Assisted Suicide Funding Restriction Act of 1997

ATTACHMENT E-1
CERTIFICATION REGARDING LOBBYING

STATE OF CALIFORNIA
DEPARTMENT OF HEALTH CARE SERVICES
CERTIFICATIN 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 Physician Group Group	Printed Name of Person Signing for Physician
Contract / Grant Number	Signature of Person Signing for Physician Group
Date	Title

After execution by or on behalf of Physician Group, please return to:

CalOptima
Attn: Regulatory Affairs
505 City Parkway West
Orange, California 92868

ATTACHMENT E-2

CERTIFICATION REGARDING LOBBYING

Approved by OMB

Complete this form to disclose lobbying activities pursuant to 31 U.S.C. 1352
0348-0046 (See reverse for public burden disclosure)

<table>
<tr><td>1. Type of Federal Action:
contract
grant
cooperative agreement loan
loan guarantee
loan insurance</td><td colspan="2">2. Status of Federal Action:
bid/offer/application initial
award post-award</td><td>3. Report Type:
initial filing
material change

For Material Change Only:
Year _____ quarter_____
date of last report</td></tr>
<tr><td colspan="2">4. Name and Address of Reporting Entity:
Prime Subawardee Tier, if known:</td><td colspan="2" rowspan="2">5. If Reporting Entity in No. 4 is Subawardee,
Enter Name and Address of Prime:

Congressional District, If known:</td></tr>
<tr><td colspan="2">Congressional District, If known:</td></tr>
<tr><td colspan="2">6. Federal Department/Agency:</td><td colspan="2">Federal Program Name/Description:
CDFA Number, if applicable:</td></tr>
<tr><td colspan="2">8. Federal Action Number, if known:</td><td colspan="2">9. Award Amount, if known:</td></tr>
<tr><td colspan="2">10. a. Name and Address of Lobbying Entity
(If individual, last name, first name, MI):
(attach Continuation Sheets(s)</td><td colspan="2">b. Name and Address of Lobbying Entity
(If individual, last name, first name, MI):
SF-LLL-A, If necessary)</td></tr>
<tr><td colspan="2">Amount of Payment (check all that apply):
$ actual planned</td><td colspan="2" rowspan="3">13. Type of Payment (check all that apply):
a. retainer
b. one-time fee
c. commission
d. contingent fee
e. deferred
f. other, specify:</td></tr>
<tr><td colspan="2">Form of Payment (check all that apply):
a. cash
b. in-kind, specify: Nature</td></tr>
<tr><td colspan="2">Value</td></tr>
</table>

14. Brief Description of Services Performed or to be Performed and Dates(s) of Service, including Officer(s), Employee(s), or Member(s) Contracted for Payment indicated in item 11: (Attach Continuation Sheet(s) SF-LLL-A, If necessary)	
15. Continuation Sheet(s) SF-LLL-A Attached: Yes No	
16. Information requested through this form is authorized by Title 31, U.S.C., Section 1352. This disclosure of lobbying activities is a material representation of fact upon which reliance was placed by the tier above when this transaction was made or entered into. This disclosure is required pursuant to Title 31, U.S.C., Section 1352. This information will be reported to the Congress semiannually and will be available for public inspection. Any person who fails to file the required disclosure shall be subject to a civil penalty of not less than $19,000 and not more than $100,000 for each such failure.	Signature: Print Name: Title: Telephone No.: Date:
Federal Use Only	

INSTRUCTIONS FOR COMPLETION OF SF-LLL, DISCLOSURE OF LOBBYING ACTIVITIES

This disclosure form shall be completed by the reporting entity, whether subawardee or prime federal recipients at the initiation or receipt of a covered federal action, or a material change to a previous filing, pursuant to Title 31, U.S.C., Section 1352. The filing of a form is required for each payment or agreement to make payment to any lobbying entity for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with a covered federal action. Use the SF-LLL-A Continuation Sheet for additional information if the space on the form is inadequate. Complete all items that apply for both the initial filing and material change report. Refer to the implementing guidance published by the Office of Management and Budget for additional information.

Identify the type of covered federal action for which lobbying activity is and/or has been secured to influence the outcome of a covered federal action.

Identify the status of the covered federal action.

Identify the appropriate classification of this report. If this is a follow-up report caused by a material change to the information previously reported, enter the year and quarter in which the change occurred. Enter the date of the last previously submitted report by this reporting entity for this covered federal action.

Enter the full name, address, city, state, and ZIP code of the reporting entity. Include Congressional District, if known. Check the appropriate classification of the reporting entity that designates if it is, or expects to be, a prime or subaward recipient. Identify the tier of the subawardee, e.g., the first subawardee of the prime is the 1st tier. Subawards include but are not limited to subcontracts, subgrants, and contract awards under grants.

If the organization filing the report in Item 4 checks "Subawardee," then enter the full name, address, city, state, and ZIP code of the prime federal recipient. Include Congressional District, if known.

Enter the name of the federal agency making the award or loan commitment. Include at least one organizational level below agency name, if known. For example, Department of Transportation United States Coast Guard.

Enter the federal program name or description for the covered federal action (Item 1). If known, enter the full Catalog of Federal Domestic Assistance (CDFA) number for grants, cooperative agreements, loans, and loan commitments.

Enter the most appropriate federal identifying number available for the federal action identified in Item 1 (e.g., Request for Proposal (RFP) number; Invitation for Bid (IFB) number; grant announcement number; the contract grant, or loan award number; the application/proposal control number assigned by the federal agency). Include prefixes, e.g., "RFP-DE-90401."

For a covered federal action where there has been an award or loan commitment by the federal agency, enter the federal amount of the award/loan commitment for the prime entity identified in Item 4 or 5.

10. (a) Enter the full name, address, city, state, and ZIP code of the lobbying entity engaged by the reporting entity identified in Item 4 to influence the covered federal action.

10. (b) Enter the full names of the Individual(s) performing services and include full address if different from 10.(a). Enter last name, first name, and middle initial (MI).

Enter the amount of compensation paid or reasonably expected to be paid by the reporting entity (Item 4) to the lobbying entity (Item 10). Indicate whether the payment has been made (actual) or will be made (planned). Check all boxes that apply. If this is a material change report, enter the cumulative amount of payment made or planned to be made.

Check the appropriate box(es). Check all boxes that apply. If payment is made through an in-kind contribution, specify the nature and value of the in-kind payment.

Check the appropriate box(es). Check all boxes that apply. If other, specify nature.

Provide a specific and detailed description of the services that the lobbyist has performed, or will be expected to perform, and the date(s) of any services rendered. Include all preparatory and related activity, not just time spent in actual contact with federal officials, identify the federal official(s) or employee(s) contacted or the officer(s), employee(s), or Member(s) of Congress that were contacted.

Check whether or not a SF-LLL-A Continuation Sheet(s) is attached.

The certifying official shall sign and date the form, print his/her name, title, and telephone number.

Public reporting burden for this collection of information is estimated to average 30 minutes per response, including time for reviewing instruction, searching existing data sources, gathering and maintaining the data needed, and completing and renewing the collection of information. Send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to the Office of Management and Budget, Paperwork Reduction Project, (0348-0046), Washington, DC 20503.

ATTACHMENT F
SUBCONTRACT REGULATORY TERMS

A. **General Terms**: Language addressing the following matters shall be included in Downstream subcontracts:

1. The right of CalOptima's Regulators to monitor, audit, evaluate, inspect and have access to books, records and other information as provided in this Contract.
2. CalOptima's Regulators' right to inspect, evaluate, and audit any pertinent information related to the Contract for a period of ten (10) years from the final date of the contract period or from the date of completion of any audit as provided in this Contract.
3. Prohibitions against holding Enrollees liable for payment of any fees that are the obligation of CalOptima or the Physician Group, as applicable.
4. The services are in accordance with CalOptima's obligations to CMS and applicable CalOptima Policies.
5. The obligations of Downstream Entities to protect Enrollee privacy and confidentiality including health records, as provided in this Contract.
6. The obligation to comply with all federal and state laws, regulations and CMS instructions, including those laws that must be incorporated into such Downstream subcontracts as indicated in this Contract.
7. Language related to the obligations to submit timely and accurate Encounter Data and other data and reports required by CalOptima and CalOptima's Regulators as provided in this Contract and in CalOptima's Policies.
8. All requirements included in Attachment E not expressly addressed herein.

B. **Delegation Terms**. If, and to the extent that sub-delegation is permitted by CalOptima and Physician Group obtains CalOptima's approval as provided in this Contract, Downstream Entity subcontracts must include:

1. Language that specifies (i) the delegated activities and reporting requirements; (ii) that provides for revocation of the delegated activities and other remedies in the event CalOptima or CalOptima's Regulators find that the delegated party as not performed satisfactorily; (iii) that the performance of the parties is monitored by CalOptima on an ongoing basis; and (iv) that CalOptima may impose corrective action as necessary.
2. If the subcontract relates to credentialing of medical providers, language that the credentials of medical professionals affiliated with the party or parties will either be reviewed by CalOptima or the credential process will be reviewed and approved by CalOptima and that CalOptima must audit the process on an ongoing basis.
3. If the subcontract delegates selection of providers it must include language that CalOptima retains the right to approve, suspend or terminate any such arrangement and that CalOptima shall provide a written statement to a provider of the reason or reasons for the termination with cause.

C. **Medical Provider Downstream Subcontract Terms**.

All subcontracts or arrangements with medical providers shall include provisions addressing:

1. The term of the contract, including the beginning and ending dates as well as methods of extension, renegotiation and termination and full disclosure of the method and amount of compensation or other consideration.

2. The obligation to pay contracted medical providers under the terms of the contract and prompt payment provision, the terms of which are developed and agreed to by the parties.

3. The obligations to provide services in a culturally competent manner to all Enrollees, including those with limited English proficiency or reading skills, and diverse culturally and ethnic background and provide interpreter services for Enrollees at all provider sites.

4. The obligation to (i) abide by all federal and state laws and regulations regarding confidentiality and disclosure of medical records, or other health and enrollment information; (ii) to ensure that medical information is released in accordance with applicable federal or state law, or pursuant to court orders or subpoenas; (iii) to maintain Enrollee records and information in an accurate and timely manner; and (iv) to ensure timely access by Enrollees to the records and information that pertain to them.

5. The obligation to hold CalOptima, CalOptima's Regulators and Enrollees harmless in the event that Physician Group cannot or will not pay for services performed by the Downstream Entity and for Medicare Part A and B cost sharing. Specifically, Medicare Parts A and B services must be provided at zero cost-sharing to Enrollees.

6. Medical providers' EMTALA obligations and that they must not create any conflicts with hospital actions required to comply with EMTALA.

7. Language prohibiting providers, including PCPs, from closing or otherwise limiting their acceptance of Enrollees as patients unless the same limitations apply to all commercially insured Enrollees.

8. Language that prohibits the Downstream Entity from refusing to contract or pay an otherwise eligible health care Provider for the provision of Covered Services solely because such Provider has in good faith: (a) Communicated with or advocated on behalf of one or more of his or her prospective, current or former patients regarding the provisions, terms or requirements of the 'Downstream Entity's health benefit plans as they relate to the needs of such Provider's patients; or (b) communicated with one or more of his or her prospective, current or former patients with respect to the method by which such Provider is compensated by the Downstream Entity for services provided to the patient.

9. Language that states the Provider is not required to indemnify the Physician Group for any expenses and liabilities, including judgments, settlements, attorneys' fees, court costs and any associated charges, incurred in connection with any claim or action brought against the Physician Group based on its management decisions, utilization review provisions or other policies, guidelines or actions.

10. The obligation of the medical provider to assist CalOptima in the transfer of care, including in the transfer of care in the event of sub-subcontract termination for any reason.

11. Acknowledgement that assignment or delegation of the subcontract will be void unless prior written approval is obtained from CMS and CalOptima.

12. 'The Provider's right to submit a grievance and a description of the formal process to resolve the Provider's grievances.

13. The obligation to participate and cooperate in Physician Group's Quality Improvement System.

14. Language addressing requirements related to payment of Non-Participating Provider

emergency and post-stabilization services.

ATTACHMENT G
CMS SPECIFIC PROGRAM PERFORMANCE REQUIREMENTS

1. HCC Coding Requirements and Performance Improvement Activities

1.1 CMS pays CalOptima health-based capitation to compensate CalOptima for services rendered to Enrollees. CMS utilizes encounter data to assign Hierarchical Condition Categories ("**HCC**") to Enrollees. The Enrollee's HCC determines the payment amount received by CalOptima accounting for the variation in expenditures for Medicare Enrollees based on an Enrollee's health status.

1.2 Physician Group shall submit Enrollee-specific accurate encounter and service data. Encounters are to be submitted no less than monthly using the ANSI 837P and/or 837I format version 5010 as appropriate, or current format as required by CalOptima.

1.3 Physician Group shall support and aid CalOptima's review of encounters, including to production and/or access of supporting medical records.

1.4 To enhance encounter submission accuracy and completeness, CalOptima has initiated performance improvement activities ("**PIAs**"). These PIAs include Enrollee medical and behavioral health assessments provided in the home or a residential facility.

1.5 Physician Group has the option to perform these PIAs provided Physician Group can demonstrate that Physician Group's PIAs meet all CalOptima standards and guidelines. Should Physician Group not perform the PIAs or Physician Group's PIAs not meet CalOptima standards and guidelines as determined by CalOptima, CalOptima shall perform these activities on behalf of Physician Group and the cost for these PIAs shall be charged to or shared with Physician Group. CalOptima will provide sixty (60) days' notification prior to taking any such action.

2. ESRD Waiver Responsibilities

2.1 Physician Group shall demonstrate to CalOptima that Physician Group administers a CalOptima-approved complex case management program for all End Stage Renal Disease (ESRD) Enrollees, which is in accordance with CMS requirements and CalOptima Policies and standards.

2.2 CalOptima shall advise Physician Group if its ESRD complex case management program does not meet CMS requirements and CalOptima Policies and clinical standards. If Physician Group cannot meet requirements as provided by CalOptima, CalOptima shall have the option to de-delegate the Physician Group for the management of ESRD Enrollees and retain a portion of the Capitation Payment for ESRD Enrollees commensurate with the costs for providing or outsourcing such services.

2.3 CalOptima shall provide notification to Physician Group of the intent to de-delegate. Physician Group shall have the opportunity to submit a corrective action plan to CalOptima in accordance with CalOptima policy.

3. Appeals Rights

Physician Group may appeal CalOptima's decision to take the actions outlined above, by filing a complaint pursuant to CalOptima Policies. If Physician Group is dissatisfied with the result of any appeal; it shall proceed in accordance with CalOptima's legal claims and judicial review policy.

MEDICARE ADVANTAGE – PHYSICIAN GROUP SERVICES CONTRACT

BETWEEN

ORANGE COUNTY HEALTH AUTHORITY DBA CALOPTIMA

AND

_____

TABLE OF CONTENTS

MEDICARE ADVANTAGE PHYSICIAN GROUP SERVICES CONTRACT

This Medicare Advantage Physician Group Services Contract ("**Contract**") is January 1, 2023 ("**Effective Date**") by and between Orange County Health Authority, a public agency dba CalOptima ("**CalOptima**"), and _____ ("**Physician Group**"), a California professional medical corporation organized under the laws of the State of California. CalOptima and Physician Group may each be referred to herein as a "**Party**" and collectively as the "**Parties**".

RECITALS

A. CalOptima is a County Organized Health System ("**COHS**") organized under Welfare & Institutions Section 14087.54 and Orange County Ordinance No. 3896.

B. CalOptima is licensed as a health care service plan by the California Department of Managed Health Care ("**DMHC**") under the Knox-Keene Health Care Service Plan Act of 1975 and its implementing regulations (collectively the "**Knox-Keene Act**") and authorized to offer a Medicare Advantage ("**MA**") plan pursuant to Title 42 of the United States Code, Chapter 7, Subchapter XVIII, Part C and its implementing regulations for individuals covered under the federal Medicare program.

C. CalOptima, as a dual–eligible special needs plan ("**DSNP**"), may only enroll those dual eligible individuals who meet all applicable Medicare Advantage eligibility requirements, and who are eligible to be enrolled in CalOptima's Medi-Cal Managed Care plan, as described in the contract between CalOptima and the California Department of Health Care Services ("**DHCS**").

D. Physician Group is a duly licensed California professional medical corporation that employs or has entered into contracts with physicians who are licensed to practice medicine in the State of California ("**State**"), and other Providers who are appropriately licensed in the State.

E. Physician Group and the facilities set forth in Addendum 1 ("**Hospital**") have affiliated to operate as a physician-hospital consortium ("**PHC**"), which is an arrangement under which Physician Group and Hospital each participate in a risk pool for Covered Services provided to Enrollees as detailed in Section 2.7, for the purpose of providing or arranging for the provision of Covered Services to Enrollees under this Contract and Hospital's contract with CalOptima ("**Hospital Contract**"). Physician Group and Hospital may collectively be referred to herein as "**PHC Participants**".

F. Physician Group recognizes that in order to comply with the requirements of this Contract, Physician Group and Hospital must operate in a manner that is mutually beneficial to both entities affiliated to operate as a PHC. Accordingly, Physician Group agrees under this Contract and Hospital has agreed under the Hospital Contract to collectively and individually coordinate and cooperate with each other and with CalOptima in arranging for and providing Covered Services to Enrollees.

G. CalOptima and Physician Group desire to enter into the Contract whereby Physician Group will perform delegated administrative services and furnish health care items and services as described herein to certain Enrollees enrolled in CalOptima's MA plan.

H. Unless defined elsewhere in the Contract, the defined terms used in this Contract shall have the meanings set forth in Attachment A.

NOW, THEREFORE, in consideration of the promises and the mutual covenants herein stated, it is agreed by and between the Parties as follows:

I. PHYSICIAN GROUP SERVICE OBLIGATIONS

1.1 **Covered Services**. Physician Group shall provide Covered Services to Enrollees selecting, and assigned to, Physician Group in accordance with all provisions of this Contract and CalOptima Policies. The Covered Services that are to be provided by and are the financial responsibility of Physician Group are described in Attachment B. Physician Group specifically agrees to accept financial risk and responsibility for injectables pursuant to Health & Safety Code Section 1375.8.

1.1.1 Physician Group shall provide Covered Services: (i) in the same manner, in accordance with the same standards, and within the same time availability as offered to non-CalOptima patients; (ii) in accordance with professionally recognized standards of practice, (iii) in a culturally competent manner to all Enrollees, including those with limited English proficiency or reading skills and from diverse cultural and ethnic backgrounds; and (iv) not discriminate in the provision of such Covered Services because of an Enrollee's race, ethnicity, color, national origin, religion, sex, sexual orientation, age, medical or claims history, mental or physical disability, genetic information, or source of payment.

1.1.2 Physician Group is prohibited from closing or otherwise limiting its acceptance of Enrollees as patients unless the same limitations apply to all of its commercially insured patients.

1.1.3 Physician Group shall use its best efforts, where consistent with sound medical practice, to ensure that Covered Services are provided only by Group Physicians and/or other Participating Providers, except in cases of Emergency Services or Urgent Care Services, or if no such Group Physician or Participating Provider is available to perform the appropriate Covered Services.

1.1.4 Physician Group shall be liable for the provision and payment of all Covered Services notwithstanding a delay in payment of the Capitation Payment.

1.1.5 Physician Group acknowledges that the determination of whether a service or supply was/is a Covered Service delegated to Physician Group rests with CalOptima, subject to the Evidence of Coverage and Appeals procedures established by the DMHC and CMS.

1.1.6 CalOptima may incorporate any change in Covered Services mandated by Laws into the Contract effective the date the change goes into effect. Whenever possible, CalOptima shall give the Physician Group thirty (30) calendar days' prior notice of any such change to the Contract. CalOptima shall determine the effective date of the change in Covered Services. Attachment B shall not be amended during the current Term without mutual consent of the Parties, except as may be required for continued compliance with Laws.

1.1.7 Decisions concerning whether to provide or authorize Covered Services under this Contract shall be based solely on Medical Necessity. Physician Group shall not deny Authorization for a Covered Service that the Enrollee or the Provider demonstrates is Medically Necessary. The actual provision of any Covered Service is subject to the professional

judgment of the PCP or other physicians and/or Providers participating with Physician Group as to the Medical Necessity of the Covered Service, except that each Physician shall provide assessment and evaluation services ordered by a court or legal mandate. Physician Group acknowledges that disputes between the Physician Group and Enrollees about Medical Necessity can be appealed pursuant to CalOptima Policies and Laws.

1.1.8 Physician Group may not arbitrarily deny or reduce the amount, duration, or scope of a required Covered Service solely because of the diagnosis, type of illness, or condition. Physician Group may place appropriate limits on a service on the basis of criteria such as Medical Necessity or for utilization control, provided the services furnished can reasonably be expected to achieve their purpose and such a limitation complies with Laws.

1.2 **Confidentiality**. Physician Group and CalOptima agree to safeguard the confidentiality of Enrollee information and comply with all Laws (including, but limited to, the Health Insurance Portability and Accountability Act ("**HIPAA**"), 42 CFR Section 431.300 *et seq*., California Welfare and Institutions Code Section 14100.2, California Civil Code Section 56 *et seq.*, and the California Information Practices Act, Civil Code Section 1798) regarding the confidentiality and disclosure of Enrollee names, health, enrollment and personal information (including medical and Behavioral Health information contained in Medical Records). Physician Group shall provide counseling to Enrollees on their right to confidentiality and obtain Enrollee consent prior to releasing confidential information unless such consent is not required pursuant to Title 22 CCR Section 51009.

1.3 **Emergency Services and Urgent Care**. Physician Group shall insure that it provides and pays for all Emergency Services and Urgent Care, including those services provided by Non-Participating Providers, without prior Authorization, twenty-four (24) hours each day, seven (7) days a week, in accordance with Laws and CalOptima Policies. Physician Group shall coordinate access to Emergency Services in accordance with CalOptima's emergency department protocol. Physician Group shall ensure adequate follow-up care for those Enrollees who have been screened in the emergency room and require non-Emergency Services. Physician Group may not specify what constitutes an Emergency Medical Condition on the basis of lists of diagnoses or symptoms.

1.4 **Days to Appointment**. Physician Group shall ensure that appointments for non-Emergency Services and non-Urgent Care Covered Services are scheduled within ten (10) business days of the Enrollee's request for PCP and fifteen (15) business days of Enrollee's request for Specialist Physician; that health assessments and general physical examinations and all preventative Covered Services are scheduled within thirty (30) calendar days of Enrollee's request for an appointment, and that, if Physician Group supplies maternity Covered Services, Physician Group shall ensure that the most current standards and guidelines of the American College of Obstetricians and Gynecologists are utilized as the minimum measure of quality for perinatal services. Physician Group shall also have a process in place for follow-up on Enrollee missed appointments.

1.5 **Twenty-Four (24) Hour Physician Group Coverage**. Physician Group shall ensure that it has, at a minimum, two Group Physicians as follows: One (1) Group Physician who is available twenty-four (24) hours a day to authorize Medically Necessary, Post-Stabilization Care Services and coordinate transfer of stabilized Enrollees in an emergency department, if necessary, and one (1) Group Physician available twenty-four (24) hours a day, seven (7) days a week to resolve disputed requests for Authorizations.

1.6 **Clinical Laboratory Improvement Amendments**. Physician Group shall only use laboratories with a Clinical Laboratory Improvement Amendments ("**CLIA**") certificate of waiver or a certificate of registration along with a CLIA identification number.

1.7 **CalOptima Formulary Compliance**. Participating Providers shall comply with the CalOptima Formulary and its associated drug utilization and disease management guidelines and protocols. Requests for items not included in the CalOptima Formulary shall require prior Authorization by CalOptima. The prescribing Physician shall be responsible for obtaining Authorization through CalOptima and/or its designated pharmacy benefit management contractor ("**PBM**"), as appropriate. The prescribing Physician shall provide CalOptima and/or the PBM with all information necessary to process Authorization requests.

1.8 **Enrollee Access**. Physician Group and its Downstream Entities shall comply with all Laws and CalOptima Policies governing Enrollee access to Covered Services.

1.8.1 If Physician Group is unable to provide necessary Covered Services to a particular Enrollee, Physician Group must adequately and timely cover these services with Non-Participating Providers for the Enrollee, for as long as Physician Group is unable to provide them. Physician Group shall make prior arrangements with Non-Participating Providers for the provision of such services, shall be fully responsible for arranging and paying for such services, and shall comply with all applicable CalOptima Policies with regard to the payment and Authorization of Non-Participating Providers.

1.8.2 Physician Group shall ensure that PCPs as well as Specialty Physicians are located so as to assure sufficient geographic and physical access of Enrollees to such providers as required by Laws and CalOptima Policies.

1.8.3 Physician Group shall ensure that each Enrollee has a PCP who is available and physically present at the service site for sufficient time to ensure access for the assigned Enrollee when medically required. This requirement does not preclude an appropriately licensed professional from being a substitute for the PCP in the event of the PCP's vacation, illness, or other unforeseen circumstances.

1.8.4 Physician Group shall ensure female Enrollees have direct access to a women's health specialist within the network to provide women's routine and preventative health care services. Such access may be in addition to the Enrollee's PCP.

1.8.5 Physician Group shall cover family planning services for all Enrollees whether they are provided by a Participating Provider or Non-Participating Provider.

1.8.6 Physician Group shall reasonably accommodate Enrollees and ensure programs and services are as accessible (including a sufficient number of Providers and geographic access) to an Enrollee with disabilities as they are to an Enrollee without disabilities in accordance with CalOptima Policies. Physician Group's facilities shall comply with the requirements of Title III of the Americans with Disabilities Act of 1990 ("**ADA**") and shall ensure access for the disabled, including, but not limited to, ramps, elevators, restrooms, designated parking spaces, and drinking water provisions. Physician Group shall have policies to ensure that physical, communication and programmatic barriers do not inhibit Enrollees with disabilities from obtaining all Covered Services, including addressing reasonable accommodations required by the CMS Contract and CalOptima Policies. Physician Group will comply with CalOptima Policies and work plan requirements related to ADA compliance relevant to services under this Contract.

1.9 **Provider Network Maintenance**. Physician Group agrees to employ or contract with a sufficient number of Physicians and other Providers representing the range of medical specialties necessary,

in the determination of CalOptima, CMS, and the DMHC to ensure Enrollees of reasonable access to the full range of Covered Services.

1.9.1 During the Term, all Participating Providers of Covered Services must: (i) be and remain qualified in accordance with current applicable legal, professional, and technical standards; (ii) be and remain appropriately licensed, certified or registered; (iii) be and remain in good standing with Medicare and not be terminated or suspended from participation in the Medicare and/or Medi-Cal programs; and (v) have a valid NPI number, as applicable. Physician Group shall ensure that PCPs are located so as to assure sufficient geographic and physical access of Enrollees to such Physicians under Laws and CalOptima Policies.

1.9.2 Physician Group shall ensure that Participating Providers have the requisite training and experience in dealing with the medical problems frequently encountered in elderly, disabled, and special needs individuals.

1.9.3 Physician Group shall use primary source verification to confirm the board certification in each clinical specialty area for which the Physician is being credentialed if the Physician lists such board certification on credentialing applications.

1.9.4 Physician Group acknowledges that the requirements of this Section 1.9 apply to each individual Provider who is affiliated with and/or part of any medical group, independent physician associations ("**IPA**"), and/or other organization or entity that contracts with Physician Group to furnish Covered Services to Enrollees.

1.9.5 Physician Group will maintain accurate records, including records detailing the status, membership, and qualifications of the Participating Providers in the Physician Group's network.

1.9.6 If a Provider who seeks to become a Participating Provider is denied a contract with Physician Group or a Participating Provider is suspended or terminated for cause, Physician Group shall provide the Provider with written notice of the reason for the action, as required by Laws, including any standards and profiling data Physician Group used to evaluate the provider, the number and mix of similar health care Providers that Physician Group needs (if applicable), and notice of the Provider's right to appeal the action, including notice of the process and timing to request a hearing. In the event Physician Group terminates a contract with a Participating Provider for deficiencies in the quality of care provided, Physician Group shall give notice of the action to CalOptima, as provided by CalOptima Policies, and to the appropriate licensing and disciplinary bodies, as provided by law.

1.9.7 In the event that a Provider, including a PCP, is terminated or leaves the Physician Group for any reason, Physician Group shall give written notification of termination of such Provider to CalOptima within fifteen (15) days after receipt or issuance of the termination notice.

1.9.8 In the event that a Provider, including a PCP, is terminated or leaves the Physician Group for any reason, Physician Group shall ensure that there is no disruption in services provided to Enrollees who are receiving treatment for a chronic or ongoing medical condition in accordance with applicable Laws.

1.9.9 Physician Group shall notify CalOptima at least sixty (60) days before any significant change in Physician Group's provider network that renders Physician Group unable to

provide one or more Covered Services within CalOptima's access to care standards. If such notice is not possible because the providers terminate their participation with less than sixty (60) days' notice or Physician Group terminates the providers without prior notice as a result of their endangering the health and safety of Enrollees, providers committed criminal or fraudulent acts, or providers engaged in grossly unprofessional conduct, then Physician Group shall notify CalOptima immediately upon receipt of notice of the termination, or sending notice to the providers of a Physician Group-initiated termination.

1.9.10 Physician Group shall ensure that no Provider who fails to meet the requirements of this section furnishes items and/or services to Enrollees, submits claims and/or receives reimbursement for any Covered Services.

1.9.11 Physician Group agrees that each Participating Provider with whom Physician Group contracts to provide Covered Services will be required to execute a contract with Physician Group. Such an agreement will require all Participating Providers to comply with those aspects of this Contract relating to activities of Participating Providers and with Laws, including the standards of accrediting and regulatory agencies governing CalOptima's MA Program, and any and all provisions required by MA regulations. The Physician Group agreement with Participating Providers shall be made available to CalOptima and its regulatory agencies for inspection and copying upon request. Physician Group shall ensure that all contracts with Participating Providers allow for termination of the contract for failure to meet the requirements of this Section 1.9.

1.10 **Enrollment**. Physician Group shall accept as Enrollees all persons indicated as Enrollees by the CalOptima information system and transmitted to Physician Group and shall comply with requirements to provide notices to Enrollees in accordance with CalOptima Policies.

1.11 **Primary Care Physician**. Physician Group agrees that each Enrollee will select or be assigned a PCP. Enrollee must request a PCP assignment from CalOptima's Customer Service department. If the Enrollee has not selected a PCP, CalOptima shall assign the PCP per its policies. Physician Group agrees that it will ensure that the PCP shall be responsible for the provision, coordination, referral, and Authorization of Covered Services in accordance with the utilization management ("**UM**") program and prevailing standards of medical practice so that there is a Physician who has ultimate responsibility for the Enrollee's care management.

1.12 **Physician Group Medical Director**. Physician Group shall designate a Group Physician as Medical Director for purposes of this Contract. The Physician Group Medical Director will be a member of the Physician Group's quality management and UM committee(s) and will be the individual to whom CalOptima communicates regarding provision of professional medical care and quality and/or appropriate utilization of medical services. The Physician Group Medical Director will be the individual responsible for representing Physician Group in the resolution of any Grievances presented to CalOptima by Enrollees related to the provision of medical care.

1.13 **Care Coordination**. CalOptima shall retain the responsibility for the initial HRA and an HRA annually thereafter in accordance with CalOptima Policies, but any update during the course of the year due to change in Enrollee's condition/circumstance would be the responsibility of the Physician Group, per policy. Physician Group shall offer care coordination and case management services to all Enrollees, which shall: (i) include coordination of care across the full continuum of service providers as appropriate to Covered Services under this Contract; (ii) ensure that care coordination services reflect a person-centered, outcome-based approach, consistent with the Model of Care and CalOptima Policies; (iii) follow Enrollee direction about level of involvement

of his or her caregivers or medical providers; (iv) include the assignment of a qualified Care Coordinator to each Enrollee needing or requesting one; and (v) reflect access to appropriate community resources with a focus on providing services in the least restrictive setting and transitions between the facilities and the community.

1.14 **Model of Care**. Physician Group shall furnish Covered Services in compliance with CalOptima's Model of Care, including the PCC component, HRA, ICP and ICT requirements.

1.14.1 CalOptima will complete and communicate the HRA to Physician Group. Physician Group shall, upon notification by CalOptima of the need to follow-up on the results of an HRA administered by CalOptima, perform and provide any follow-up required by CalOptima.

1.14.2 Physician Group shall develop an ICP for each Enrollee and engage Enrollees and/or their representative in the design of the ICP in accordance with CalOptima Policies.

1.14.3 Physician Group shall offer an ICT for each Enrollee, as necessary, which will be developed around the Enrollee and integrate medical and LTSS and the coordination of Behavioral Health services. Enrollees shall not be required to participate in the ICT and may opt-out at any time. Enrollees may not be dis-enrolled from the ICT for lack of participation on the ICT. The ICT shall comply with CalOptima Policies.

1.14.4 PCPs and/or the Care Coordinator, in collaboration with CalOptima, will provide basic case management services to Enrollees in accordance with CalOptima's Policies. If the Enrollee has been identified as potentially benefiting from complex case management services, Physician Group shall provide such services to the Enrollee.

1.14.5 Physician Group shall ensure the provision of discharge planning when an Enrollee is admitted to a hospital or institution and continues into the post-discharge period. Discharge planning shall include ensuring that the necessary care, services, and supports are in place in the community for the Enrollee once he or she is discharged, including scheduling an outpatient appointment and/or conducting follow-up with the Enrollee or caregiver. Physician Group shall comply with CalOptima Policies addressing minimum criteria requirements for discharge planning.

1.15 **Behavioral Health Services Referrals**. Physician Group shall furnish and/or coordinate Behavioral Health services as specified in CalOptima Policies and this Contract.

1.15.1 For Specialty Mental Health Services, Physician Group shall refer Enrollees to CalOptima as the Administrative Service Organization contracted to provide assessment, referral and Authorization services.

1.15.2 For Outpatient Mental Health Services that are within a Physician Group' PCP's scope of practice, Physician Group shall manage according to current appropriate treatment guidelines. If the Outpatient Mental Health Services are outside its PCPs' scope of practice, Physician Group shall refer Enrollees to CalOptima's contracted behavioral health provider.

1.15.3 For Enrollees requiring alcohol or substance use disorder treatment, Physician Group shall manage according to the appropriate PCP treatment guidelines. If the alcohol or substance use disorder treatment are outside its PCPs' scope of practice, Physician Group shall refer

Enrollees to CalOptima's contracted behavioral health provider. Coordination of care through the ICT will occur as is specified in CalOptima Policies and this Contract.

1.16 **LTSS Referrals**. Physician Group shall refer Enrollees to CalOptima for LTSS pursuant to CalOptima Policies.

1.17 **Facility Site and Medical Record Reviews**. Physician Group shall participate in, and comply with requirements for, PCP site and medical reviews, including facility site physical accessibility reviews, in accordance with CalOptima Policies and guidance issued by CalOptima's Regulators, including requirements, if any, related to collaborative programs.

1.18 **Transfers**. Physician Group agrees to assist CalOptima in facilitating the transfer of care of Enrollees if determined medically acceptable by attending Physicians and the CalOptima Medical Director. Physician Group will be responsible for the cost of Covered Services provided if Physician Group refuses to accept such transfer.

1.19 **Delegation by CalOptima to Physician Group**. Physician Group agrees to accept delegated responsibility for those activities listed in the Delegation Agreement and to perform the delegated activities in a manner consistent with the Delegation Criteria. Physician Group warrants that it meets CalOptima's Delegation Criteria and acknowledges that delegation to another entity does not alter Physician Group's ultimate obligations and responsibilities set forth in this Contract. Physician Group agrees to notify CalOptima of any change in its ability to meet the Delegation Criteria within twenty-four (24) hours from the date it fails to meet such Delegation Criteria. At CalOptima's request, Physician Group shall identify the Compliance Officer or other appropriate health network representative to be the liaison expressly responsible for oversight of delegated obligations.

1.19.1 Physician Group acknowledges that it is CalOptima's responsibility to oversee, monitor and evaluate Physician Group's ongoing eligibility for delegation according to the Delegation Criteria and performance of the delegated activities according to the Delegation Criteria. Physician Group agrees to cooperate with CalOptima's oversight, monitoring, and evaluation of Physician Group's eligibility and performance of delegated activities, including the provision of reasonable access during regular business hours to the Enrollee inquiry files, credentialing files, clinical and Medical Records of Enrollees, and all other information requested by CalOptima. Physician Group shall comply with corrective actions imposed by CalOptima and/or CalOptima's Regulators in the time and manner required by them.

1.19.2 Physician Group acknowledges and agrees that CalOptima retains final authority and responsibility for activities delegated under this Contract. Activities not expressly delegated herein and in the Delegation Agreement by CalOptima or for which delegation is terminated are the responsibility of CalOptima.

1.19.3 Physician Group agrees to provide CalOptima with periodic reports on delegated activities performed by Physician Group as provided in the Delegation Criteria or specified in CalOptima Policies.

1.19.4 In the event CalOptima, DMHC, or CMS is dissatisfied with the performance of delegated functions and activities by Physician Group or its Downstream Entities, CalOptima may, in its sole discretion, modify Physician Group's delegated status (in respect to all or a particular delegated activity), including from fully delegated to delegated with corrective

action, or may immediately revoke all or part of the delegated activities. In the event Physician Group breaches its obligation to perform any delegated obligations, CalOptima shall have all remedies set forth in this Contract, including the right to revoke delegation of such function(s) and impose financial and other penalties. Moreover, CalOptima shall have the right to require Physician Group to terminate any Downstream Entity for good cause, including breach of its obligations to perform any delegated duties. Nothing herein is intended to limit CalOptima's remedies as provided for in this Contract or at law.

1.19.5 Physician Group acknowledges and agrees that CalOptima, in its sole and absolute discretion, may reduce Physician Group's Capitation Payments to recoup additional administrative costs where CalOptima revokes or modifies activities or functions delegated to Physician Group under this Contract.

1.20 **Delegation and Subcontracting of Administrative Services by Physician Group**. Except as otherwise limited by this Contract and/or CalOptima Policies, Physician Group may sub-delegate Administrative Services required of Physician Group to a management services organization ("**MSO**"), medical group and/or IPA. Delegation shall not absolve Physician Group of oversight responsibilities or its obligations under this Contract. All requests for delegation of Administrative Services (i) must be in writing; (ii) are subject to successful completion of CalOptima's readiness assessment requirements; and (iii) must be approved by CalOptima in advance of undertaking the Administrative Services. Physician Group shall obtain written approval of delegation from CalOptima pursuant to the process detailed in CalOptima Policies.

1.21 **Subcontracts**. Physician Group is required to inform CalOptima of the name and business addresses of all subcontracted Downstream Entities. Physician Group is required to ensure that all such subcontracts are in writing and include all provisions required by this Contract to be incorporated into subcontracts. Physician Group acknowledges that CalOptima's FDR subcontracts are subject to the review and approval of CMS.

1.22 **Payment to Providers**. CalOptima hereby delegates claims processing functions to Physician Group. Physician Group shall review, adjudicate, and pay (as appropriate) all claims in accordance with the benefits set forth in the Evidence of Coverage, the requirements established by Laws, and the terms of this Contract. In making payments to Providers, Physician Group shall comply with the provisions of Attachment D, including requirements related to payment of Non-Participating Provider Emergency Services and Urgent Care claims.

1.23 **Documentation and Data Submission Integrity**. Physician Group and its Downstream Entities shall not submit false claims or financial reports, encounter data, and other information to CalOptima, CMS or DMHC, whether by commission or omission. Physician Group and applicable Downstream Entities shall implement and maintain policies and procedures that address correct completion of claims, financial reports, encounter data, and other documentation requirements and penalties for falsifying such reports and other information that require all new and current employees and/or agents compiling or providing this information to sign a statement of attestation that will acknowledge understanding and compliance with said Physician Group policy.

1.24 **Advance Directives**. Physician Group shall maintain written policies and procedures related to Advanced Directives in compliance with Laws. Providers shall document Advance Directives in patient records in accordance with Laws. Physician Group shall not discriminate against any Enrollee on the basis of that Enrollee's Advance Directive status. Nothing in this Contract shall be interpreted to require an Enrollee to execute an Advance Directive or agree to orders regarding the provision of life-sustaining treatment as a condition of receipt of services.

1.25 **Enrollee Appeals**. Enrollees will be notified of all applicable MA and/or Medicare Appeal rights, the form and content of which is approved by CMS. . Medicare Appeal rights and protections will be maintained and enhanced for Medicare services. Physician Group agrees to cooperate with CalOptima in resolving Appeals related to Physician Group or Physician Group's Participating Providers and will comply with CalOptima Policies related to Appeals.

1.26 **Organization Determination Process**. Physician Group agrees to comply with CMS regulations and instructions and CalOptima Policies pertaining to timely organization determination by Physician Group with regard to the provision, denial, reduction, or suspension of a Covered Service to an Enrollee. "**Organization determination**" is defined as a decision to provide or deny service based on CMS and CalOptima criteria. Such determinations shall be made in accordance with procedures and instructions set forth in the CalOptima Policies and Laws. Physician Group shall immediately notify CalOptima of any request for an expedited initial organization determination and submit to CalOptima on a monthly basis a report which tracks the requests for standard and expedited organization determinations and the timeframe within which Enrollees were informed of decisions made by Physician Group.

1.27 **Expedited Review Process**. Physician Group shall comply with CMS regulations and CalOptima Policies pertaining to expedited initial organization determinations of Enrollee's medical care and reconsideration (Appeals) thereof in the time sensitive situations. Time sensitive situations are those outlined by CMS which include medical conditions that require initial determinations to be made within seventy-two (72) hours upon Physician Group receiving a request for an expedited review from a Provider, Enrollee, or CalOptima.

1.28 **Linguistic and Cultural Sensitivity**. Physician Group shall comply with all requirements related to the provision of linguistic and culturally sensitive services in accordance to this Contract, CalOptima's Cultural and Linguistic Services Program, and CalOptima Policies. Physician Group shall address the special health needs of Enrollees who are of any minority, are homeless, are disabled (both congenital and acquired disabilities), or are part of other special populations served by the CalOptima MA Program, including the capacity to communicate with Enrollees in languages other than English, when necessary, as well as those Enrollees who are deaf, hard-of-hearing, and/or visually impaired. Physician shall, in policies, administration, and services, practice the values of: (a) honoring the Enrollees' beliefs, traditions and customs; (b) recognizing individual differences within a culture; (c) creating an open, supportive, and responsive organization in which differences are valued, respected and managed; (d) through cultural diversity training, foster in staff and Participating Providers attitudes and interpersonal communication styles that respect Enrollees' cultural backgrounds and are sensitive to their special needs; and (e) referring Enrollees to linguistically and culturally sensitive programs. Pursuant to CalOptima Policies, Physician Group shall provide translation of written materials in the Threshold Languages as provided by CalOptima Policies. Written materials to be translated include, but are not limited to, signage, the Enrollee services guide, Enrollee information, Explanation of Coverage, Enrollee forms, Enrollee notices, and Enrollee welcome packages.

1.29 **Provision of Interpreters**. Oral interpreters, signers, and bilingual Provider services shall be provided in all languages spoken by all MA Enrollees. Physician Group shall provide linguistic interpreter/translator services for Enrollees as necessary at all Physician Group sites to ensure the availability of effective communication regarding treatment, diagnosis, medical history, and health education to Enrollees. Physician Group shall provide twenty-four (24)-hour access to interpreter services for all Enrollees. Upon an Enrollee or Participating Provider request for interpreter services in a specific situation where care is needed, Physician Group shall make all reasonable efforts to provide an interpreter in time to assist adequately with all necessary Covered Services,

including Urgent Care Services and Emergency Services, as required by Laws. Physician Group shall routinely document all such efforts and make this documentation available to CalOptima at its request. Interpreters shall be used where needed where technical, medical, or treatment information is to be discussed. Physician Group shall not require an Enrollee to use friends or family as interpreters. However, a family member or friend may be used when the use of the family member or friend: (i) is requested by the Enrollee; (ii) will not compromise the effectiveness of service; (iii) will not violate Enrollee's confidentiality; and (iv) the Enrollee is advised that an interpreter is available at no cost to the Enrollee. Physician Group shall maintain a contract with an interpreter service agency that is on "on call" status to provide interpreter services.

1.30 **Identification of Physician Group and Group Physicians**. Physician Group agrees that CalOptima may list the Physician Group's name, address, and telephone number and that of its Group Physicians and Downstream Entities in CalOptima's roster of Participating Providers that is given to Enrollees and prospective Enrollees, and CalOptima may use such names for advertising/marketing purposes. However, CalOptima is not obligated to list the name of any particular Group Physician in the roster of Participating Providers. The use of Physician Group's trademarks or logos by CalOptima is prohibited without Physician Group's prior written approval.

1.31 **Liaisons**. Physician Group shall designate an individual(s) who will assume the day-to-day responsibilities with regard to Physician Group's obligations under this Contract and to serve as liaison with CalOptima. Physician Group will also designate an individual(s) to be responsible for answering Enrollee inquiries and responding promptly to any Enrollee grievance in accordance with CalOptima's grievance procedures and Laws.

1.32 **Provider Private Contract**. Physician Group understands that CalOptima is prohibited by CMS from paying capitation to, or including in its provider network, any provider that has entered into a private contract with a Medicare beneficiary for the provision of Covered Services. Physician Group shall notify CalOptima immediately in the event that any Group Physician has a private contract with a Medicare beneficiary. In such an event, CalOptima reserves the right to exclude any such Group Physician from its provider network. In addition, Physician Group agrees that CalOptima shall have the right to offset the amount of any reimbursement that was paid either directly or indirectly to such Provider(s) against Capitation Payments or other amounts due from CalOptima to Physician Group, if any.

1.33 **Disclosure of Physician Group PIPs**. In the event that Physician Group implements and maintains a physician incentive plan ("**PIP**"), Physician Group and its Downstream Entities must comply with all applicable requirements governing PIPs, including such requirements appearing at 42 CFR Parts 417, 422, 434, 438.6(h), and 1003.

1.33.1 Physician Group shall ensure that no specific payment is made directly or indirectly under a PIP to a Physician or Physician Group as an inducement to reduce or limit Medically Necessary services furnished to an Enrollee.

1.33.2 On an annual basis, Physician Group and its Downstream Entities must submit to CalOptima all information required to be disclosed to CMS and the DMHC in the manner and format specified by them.

1.33.3 Physician Group must provide information on its PIP to any Enrollee upon request as provided in 42 CFR Section 422.208.

1.33.4 In the event that CalOptima's Regulators find that Physician Group (or its Downstream Entities) has failed to comply with the requirements governing physician incentive plans and CalOptima's Regulators offset, recoup and/or otherwise seek recovery of federal financial participation ("**FFP**") amounts from CalOptima, Physician Group agrees that CalOptima may recover such FFP amounts attributable to Physician Group from Physician Group, including through recoupment or offset to future Capitation Payments or other amounts due from CalOptima to Physician Group, if any.

1.34 **Provider Grievance Process**. Physician Group shall establish and maintain a Provider dispute resolution process that at all times complies with the requirements of Laws. Physician Group shall provide CalOptima with all necessary information and reports regarding the provider dispute resolution process as required by CalOptima to meet its obligations under the CMS Contract and Laws. If Physician Group fails to maintain a process that complies with the requirements stated in Laws and CalOptima Policies, then following written notice of such deficiency from CalOptima to Physician Group, CalOptima may revoke the delegation and assume responsibility for the administration of Physician Group's Provider dispute resolution process.

1.35 **Provider Education**. Physician Group acknowledges that CMS requires that CalOptima furnish to Participating Providers certain training, education, and orientation related to the MA Program in order to operate in full compliance with this Contract and Laws. Such training and education may address the MA Program, Enrollee rights, cultural competency and clinical protocols, evidence-based guidelines and cultural awareness and sensitivity instruction. Physician Group and its Participating Providers shall participate in such training, education, and orientation programs, as required by CalOptima, and shall attest to compliance with training requirements as required by CalOptima.

1.36 **State Licensure**. If Physician Group is licensed by the DMHC as a heath care service plan for purposes of the MA Program, it shall maintain such licensure in accordance with the Knox-Keene Act, as amended, and have no adverse actions with regard to enforcement or quality management.

1.37 **CalOptima's Regulator Requirements**. The MA Program is subject to oversight by CalOptima's Regulators, which mandate that CalOptima and its FDRs comply with certain terms and conditions in rendering services to Enrollees and that certain terms be incorporated in FDR subcontracts. Physician Group acknowledges that it will comply with CalOptima's Regulators' requirements set forth in Attachment E.

1.38 **COB Obligations of Physician Group**. Physician Group agrees to coordinate with CalOptima for proper determination of COB and to bill and collect from other payers and third-party liens such charges for which the other payer is responsible pursuant to CalOptima Policies. Physician Group agrees to establish procedures to effectively identify, at the time of service and as part of its claims payment procedures, individuals and services for which there may be a financially responsible party other than the CalOptima MA Program.

1.39 **CMS Lien Rights.** Physician Group shall coordinate benefits either operating a cost avoidance method of paying claims, when the existence of private health coverage is known at the time the claim is processed, or using the method of post-payment recovery of the cost of services, if the coverage is identified retroactively, as set forth in CalOptima Policies. Nothing herein shall be interpreted to, in any manner, impair any lien rights retained by the U.S. Department of Health and Human Services ("**HHS**") through CMS. Physician Group shall make no claim for the recovery of the value of Covered Services rendered to an Enrollee when such recovery would result from an action involving tort liability of a third party, recovery from the estate of deceased Enrollee,

Workers' Compensation, or casualty liability insurance awards and uninsured motorist coverage. Physician Group shall identify and notify CalOptima, within five (5) calendar days of discovery of potential third-party liability ("**TPL**") claims, and provide information relative to potential TPL claims, in accordance with CalOptima Policies.

1.40 **Provider Training.** Physician Group shall ensure that all network Providers receive training regarding the MA Program in order to operate in full compliance with all Laws, including rights and responsibilities pertaining to grievance and appeals procedures and timelines under this Contract. Physician Group shall ensure that network Provider training relates to MA services, policies, procedures and any modifications to existing services, policies or procedures. Training shall include methods for sharing information among network Providers, Enrollees, and/or other healthcare professionals. Physician Group shall conduct training for all network Providers within thirty (30) working days after the Physician Group places a newly contracted Provider on active status. Physician Group shall ensure that network Provider training includes information on all Enrollee rights, including the right to full disclosure of health care information and the right to actively participate in health care decisions. Physician Group will maintain policies and procedures on advance directives pursuant to 42 CFR §§ 422.128, 438.3(j), and 489.102, and will educate its network Providers concerning its policies and procedures on Advance Directives. Physician Group shall ensure that ongoing training is conducted when deemed necessary by either the Physician Group or CMS.

II. PHYSICIAN GROUP FINANCIAL OBLIGATIONS

2.1 **Financial Security Requirements**. Physician Group must establish and maintain during the Term financial security requirements as specified in Article 9 of Chapter 2 of Division 1 of Title 28 of the California Code of Regulations (SB 260 Regulations), and in compliance with CalOptima Policies. Physician Group must establish and maintain, throughout the Term, financial security reserves, in the form of time certificates of deposit, irrevocable standby letters of credit, surety bonds naming CalOptima as beneficiary, and/or other forms of financial instruments acceptable by CalOptima, as required in CalOptima Policies.

2.2 **Financial Viability Standards and Reporting**. Physician Group must establish and maintain a minimum reserve of twenty-five percent (25%) of one month's Capitation Payment. Physician shall have thirty (30) days upon receiving notice from CalOptima to cure any deficit. Physician Group shall maintain a cash-to-claims ratio of no less than 0.75 at all times during the Term. Physician Group shall substantiate compliance with this requirement by submitting all applicable reports to the DMHC that are required under Title 28 CCR Section 1300.75.4.2.

2.3 **Medical Loss Ratio**. Physician Group shall ensure that it, as well as the PHC, maintains a minimum acceptable loss ratio (as defined by CalOptima Policies) of eight five percent (85%). Physician Group shall comply with CalOptima requirements related to limitations on administrative costs, as set forth in CalOptima Policies.

2.4 **Termination of Physician Group Health Network**. If this Contract terminates or expires for any reason, CalOptima may require that Physician Group take certain actions and/or CalOptima may take certain actions to ensure that all items and services for which Physician Group is delegated financial risk under this Contract are reimbursed by Physician Group, including the following: (i) require Physician Group to reserve sufficient funds to pay any claims run out; (ii) offset Physician Group's future Capitation Payments or other amounts due from CalOptima to Physician Group under this Contract or any other agreement, if any, in order to pay Physician Group's claims; and/or (iii) withhold or offset Physician Group's Capitation Payments or other amounts due from

CalOptima to Physician Group, including to pay-for-performance, quality incentives, and shared risk pool surpluses, if any, in order to pay amounts owed by Physician Group to Providers.

2.5 **Conversion of Health Network Model**. If CalOptima approves a change in the delegated model of Physician Group at any time during the Term, CalOptima may require additional financial protections as a condition precedent to such approval, including: (i) require Physician Group to reserve sufficient funds to pay any claims run out related to claims which are the financial responsibility of Physician Group under the existing delegated relationship; (ii) require Physician Group to meet additional financial security requirements, including the maintenance of financial deposits; and/or (iii) withhold or offset Physician Group's Capitation Payments or other amounts due from CalOptima to Physician Group, including pay-for-performance, quality incentives and shared risk pool surpluses, if any, in order to pay amounts owed by Physician Group to Providers.

2.6 **Cooperation with DMHC**. Physician Group shall fully cooperate and comply with the DMHC's review and audit process and permit DMHC to obtain and evaluate supplemental financial information related to Physician Group, in accordance with Title 28 CCR Section 1300.75.4.7. Physician Group shall also fully cooperate and participate in DMHC's Corrective Action Plan process, in accordance with Title 28 CCR Section 1300.75.4.8.

2.7 **Risk Pools**. PHC in which Physician Group and Hospital participate shall have a risk pool arrangement between Hospital and Physician Group, as detailed in this Section 2.7 and Addendum 1 to this Agreement and the Hospital Contract. During the Term, Hospital and Physician Group shall annually negotiate and agree upon the terms and conditions of the risk pool arrangement ("**Risk Pool**") and shall submit the Risk Pool to CalOptima by November 30 for the next year. Physician Group shall submit to CalOptima an attestation signed by an authorized signatory of PHC Participants indicating that both Physician Group's and Hospital's Boards of Directors approved the Risk Pool. CalOptima shall pre-approve the Risk Pool before it may go into effect for the next year beginning January l. The Risk Pool shall include the following:

2.7.1 Covered Services for which PHC Participants will share risk.

2.7.2 If any part of the Risk Pool is based on utilization, the Risk Pool shall additionally include:

(a) The expected utilization of Covered Services for which PHC Participants will share risk. Recommended measures are bed days/per 1,000 Enrollees for inpatient services and $ [insert amount] per Enrollee per month for other Covered Services.

(b) The price or value for each Covered Service for which PHC Participants will share risk. These are the amounts that each unit of service will be valued at and charged against the portion of Hospital's capitation payment that the Hospital receives under the Hospital Contract and uses to fund to the Risk Pool. Inpatient rates should be listed as per diem rates, while other Covered Services should be priced by fee schedules or as a percentage of billed charges.

(c) A pro forma settlement calculation, which shall state the amount of surplus that is expected to result if Physician Group and/or Hospital achieve their utilization targets and the agreed-upon pricing model employed for the Risk Pool.

(d) A description of audit and/or other procedures required to ensure the accuracy of the surplus or deficit calculations related to the cost and volume of services rendered under the Risk Pool and other revenues and expenses, including interest

income, reinsurance premiums, and reinsurance recoveries associated with risk sharing.

(e) Defined responsibilities should deficits occur under the Risk Pool.

(f) Timing and documentation requirements for interim or final surplus distributions from the Risk Pool by Hospital, as agreed upon between the PHC Participants.

2.7.3 Physician Group shall submit [insert requirement for when these should be submitted] to CalOptima interim and final settlement calculations and attestations from all PHC Participants stating that (i) PHC Participants have met all the requirements of this Section 2.7, (ii) PHC Participants have performed all audit and reconciliation procedures, and (iii) the distribution amount to each PHC Participant is consistent with the terms of the Risk Pool, which (as approved by CalOptima annually during the Term) is incorporated into this Contract by this reference.

III. CALOPTIMA OBLIGATIONS

3.1 **CalOptima Services**. CalOptima agrees to provide certain Enrollee and Administrative Services, including processing Enrollee applications, maintaining eligibility records and a system of verifying eligibility, processing enrollments and dis-enrollments, responding to Enrollee complaints and grievances, informing Enrollees of CalOptima Policies, providing Enrollees with membership cards and informational material, and informing Enrollees of Health Networks.

3.2 **Enrollment**. CalOptima agrees to process all enrollment applications and ensure that each Enrollee selects or is assigned to Health Networks in accordance with CalOptima Policies. CalOptima reserves the right to assign Enrollees to a Health Networks other than that selected by Enrollee.

3.3 **Model of Care and Health Risk Assessment**. CalOptima shall maintain a Model of Care, as required by CalOptima's Regulators. CalOptima shall ensure that, upon enrollment in the CalOptima MA Program, each Enrollee receives an initial HRA and an HRA annually thereafter in accordance with CalOptima Policies and that results of the HRA are shared with Physician Group in order to coordinate Enrollee care. Physician Group is responsible for interim updates to the HRA.

3.4 **Authorization Process**. CalOptima shall provide a written Authorization process for Covered Services pursuant to CalOptima Policies.

3.5 **Enrollee Grievance Process**. CalOptima will inform Enrollees that they may file a grievance through CalOptima or the CMS Ombudsman Program for complaints related to Medicare-covered benefits and services. Enrollees may also file a grievance through 1-800 Medicare.

3.6 **Enrollee Appeals**. Enrollees will be notified of all applicable MA Medicare Appeal rights through a single notice prior approved by CMS.

3.7 **CalOptima Formulary**. CalOptima shall publish and maintain the CalOptima Formulary pursuant to CalOptima Policies.

3.8 **Training and Education**. CalOptima agrees to provide Participating Provider education, training, and orientation in accordance with CMS requirements, including training regarding the CalOptima MA Program, Enrollee rights, clinical protocols, evidence-based practice guidelines, and

CalOptima's cultural awareness and sensitivity instruction and cultural competency training, as applicable.

3.9 **Marketing**. Physician Group acknowledges that CalOptima will be responsible for marketing the CalOptima MA Program to Medicare beneficiaries. Physician Group acknowledges that it shall not conduct any marketing activities except as expressly approved in advance and in writing by CalOptima.

3.10 **Administration of Funds**. CalOptima will administer the funds and payments called for in this Contract to Physician Group in accordance with provisions outlined in Article VI.

3.11 **No Refusal to Pay or Contract Based on Physician Group Communications with Enrollees**. CalOptima will not refuse to contract or pay an otherwise eligible health care Provider for the provision of Covered Services solely because such Provider has, in good faith, communicated with or advocated on behalf of one or more of his or her prospective, current, or former patients regarding: (i) the provisions, terms or requirements of CalOptima's health care plans as they relate to the needs of such Provider's Enrollees; or (ii) the method by which such Provider is compensated by CalOptima for Covered Services rendered to the Enrollee.

3.12 **CalOptima Policies**. CalOptima will provide Physician Group with CalOptima Policies as necessary for Group to provide Covered Services to Enrollees. Those CalOptima Policies shall describe all benefit plans, including copayments, limitations, and exclusions offered by CalOptima to Enrollees. The Provider Manual will be made available to Physician Group to disseminate to Physicians.

3.13 **Listing of CalOptima**. CalOptima agrees that Physician Group may list its name, address, telephone number, and a description of the CalOptima MA Program, along with CalOptima's name, in Physician Group's promotional materials and advertisements. The use of CalOptima's trademarks and logos by Physician Group is prohibited without CalOptima's prior written approval.

3.14 **CalOptima Oversight**. CalOptima shall monitor Physician Group's performance under this Contract on an ongoing basis. CalOptima may conduct regularly scheduled audits as well as an annual evaluation of the delegated functions to determine Physician Group's continued compliance with the Delegation Criteria. CalOptima may impose corrective action plans on Physician Group and/or its Downstream Entities, as necessary.

3.15 **CalOptima Accountability**. The delegation of the functions and responsibilities stated in this Contract and the Delegation Agreement does not relieve CalOptima of any of its accountability to CMS and obligations to its Enrollees under Laws. CalOptima is authorized to perform and remains liable for the performance of such obligations, notwithstanding any delegation of some or all of those obligations to Physician Group.

3.16 **COB Obligations of CalOptima**. CalOptima will cooperate in providing COB information to Physician Group by collecting appropriate data from the Enrollee at the point of enrollment and supplying such data to Physician Group.

3.17 **Enrollee Rights**. CalOptima shall ensure that Enrollee rights are fully respected and observed in accordance with Laws and CalOptima Policies. CalOptima shall notify Enrollees of their rights and protections at least annually and in a manner that accounts for cultural considerations, functional status, and language needs.

3.18 **Enrollee Grievances**. CalOptima retains responsibility for the Enrollee grievance process. Physician Group will comply with CalOptima Policies related to Enrollee grievances, including timely reporting to CalOptima and resolution of Enrollee grievances. Enrollees may file an internal Enrollee grievance at any time with CalOptima or Physician Group, including grievances related to reasonable accommodations and access to services under the ADA.

IV. QUALITY IMPROVEMENT PROGRAM AND CREDENTIALING

4.1 **CalOptima's Quality Improvement Program**. Physician Group shall comply with, and participate in, CalOptima's Quality Improvement Program ("**QIP**"). Physician Group shall immediately notify CalOptima of those Enrollees and cases that fall within the catastrophic and targeted case management guidelines and shall cooperate with CalOptima's case management program for catastrophic and targeted cases. Physician Group and its Downstream Entities shall fully cooperate with CalOptima with regard to the HEDIS measurements and HEDIS audits, guideline development, preventive services utilization, disease/risk management, clinical service monitoring, and quality improvement studies and initiatives. Physician Group shall comply with and accept as final the decisions of the CalOptima QIP and, pending resolution of any dispute through the dispute resolution process, comply with the decisions of the CalOptima Quality Improvement Committee.

4.2 **Quality Improvement Functions – Delegation to Physician Group**. Physician Group shall establish, maintain and operate a Quality Improvement ("**QI**") program, in accordance with the delineation of responsibilities in the Delegation Agreement, which shall include preparation of an annual QI program plan, semi-annual work plan, and annual evaluation of effectiveness of the QI program, and report to CalOptima's QI department using the Health Industry Collaboration Effort Reporting Tool. All of the foregoing elements of the QI program shall be consistent with current industry standards, and meet CMS, National Committee for Quality Assurance ("**NCQA**"), The Joint Commission, and CalOptima QIP requirements.

4.2.1 Physician Group shall adopt a detailed written QI plan, which shall include: (i) well defined goals and objectives; (ii) a well-defined scope that considers all different types and levels of care and service provided to Enrollees; and (iii) clearly defined accountability and responsibility for the QI program.

4.2.2 The Board of Directors of the Physician Group or a multi-disciplinary QI committee designated by the Board of Directors of Physician Group shall oversee the QI program. This committee shall be separate from the utilization review committee (though members may be the same) and have a separate agenda. The QI committee shall meet at least on a quarterly basis. Physician Group shall maintain attendance records and meeting minutes related to the QI program. The QI committee shall have adequate representation from all categories of the Physician Group such as Physicians and non-Physician practitioners.

4.2.3 QI Program activities shall be reported in writing to Physician Group's Board of Directors at least on a quarterly basis. These reports shall be available to CalOptima upon request.

4.2.4 Physician Group's QI program shall include involvement and participation in network-wide studies/projects initiated by CalOptima. Physician Group shall facilitate quality studies and assist in collection of comparative data collected from all Participating Providers using objective parameters (e.g., the current version of HEDIS).

4.2.5 Physician Group shall develop an annual QI work plan, which includes the following: (i) goals, scope, and planned projects for the year; (ii) planned monitoring of identified issues and tracking these issues over time; (iii) planned studies/audits suggested by CalOptima or Physician Group; and (iv) an annual evaluation of the QI program/plan.

4.2.6 Physician Group shall have a written procedure for responding to the findings of QI activities, such as collecting data, analyzing results, implementing corrective action plans, and reassessing the same data for improvement.

4.2.7 Requirements for the Physician Group's QI program shall be established by the Physician Group's QI committee and requirements may change based on changes in industry standards. CalOptima's QI committee shall notify Physician Group of any additional changes in QI standards and requirements that shall be incorporated in Physician Group's QI program. Physician Group shall not be required to change QI program requirements more frequently than once per year.

4.2.8 Physician Group shall provide, upon CalOptima's request: (i) summaries of QI Committee meetings; (ii) findings following review of specific cases and other reviews; (iii) Medical Records; (iv) written responses to quality-of-care issues or Enrollee complaints; and/or (v) other information as required by CalOptima.

4.2.9 Physician Group shall comply with all measurement and improvement projects in the manner required by CMS, including the reporting of HEDIS, Health Outcomes Survey and Consumer Assessment of Healthcare Providers and Services measurement results consistent with Medicare requirements. Physician Group shall contribute to all applicable CMS data quality assurance processes.

4.3 **Quality Improvement and Credentialing Program**. CalOptima delegates credentialing requirements to Physician Group as provided in the Delegation Agreement. Physician Group agrees to comply with CalOptima Policies regarding credentialing standards. In order to ascertain Physician Group's continuous compliance with CalOptima standards, CalOptima retains the right to oversee Physician Group's credentialing processes and to mandate changes thereto.

4.3.1 At least annually, Physician Group shall provide CalOptima with a written credentialing program for the purpose of review and approval by CalOptima. Physician Group shall also allow CalOptima, after reasonable prior notice, to conduct an on-site audit and review a sample of physician credentialing files to determine that delegation of the credentialing process is appropriate.

4.3.2 Physician Group's credentialing program shall comply with the requirements specified in 42 CFR Sections 422.504, 423.505 and 438.214, as applicable, which include requirements addressing selection and retention of providers, credentialing and re-credentialing requirements, and nondiscrimination. Physician Group's credentialing program shall include procedures used for credentialing and re-credentialing Participating Provider's according to current NCQA standards, in addition to procedures used for reducing, suspending or terminating Participating Provider's participation in the organization for reasons relating to quality of care, competence, professional conduct, or service-related issues; procedures for reporting to appropriate authorities serious quality deficiencies that could result in suspension or termination of a Participating Provider's participation; and procedures for provider appeal, as afforded by Physician Group's fair hearing plan and corrective actions.

4.3.3 Physician Group shall make best efforts to notify CalOptima within thirty (30) days of any changes involving the rules, regulations, authorities, and responsibilities of the credentialing program. In accordance with CMS requirements, CalOptima also retains the right, based on quality-of-care and service issues, to approve, suspend, or terminate arrangements with practitioners, providers, and sites. In the event that this occurs, CalOptima will notify the Physician Group of the quality-of-care and/or service issue, and Physician Group shall take appropriate action, report to appropriate authorities any serious quality deficiencies in accordance with Laws, and provide all due process as afforded by the Physician Group's fair hearing plan and Laws.

4.3.4 If CalOptima exercises its right to terminate a Provider's participation in the CalOptima MA program, CalOptima shall give the Provider a written statement of the reason or reasons for termination with cause and comply with the procedures required by Laws, if any.

4.4 **Release of Performance Information and Data**. Physician Group acknowledges that the CalOptima MA Program focuses on improving the coordination and quality of medical, Behavioral Health, LTSS, and other services for Enrollees, and, in that regard, CalOptima's Regulators will implement capitation withholds to ensure performance consistent with established quality thresholds. Physician Group acknowledges and agrees that CalOptima may release information and data related to the performance of Physician Group under this Contract to CalOptima Regulators, Providers, Enrollees, and others without further notice to Physician Group. The performance data will be used for purposes, including quality improvement activities, and public reporting to consumers, as identified in CalOptima Policies.

V. UTILIZATION MANAGEMENT PROGRAM

5.1 **CalOptima's Utilization Management Program**. CalOptima has implemented, and continuously updates, a UM program to ensure appropriate processes are used to review and approve the provision of Medically Necessary Covered Services to Enrollees in the timeframes required by CalOptima's Regulators. Physician Group and its Downstream Entities shall comply with and cooperate in CalOptima's UM program, as established in CalOptima Policies and the CalOptima UM plan, regardless of CalOptima's delegation to Physician Group under Section 5.2.

5.2 **UM Program Responsibility—Delegation to Physician Group**. CalOptima is hereby delegating to Physician Group the process of monitoring and evaluating on a prospective, concurrent, and retrospective basis, the utilization and Medical Necessity of Covered Services provided to Physician Group's Enrollees.

5.2.1 Physician Group's UM process shall include performing case management activities, referral management and discharge planning, and managing the denial sanction process, as well as conducting peer review for Medical Necessity and appropriateness. Physician Group (and its Downstream Entities) shall ensure that its UM program complies with all criteria as set forth in CalOptima Policies and required by CalOptima's Regulators.

5.2.2 In accordance with 42 CFR §§ 438.6(h) and 422.208, compensation to individuals or entities that conduct UM activities must not be structured so as to provide incentives for Physician Group (including Group Physicians) or Downstream Entities to deny, limit, or discontinue Medically Necessary Covered Services to any Enrollee.

5.2.3 In the event Physician Group (or its Downstream Entities) fails to comply with CalOptima standards and Laws and fails to correct deficiencies within the stated time required by those provisions, CalOptima retains the right to revoke delegation of UM activities.

5.3 **Utilization Management Plan**. Physician Group will provide to CalOptima initially upon execution of this Contract, and annually thereafter, a written UM plan for review and approval by CalOptima.

5.3.1 Physician Group shall notify CalOptima within thirty (30) days of any changes involving the rules, regulations, authorities, and responsibilities for the UM plan, which shall be subject to reasonable approval by CalOptima. CalOptima approval will be assumed unless Physician Group is notified otherwise by CalOptima. Physician Group shall comply with and accept as final, the decisions of CalOptima's UM program and, pending resolution of any dispute through the dispute resolution process, comply with the decisions of CalOptima's UM program.

5.3.2 The UM plan shall include procedures approved by CalOptima to identify, assess, establish, and implement a treatment plan for Enrollees with complex or serious medical conditions. The UM plan shall also contain procedures for direct access of Enrollees to services as mandated by CMS regulations and instructions. All Physician Group denial letters shall provide Enrollees with timely notice and shall contain appropriate Enrollee appeals rights as approved by CMS and CalOptima. Physician Group agrees to cooperate with CalOptima in furnishing the required reports identified in CalOptima' Policies

5.4 **Utilization Management Committee**. Physician Group shall establish a UM committee that shall review and document the quality, appropriateness, level of care, and utilization of health care services provided to Enrollees. CalOptima's Medical Director and/or CalOptima staff may attend Physician Group UM committee meetings.

5.5 **Process and Timeframes for Authorization**. Physician Group (and its Downstream Entities) shall ensure that its process for initial and continuing Authorizations complies with CalOptima Policies, the UM plan and requirements established by CalOptima's Regulators, including timeframes for, and manner of, Authorization.

5.6 **No Prior Authorization**. Physician Group (and its Downstream Entities) shall not require prior Authorization for the following services: (i) any services for Emergency Medical Conditions (which include emergency Behavioral Health care); (ii) Urgent Care sought outside the Service Area: (iii) Urgent Care under unusual or extraordinary circumstances provided in the Service Area when the Participating Provider is unavailable or inaccessible; (iv) preventative services; (v) family planning services; (vi) Out-of-Area renal dialysis services; (vii) basic prenatal care; (viii) sexually transmitted disease services; and (ix) HIV testing.

5.7 **Second Opinions**. Physician Group (and Downstream Entities) shall ensure that Enrollees have the right to second opinions from qualified health professionals at no cost to the Enrollee.

5.8 **Physician Direct Referral**. Physician Group agrees that an Enrollee shall, without obtaining the prior Authorization of the PCP or Physician Group, refer him or herself directly to a specialist within said Physician Group per policy including any of the following conditions: an annual well woman exam by a Gynecologist, prenatal care and delivery by an Obstetrician, annual eye exam by an Optometrist, professional services related to audiology, and family planning services, including but not limited to vasectomy.

5.8.1 CalOptima will identify Physician Group as a provider that offers Physician Group Direct Referrals to Enrollees in CalOptima's provider directory and other marketing literature, if any. In the event CalOptima determines that Physician Group is non-compliant with the requirements of the Physician Direct Referral process, CalOptima reserves the right, at its sole discretion, to cease marketing Physician Group as a Physician Direct Referral provider to Enrollees.

5.8.2 Physician Group agrees to cooperate with CalOptima and, upon reasonable prior notice, provide CalOptima with all necessary Medical Records, policies and procedures, including utilization review, reports, and other pertinent information that may be necessary or required to enable CalOptima to ensure and verify that Physician Group has a Physician Direct Referral process acceptable to and in accordance with the requirements of CalOptima.

5.9 **Hospital Referrals**. Physician Group agrees to require Group Physicians to admit Enrollees only to Hospital with the concurrence of CalOptima, except for Emergency Services, Urgent Care, or when Authorization has been received in accordance with the UM Plan.

5.10 **Personal Care Coordinator Component to the Model of Care.**

5.10.1 "**PCC Profile**" is a monthly report generated by CalOptima that provides the compliance parameters required to receive PCC supplemental capitation.

5.10.2 Physician Group shall employ PCCs and participate in all PCC component requirements, as defined in the Model of Care Profile. PCCs shall assist Enrollees in the development of an ICP, ensure communication of the Enrollee's care plan with the Enrollee, physicians, Physician Group and health care team, and provide other related services as described in the job description, CalOptima Policy, and Model of Care Profile. Physician Group shall submit monthly reports and ICPs to demonstrate adherence to Model of Care requirements, including staffing of PCCs.

5.10.3 CalOptima may amend the Model of Care Profile at any time and, in such event, CalOptima shall provide Physician Group with thirty (30) days' written notice before the effective date of any such revisions. If Physician Group is unable to agree to the revisions and no resolution is reached in the thirty (30)-day period, Physician Group may proceed with the termination of the Contract under Article 11. In the event Physician Group terminates the Contract, it shall comply with all of its obligations required by this Contract and Laws including obligations related to transfer and coordination of Enrollee care following termination.

VI. COMPENSATION

6.1 **Physician Group Compensation**. CalOptima shall compensate Physician Group for Covered Services and Administrative Services delegated to Physician Group, as set forth in Attachment C. Such Capitation Payments shall be payment in full for Covered Services and Administrative Services, except for amounts recovered through collection of Enrollee's Share of Cost, COBs, and Stop Loss Program, if applicable. Capitation Payment shall be sent on a monthly basis by the twentieth (20th) calendar day of the month, or if such day falls on a weekend or national holiday, on the first business day thereafter, for all Enrollees eligible from the first (1st) of the month, and on whose behalf payment has been received by CalOptima from CMS by the nineteenth (19th) calendar day of the month. In the event CalOptima receives payment from CMS after the

nineteenth (19th) calendar day of the month, capitation payment to Physician Group will be made within five (5) working days of receipt of the monthly payment by CalOptima.

6.2 **Disputes Regarding Payments or Enrollment**. Any and all disputes related to Capitation Payments and/or enrollments shall be reported to CalOptima within ninety (90) calendar days of payment, and each dispute shall be clearly defined and include supporting documentation. Failure to dispute within the established time frame indicates acceptance of the Capitation Payment by Physician Group.

6.3 **Capitation Rate Adjustments**. The Capitation Rates may be adjusted by CalOptima during the Contract period to reflect implementation of State or federal laws or regulations, changes in the CMS Contract or CMS policy, and/or changes in Covered Services. If CalOptima receives advance notice of adjustment from CalOptima's Regulators, CalOptima shall provide notice thereof to Physician Group as soon as practicable. Capitation Rates may also be adjusted in the event of de-delegation of any function delegated under this Contract.

6.4 **Enrollee Non-Liability and Hold Harmless Requirements.** Physician Group and its Downstream Entities shall accept CalOptima's payment as described in this Contract as payment in full. Physician Group and its Downstream Entities for all Covered Services and Administrative Services under this Contract and shall not hold Enrollees liable to the Physician Group or Providers for any sums owed to Physician Group by CalOptima or owed to Providers by Physician Group.

6.4.1 Physician Group and its Downstream Entities shall hold harmless CMS, CalOptima, and Enrollees in the event Physician Group and/or Downstream Entities cannot or will not pay for services performed by Physician Group or Downstream Entities pursuant to this Contract or subcontract, as applicable.

6.4.2 Physician Group and its Downstream Entities shall ensure that Enrollees will not be held liable for Medicare Part A and B cost sharing when the State is responsible for paying such amounts and that the Physician Group will (i) accept Capitation Payment as payment in full under the Contract, or (ii) bill the appropriate State source, as required at 42 CFR §422.504(g)(1)(iii). Such services must be provided at zero cost-sharing to Enrollees.

6.4.3 Physician Group shall not hold an Enrollee liable for the following: (i) debts of Physician Group, in the event of 'Physician Group's insolvency; (ii) Covered Services provided to the Enrollee in the event that CalOptima or Physician Group fails to receive payment from CMS for such services; or (iii) payments to a clinical FDR or Downstream Entity in excess of the amount that would be owed by the Enrollee if Physician Group had directly provided the services.

6.4.4 Physician Group and its Downstream Entities shall not charge Enrollees coinsurance, co-payments, deductibles, financial penalties, or any other amount in full or part, for any service provided under this Contract, except as otherwise permitted under this Contract.

6.4.5 Physician Group and its Downstream Entities shall not deny any service provided under this Contract to an Enrollee for Enrollee's (or any entity responsible for making payment on Enrollee's behalf) failure or inability to pay any applicable charge or shall not deny any service provided under this Contract to an Enrollee who, prior to becoming eligible, incurred a bill that has not been paid.

6.5 **Physician Group-Discovered Overpayments**. Physician Group shall disclose and return all overpayments to CalOptima within sixty (60) days of when Physician Group identified the overpayment or should have identified the overpayment through the exercise of reasonable diligence.

6.6 **Recoupment for Ineligibility; Conlan Reimbursements**. CalOptima shall recoup payments made to Physician Group when CMS has determined that an individual was not eligible for the MA Program and retroactively terminates the individual, including recouping any payments made for a deceased Enrollee. CalOptima may also recoup overpayments to Physician Group owed by Physician Group to Enrollees, including offsetting any such amounts owed against Physician Group's Capitation Payments or other amounts due from CalOptima to Physician Group under this Contract or any other agreement between the parties, if any. This Section 6.6 shall not be construed to limit CalOptima's right to recoup payment made to Physician Group on any other basis for which recoupment is appropriate.

6.7 **CalOptima Right to Recover**.

6.7.1 Overpayments. Physician Group acknowledges and agrees that, in the event that CalOptima determines that an amount has been overpaid or paid in duplicate, or that funds were paid which were not due under this Contract to Physician Group, CalOptima shall have the right to recover such amounts from Physician Group by recoupment or offset from current or future amounts due from CalOptima to Physician Group under this Contract or any other agreement between the parties, after giving Physician Group notice and an opportunity to return/pay such amounts.

6.7.2 Health Network Termination. In the event of termination of the Health Network or the transition of the Health Network to a different delegation model, CalOptima shall have the right to offset any unpaid claims that are the financial responsibility of Physician Group paid by CalOptima against any funds owed to Physician Group by CalOptima, including capitation payments, financial security withholds, pay-for-performance amounts, quality incentives, and shared risk pool surpluses.

6.7.3 Shared Risk Pool Payments Upon Termination. If this Contract terminates or expires for any reason and Physician Group is responsible for a deficit under any shared risk program under this Contract based on the final shared risk pool report results ("**Deficit**"), such Deficit shall be due to CalOptima as follows, as allowed by Laws: CalOptima may elect to recoup such Deficit by either (1) offsetting such Deficit amounts, upon notice to Physician Group, from any current or future amounts owed by CalOptima to Physician Group under the Contract or any other agreement between the Parties, including capitation payments, financial security withholds, pay-for-performance amounts, quality incentives, and shared risk pool surpluses; or (2) sending an invoice to Physician Group that payment for such Deficits are due to CalOptima within thirty (30) days of Physician Group's receipt of the CalOptima invoice.

6.7.4 Regulator Recoupment Upon Termination. If following the termination or expiration of this Contract, CalOptima's Regulators find that Physician Group (or its Downstream Entities) has failed to comply with the requirements governing physician incentive plans and CalOptima's Regulators offset, recoup and/or otherwise seek recovery of FFP, as described in Section 1.33, CalOptima may elect to recoup such FFP amounts, as allowed by Laws, by either: (1) offsetting such FFP amounts, upon notice to Physician Group, from any current or future amounts owed by CalOptima to Physician Group under the Contract or any other agreement between the Parties, including capitation payments, financial security withholds, pay-for-performance amounts, quality incentives, or shared risk pool surpluses; or (2) sending an invoice to Physician Group that

payment for such FFP amounts are due to CalOptima within thirty (30) days of Physician Group's receipt of the CalOptima invoice.

6.7.5 Dispute Resolution. Physician Group may use CalOptima's provider dispute resolution procedure, as described under CalOptima's Policies, and/or the dispute resolution procedures under this Contract to resolve any disputes related to the calculation or payment of such Deficits or FFP amounts.

6.7.6 Survival. This Section 6.7 shall survive the termination or expiration of the Contract.

6.8 **Retroactive Cancellation**. CalOptima will discourage retroactive cancellation of any Enrollee. However, CalOptima may make exceptions as required by CMS or due to legitimate administrative processing requirements of CMS. CalOptima may make retroactive additions or cancellations of Enrollees, as necessary for administrative or business reasons, and such retroactive additions or cancellations of Enrollees shall not exceed ninety (90) days.

VII. REPORTING REQUIREMENTS

7.1 **Data Reporting Requirements**. Physician Group shall comply with the data reporting requirements set forth in this Contract, including the requirements specified in Standard Reporting Requirements set forth in CalOptima Policies and guidelines (referred to as the Timely and Appropriate Submission requirements). Physician Group shall provide such additional data and modify the form, content, instructions, and timetables for the collection and reporting of data, as may be required by CalOptima Policies.

7.2 **Eligibility Reports**. CalOptima will maintain, update, and distribute monthly Enrollee eligibility reports for each month in which the persons included on such list are eligible for CalOptima MA Program. This report will identify the Physician Group, PCP selected by the Enrollee, and the Enrollee's coverage. The report will be sent to Physician Group and PCPs by the tenth (10th) of each month, identifying eligible Enrollees from the first (1st) of the month.

7.3 **Utilization Data**. Physician Group shall, upon request, provide CalOptima with information on the utilization and cost of Covered Services provided to Enrollees in such detail as to allow CalOptima to conduct analysis of costs as required by CMS, as dictated by sound business practices and for the conduct of quality management and UM activities by CalOptima. Such information to be provided by Physician Group will not include information beyond that customarily provided on a claim form (such as Form CMS-1500) and shall be provided in the form of a paper report, computer disc, computer tape, or electronic file, as agreed by the parties. Required data will be delivered by Physician Group to CalOptima not later than forty-five (45) days following written request by CalOptima.

7.4 **Submission of Electronic Encounter Data**. Physician Group must meet any claims, diagnosis, and Encounter Data reporting requirements, as determined from time to time by CalOptima and CalOptima's Regulators.

7.4.1 Physician Group agrees to furnish CalOptima with complete, timely, reasonable, and accurate Encounter Data for Covered Services rendered to Enrollees. The Encounter Data will be furnished to CalOptima through Electronic Data Interchange (EDI) or a mutually acceptable format and shall be received by CalOptima per the Policy and Encounter Requirements Manual. Physician Group also agrees to furnish Medical Records that may

be required to obtain any additional information or corroborate the Encounter Data. Physician Group further agrees to have its Chief Executive Officer (CEO) attest and certify the completeness and truthfulness of the Encounter Data submitted.

7.4.2 Physician Group shall be subject to financial penalties and/or sanctions if CalOptima determines that Physician is reporting to CalOptima less than all professional encounters in the CalOptima required format and timelines. Financial penalties or sanctions shall be assessed upon Physician Group should CalOptima determine that Physician Group is not meeting the standards defined in CalOptima Policies. This Section 7.4.2 shall survive the expiration or termination of this Contract, whether with or without cause, by rescission or otherwise, as to all Covered Services provided under this Contract prior to termination. Based on CalOptima's quarterly determinations and following thirty (30) days' prior notice to Physician Group, CalOptima may withhold three (3%) percent of Capitation Payment if CalOptima determines that the monthly Encounter Data that Physician Group must provide has not been received by CalOptima within the prior quarter. If at the quarterly determination following such withhold, CalOptima determines that Physician Group has satisfactorily delivered to CalOptima the previously non-delivered Encounter Data; such withheld Capitation Payment shall be paid to Physician Group, without interest. In the event that Physician Group does not deliver such Encounter Data to CalOptima prior to such quarterly determination, CalOptima shall be entitled to retain such withheld Capitation Payment and may withhold three (3%) percent from each quarter's Capitation Payment until CalOptima receives the Encounter Data.

7.5 **Disclosure of Provider Profiling**. Physician Group shall, upon request from CalOptima, provide. CalOptima with information regarding any "economic profiling" of Group Physician Groups by Physician Group in order to permit CalOptima to comply with the provisions of Section 1367.02 of the Knox-Keene Act. Further, to the extent that Physician Group utilizes "economic profiling" as defined in Section 1367.02, Physician Group shall provide copies of economic profiling information to Providers in accordance with the requirements of Section 1367.02.

7.6 **Financial Reporting**. Physician Group shall prepare financial information requested in accordance with Generally Accepted Accounting Principles ("**GAAP**"). Where financial statements and projections are requested by CalOptima and/or CalOptima's Regulators, these statements and projections should be prepared in accordance with the 1989 HMO Financial Report of Affairs and Conditions Format. Where appropriate, reference has been made to the Knox-Keene Act rules found under Title 28 CCR Section 1300.51 *et. seq*. Information submitted shall be based on Physician Group's current operations. Physician Group shall submit financial information consistent with filing requirements of the DMHC, unless otherwise specified by CMS.

7.7 **Financial Statements**. CalOptima, as a Knox-Keene Act health care service plan, is required by CalOptima's Regulators to monitor the financial viability of its contracted provider network on an on-going basis. Physician Group agrees to provide CalOptima annually with a copy of Physician Group's audited financial statements, including letters to management for the most recent fiscal year end along with an opinion letter on these statements from the accounting firm that completed an audit on these financial statements. Financial statements shall be presented in a form specified by CalOptima that clearly shows the financial position of Physician Group as related to Enrollees. Physician Group shall allow representatives of CalOptima, upon written request, to verify the financial reports. In the event audited statements are unavailable, Physician Group agrees to provide CalOptima with the unaudited financial statements at Physician Group's fiscal year end. The unaudited financial statements will include: balance sheets, income statement and statement of cash flows, notes to the financial statement, name of the person preparing these statements, and

representation letters from the senior financial executives of the Physician Group, attesting that these financial statements were prepared in accordance with GAAP and fairly present the financial condition of the Physician Group.

7.8 **Reports Regarding Disclosure of Confidential Enrollee Information**. If Physician Group, or any of its officers, employees, agents, or Downstream Entities, becomes aware of the unauthorized disclosure of confidential Enrollee information or of "personal information", within the meaning of California Civil Code Section 1798.3, Physician Group shall report said unauthorized disclosure to CalOptima's Privacy Officer immediately upon discovery of said disclosure, providing information on the information disclosed and how the disclosure occurred. For purposes of this section, "unauthorized disclosure" includes any unauthorized access, whether such access was through inadvertence, mistake, theft, or other means, and whether or not Physician Group had reasonable control to avoid the disclosure. Nothing herein is intended to limit or replace Physician Group's separate obligations under the Business Associate Agreement and Laws.

7.9 **Additional Information Required by CalOptima's Regulators**. Physician Group and Downstream Entities shall, at the request of CalOptima or CalOptima's Regulators, provide the following: (i) all information related to the performance of CalOptima's responsibilities, including non-medical information for the purposes of research and evaluation, to CalOptima's Regulators; (ii) any information required to comply with all Laws; and (iii) any information required for external rapid cycle evaluation, including program expenditures, service utilization rates, rebalancing from institutional to community settings, Enrollee satisfaction, Enrollee complaints and Appeals, and enrollment/disenrollment rates.

VIII. RECORD RETENTION, ACCESS AND CONFIDENTIALITY

8.1 **Disclosure of Records**. Physician Group and its Downstream Entities agree to maintain and make available contracts, books, documents, records, and electronic systems, including, Medical Records, (collectively, the "**Records**") to CalOptima, HHS, CMS, the Comptroller General, the U.S. Government Accountability Office, any Quality Improvement Organization, or accrediting organizations, including NCQA, their designees, and other representatives of regulatory or accrediting organizations, for inspection, evaluation, and auditing. For purposes of utilization management, quality improvement, and other CalOptima administrative purposes, CalOptima and CalOptima's Regulators shall have access to, and copies of, at reasonable time upon request, the Medical Records, books, charts, and papers relating to the provision of health care services to Enrollees, the cost of such services, and payments received by Physician Group or any of Group Physicians from Enrollees (or from others on their behalf). Copies of the Medical Record shall be provided at no charge to CalOptima. Unless a longer time is required under applicable law, the records described herein shall be maintained for at least ten (10) years from the final date of the Contract or from the completion of any audit, whichever is later.

8.2 **Medical Records**. Physician Group will require that all Group Physicians and Downstream Entities establish and maintain in an accurate and timely manner, for each Enrollee who has obtained Covered Services from a Group Provider or Downstream Entity, a legible Medical Record which shall be kept in detail consistent with good medical and professional practice in accordance with Laws and CalOptima Policies. Such Medical Records shall include a historical record of diagnostic and therapeutic services recommended or provided by, or under the direction of, the Provider. Such Medical Records shall be in such a form as to allow trained health professionals, other than the Provider, to readily determine the nature and extent of the Enrollee's medical problem and the services provided and permit peer review of the care provided. Physician Group shall ensure that medical information is released in accordance with applicable Laws, or pursuant to valid court

orders or subpoenas, subject to compliance with applicable privacy laws. Physician Group shall ensure than an individual is delegated the responsibility of securing and maintaining Medical Records at each Physician Group or Downstream Entity site.

8.3 **Right to Inspection**. Medical Records referred to in Section 8.2 above will be and remain the property of Physician Group or Group Physicians and will not be removed or transferred from their offices except in accordance with Laws. CalOptima or its designated representatives will have the right, in accordance with this Article 8, to inspect, review, and make copies of such records at Physician Group's expense upon request to facilitate CalOptima's obligation to conduct quality management, utilization monitoring, and peer review activities.

8.4 **Records Related to Recovery for Litigation**. Upon request by CalOptima, Physician Group and its Downstream Entities shall timely gather, preserve, and provide to CalOptima, in the form and manner specified by CalOptima, any information specified by CalOptima, subject to any lawful privileges, in Physician Group's or its Downstream Entities' possession, relating to threatened or pending litigation by or against CalOptima, HHS, and CMS. If Physician Group asserts that any requested documents are covered by a privilege, Physician Group shall: (1) identify such privileged documents with sufficient particularity to reasonably identify the document while retaining the privilege; and (2) state the privilege being claimed that supports withholding production of the document. Such request shall include a response to a request for documents submitted by any party in any litigation by or against CalOptima. Physician Group acknowledges that time may be of the essence in responding to such request. Physician Group shall use all reasonable efforts to immediately notify CalOptima of any subpoenas, document production requests, or requests for records received by Physician Group or its Downstream Entities related to this Contract or subcontracts entered into under this Contract.

8.5 **State and Federal Site Visits**. Physician Group agrees to permit CalOptima, the DMHC, HHS, and/or CMS to conduct a site evaluation of Physician Group and its facilities in accordance with Laws and to comply with the agencies' recommendations, if any.

8.6 **Enrollee Access to Records**. Physician Group (including Physician Group Providers) and its Downstream Entities shall ensure that Enrollees have access to their Medical Records in accordance with the requirements of Laws. An Enrollee shall be provided a copy of his or her Medical Records, upon request, and shall have the right to request corrections or amendments to their Medical Records as specified in 45 CFR Part 164. Physician Group and Downstream Entities shall furnish a copy of the Enrollee's Medical Records to another treating or consulting Provider regardless of whether the requesting Provider is a Participating Provider, at no cost to CalOptima or the Enrollee when (i) such a transfer of Medical Records facilitates the continuity of that Enrollee's care; (ii) the Enrollee is transferring from one Provider to another for treatment; and (iii) an Enrollee seeks to obtain a second opinion on the diagnosis or treatment of a medical condition.

IX. INSURANCE AND LIABILITY

9.1 **Indemnification**. Each Party agrees to defend, indemnify, and the other Party and the State and CMS harmless, with respect to any and all claims, costs, damages, and expenses, including reasonable attorney's fees, that are related to or arise out of the negligent or willful performance or non-performance by the indemnifying Party, or any functions, duties, or obligations of such Party. Neither termination of the Contract nor completion of the acts to be performed under this Contract shall release either Party from its obligation to indemnify as to any claims or cause of action asserted so long as the event(s) upon which such claims or cause of action is predicated shall have occurred prior to the effective date of termination or completion. CalOptima and Physician Group

agree to promptly notify the other Party of any claims or demands that arise and for which indemnification hereunder is sought.

9.2 **Insurance Requirements**.

9.2.1 **Physician Group and Downstream Entity Insurance**. Physician Group agrees to procure and maintain, at its own expense, the insurance policies required by this Section 9.2 and Laws and shall require its Downstream Entities to maintain similar policies of insurance where Physician Group's insurance does not cover its Downstream Entities.

9.2.2 **Professional/Medical Malpractice**. Each Group Physician and Participating Provider providing Covered Services to Enrollees shall maintain a professional liability (medical malpractice) insurance policy for the specialty or type of service that the Group Physician provides with minimum limits of one million dollars ($1,000,000) per incident and three million dollars ($3,000,000) in the aggregate per year.

9.2.3 **Commercial General Liability**. Physician Group and each Participating Provider who has entered into a contract with Physician Group to provide Covered Services under this Contract shall maintain a Commercial General Liability insurance policy with minimum limits of one million dollars ($1,000,000) per occurrence and three million dollars ($3,000,000) in the aggregate. CalOptima must be named as an additional insured on Comprehensive General Liability insurance policy with respect to performance under this Contract.

9.2.4 **Workers' Compensation**. Group Physician and each Participating Provider who has entered into a contract with Physician Group to provide Covered Services under this Contract shall maintain a Workers' Compensation Insurance policy with minimum limits as follows:

- Employers' Liability Insurance:
  - One million dollars ($1,000,000) Bodily Injury by Accident - each accident.
  - One million dollars ($1,000,000) Bodily Injury by Disease - policy limit
  - One million dollars ($1,000,000) Bodily Injury by Disease - each employee

9.2.5 **Managed Care Errors and Omissions**. Physician shall maintain a Managed Care Errors and Omissions Insurance policy with minimum limits as follows:

- Managed Care Errors and Omissions: Ten million dollars ($10,000,000) each claim/ten million dollars ($10,000,000) aggregate

9.2.6 **Electronic and Computer Crimes Insurance**. Physician Group and its Downstream Entities shall maintain electronic and computer crimes insurance and employee fidelity insurance with limits of at least one million dollars ($1,000,000) if Physician Group and/or its Downstream Entities will be paying claims or receiving funds on behalf of CalOptima, or will be storing, transmitting, and/or receiving personally identifiable and/or protected health information on a regular basis in carrying out its obligations under this Contract..

9.2.7 **Insurer Ratings**. Insurance required under this Article IX shall be provided by an insurer:

(a) Rated by A.M. Best with a rating of A V or better; and

(b) "Admitted" to do business in California or an insurer approved to do business in California by the California Department of Insurance and listed on the Surplus Lines Association of California List of Eligible Surplus Lines Insurers (LESLI); or

(c) An Unincorporated Interindemnity Trust Arrangement as authorized by the California Insurance Code 12180.7

9.2.8 **Captive Risk Retention Group/Self Insured**. Where any of the insurance(s) mentioned in this Article IX is provided by a captive risk retention group or self-insured, insurer ratings requirements above may be waived at the sole discretion of CalOptima, but only after review of the captive risk retention group's or self-insured's audited financial statements.

9.2.9 **Cancellation or Material Change**. Physician Group shall not of its own initiative cause such insurance as addressed in this Article IX to be cancelled or materially changed during the Term.

9.2.10 **Proof of Insurance**. Certificates of Insurance of the insurance policies and/or evidence of self-insurance required under this Article IX shall be provided to CalOptima prior to Effective Date, annually thereafter, and upon request.

X. COOPERATION

10.1 **Non-Interference**. Physician Group and Downstream Entities may not prohibit of otherwise restrict a health care professional, acting within the lawful scope of practice, from freely communicating with Enrollees about their treatment and the following, regardless of benefit coverage limitations:

10.1.1 The Enrollee's health status, medical care, or treatment options (including any alternative treatments that may be self-administered), including the provision of sufficient information to provide an opportunity for the Enrollee to decide among all relevant treatment options;

10.1.2 The risks, benefits, and consequences of treatment or non-treatment; or

10.1.3 The opportunity for the Enrollee to refuse treatment and to express preferences about future treatment decisions.

10.2 **No Counseling to Dis-enroll**. Physician Group and Group Physicians agree that they will not, during the Term, provide advice to or counsel any Enrollee to dis-enroll from CalOptima, and Physician Group and Group Physicians will not solicit such Enrollee to become enrolled with any other health maintenance organization, preferred provider organization, or any other similar hospitalization, medical payment plan or insurance program.

10.3 **Cooperation**. CalOptima and Physician Group agree that, to the extent compatible with the separate and independent management of each, they will at all times maintain an effective liaison and close cooperation with each other to provide maximum benefits to Enrollees at the most reasonable cost, consistent with quality standards of hospital and physician care.

10.4 **Signs**. Physician Group agrees that CalOptima may post notices, mutually acceptable as to size, content and form in a prominent place instructing Enrollees as to proper procedures and limitations on coverage.

10.5 **Free Exchange of Information**. No provision of this Contract shall be construed to prohibit, nor shall any provision in any contract between Physician Group and its employees or Downstream Entities, prohibit, the free, open, and unrestricted exchange of any and all information of any kind between Providers and Enrollees regarding the nature of the Enrollee's medical condition, the health care treatment options and alternatives available and their relative risks and benefits, whether or not covered or excluded under the Enrollee's Evidence of Coverage, and the Enrollee's right to appeal any adverse decision made by Physician Group or CalOptima regarding coverage of treatment which has been recommended or rendered. Physician Group and CalOptima agree not to penalize nor sanction any Provider in any way for engaging in such free, open, and unrestricted communication with an Enrollee nor for advocating for a particular service on an Enrollee's behalf.

XI. TERM AND TERMINATION

11.1 **Term of Contract**. The term of this Contract shall become effective on the Effective Date and continue in effect for five (5) years through _____ ("Initial Term") and five (5) additional one-year automatic extensions except as directed otherwise by the Board.

11.2 **Sanctions and Terminations for Cause**. If Physician Group fails to fulfill any of its duties and obligations under this Contract, including: (i) committing acts to discriminate against Enrollees; (ii) engaging in any practice that would reasonably be expected to have the effect of denying or discouraging enrollment with the Physician Group by Enrollees whose medical condition or history indicated a need for substantial future medical services; (iii) not providing Covered Services in the scope or manner required under this Contract; (iv) engaging in prohibited marketing activities; (v) failing to comply with CalOptima's compliance and fraud, waste and abuse programs; (vi) failing to meet financial requirements in Article II; (vii) committing fraud, waste or abuse relating to Covered Services or any and all obligations, duties, and responsibilities under this Contract; (viii) failure to enforce claims payment prohibitions on Group Physicians who are denied the right to submit claims and/or receive reimbursement for services furnished to Enrollees; (ix) failure of Group Physicians to comply with pharmacy requirements as determined by CalOptima; (x) failure to submit Encounter Data or comply with other reporting requirements pursuant to this Contract and CalOptima Policies; and/or (xi) failure to take corrective action related to any such obligation or duty in the time or manner required by CalOptima, CalOptima may take any one or more of the actions described in this Article XI.

11.3 **Corrective Action Plans**. CalOptima may require a Corrective Action Plan ("**CAP**") in the event that any report, audit, survey, site review or investigation indicates that the Physician Group or any Downstream Entity is not in compliance with any provision of this Contract.

11.3.1 A CAP shall be required if CalOptima receives a substantiated complaint or grievance related to the standard of care provided by the Physician Group or any Downstream Entities. CalOptima shall issue a written notice of deficiency and shall require that a CAP to be submitted within thirty (30) calendar days following the date of notice unless otherwise stated. The CAP shall include the time and manner in which the deficiency shall be corrected. CAPs are subject to approval by CalOptima, which may be approved as submitted, accepted with specific modifications, or rejected. CalOptima may extend or reduce the time allowed for completion of the CAP depending upon the nature of the deficiency.

11.3.2 Notwithstanding any request for a CAP, CalOptima may impose monetary penalties, suspend enrollment, reduce maximum enrollment, or impose other sanctions when the Physician Group is not in compliance with the provisions of this Contract, CalOptima Policies, and minimum performance requirements as established by CalOptima. All monetary fines are payable to CalOptima within thirty (30) calendar days of receipt of written notice, unless otherwise stated in the notice. Failure to submit payment to CalOptima for any monetary fines within the thirty (30) calendar day period shall result in CalOptima deducting the penalty plus administrative fees from the Physician Group's Capitation Payment.

11.3.3 CalOptima may apply sanctions pursuant to this Contract and CalOptima Policies to all PHC Participants independent of the PHC Participant whose action(s) caused sanctions to be applied by CalOptima.

11.4 **CalOptima Termination for Cause**. Notwithstanding and in addition to any other provisions of this Contract, CalOptima may terminate this Contract for cause effective upon thirty (30) calendar days' written notice; cause shall include, but shall not be limited to, the actions set forth in Section 11.2. CalOptima's rights and remedies provided in this provision shall not be exclusive and are in addition to any other rights and remedies provided by law or this Contract.

11.5 **Physician Group Termination for Cause**. Physician Group may terminate this Contract for cause only upon thirty (30) calendar days' written notice and only in the event that CalOptima fails to make payments due under this Contract within fifteen (15) calendar days of when such amounts are due and payable.

11.6 **Immediate Terminations**. In addition to all other sanction and termination rights, CalOptima may terminate Contract immediately upon delivery of written notice to Physician Group if:

11.6.1 Physician Group (including Group Physicians) and/or its Downstream Entities are unable to secure the necessary governmental licenses, approvals, and/or certificates required for the performance of their duties;

11.6.2 CalOptima determines that the health, safety, or welfare of Enrollees is jeopardized by continuation of this Contract;

11.6.3 Physician Group commits fraud, waste, or abuse; or

11.6.4 CMS fails to authorize or reauthorize CalOptima to operate a MA Program for a period that overlaps the Term.

11.6.5 This Contract shall terminate upon the termination of the Hospital Contract. Notification of termination to any PHC Participant shall constitute notification of termination to all PHC Participants.

11.7 **Without Cause Termination**. Following the Initial Term, either Party may terminate this Contract for convenience, without cause, by giving written notice to the other Party of at least one hundred and eighty (180) calendar days' prior to the effective date of such termination.

11.8 **Bankruptcy**. If during the Term there is filed by or against Physician Group in any court pursuant to any statute of the United States or any state, a petition in bankruptcy or insolvency or for reorganization or for the appointment of a receiver or trustee or conservator of all or a portion of

Physician Group's assets, or if Physician Group makes an assignment for the benefit of creditors, or if Physician Group becomes unable, admits in writing its inability, or fails generally to pay its debts as they become due, this Contract may, at the option of CalOptima, be canceled and terminated. In the event of the filing of a petition for bankruptcy by or against Physician Group, Physician Group shall assure that all of Physician Group's functions and duties related to the Contract are performed in accordance with the terms of the Contract. CalOptima shall have the right to withhold any and all amounts otherwise due to Physician Group until Physician Group fully discharges its obligations under the Contract. CalOptima shall also have the immediate right of offset by permanently retaining any and all withheld amounts as necessary to ensure that all Physician Group obligations have been met.

11.9 **Termination of CMS Contract.** In the event the CMS Contract with CalOptima is terminated or not renewed, the provisions of this Contract shall automatically terminate unless otherwise specified by CalOptima and subject to any provisions that survive termination. Any term provided in the Contract is subject to CMS's continuing approval of CalOptima's MA Program. Physician Group agrees to assist CalOptima with such transfer of care requirements mandated by CMS in the event of termination of the CMS Contract.

11.10 **Continuation of Benefits**. Physician Group and its Participating Providers agree that, in the event of CalOptima's insolvency or cessation of operations, benefits to Enrollees will continue through the period for which capitation has been paid or until the discharge of Enrollee from an inpatient facility, whichever time is greater. Covered Services to an Enrollee confined in an inpatient facility on the date of insolvency or other cessation of operations will continue until their appropriate discharge.

11.11 **Physician Group Obligations Following Termination**. In the event of termination of this Contract, at CalOptima's sole option, Physician Group will continue to provide Covered Services, and CalOptima shall reimburse for such services per the Medicare fee schedule, to Enrollees until CalOptima has made arrangements with alternative Providers to render care to Enrollees. Physician Group shall cooperate and assist CalOptima in the transfer of Enrollee care in the event this Contract or any relevant Downstream Entity subcontract is terminated for any reason. Physician Group shall provide a plan for the orderly termination of services under this Contract, in form and substance acceptable to CalOptima.

11.12 **Prohibition on Use of Certain Group Physicians**. Physician Group agrees that CalOptima reserves the right to require Physician Group, upon notification from CalOptima, to prohibit any Group Physician or Downstream Entity from providing services, whether Covered Services or otherwise, to Enrollees when CalOptima deems such prohibition to be in the best interests of the Enrollees, provided that imposition of the foregoing prohibition shall not terminate this Contract.

11.13 **PHC Primary Hospital Usage Requirement**. In order to qualify as a PHC, PHC Participants must ensure that, during every annual contract year period during the Term, at least seventy percent (70%) of the bed days for those Enrollees assigned to the PHC who require inpatient hospitalization during the previous calendar year must have occurred at Hospital or within the same hospital system as Hospital, except as otherwise provided under CalOptima Policies. For purposes of calculating the bed day percentage, only bed days in Orange County hospitals shall count. Failure to meet this requirement shall be cause for termination by CalOptima under Section 11.4 of this Contract. In the event of termination as a result of breaching this Section 11.13, Physician Group shall be offered the opportunity to continue be a Participating Provider through a separate risk-sharing arrangement with CalOptima, subject to meeting all applicable financial, operational, and other criteria for such an arrangement. Termination of Hospital under the

equivalent of this section in the Hospital Contract shall have no effect on any fee-for-service contract between CalOptima and Hospital.

XII. GENERAL PROVISIONS

12.1 **Dispute Resolution**.

12.1.1 **Provider Appeals Process**. CalOptima maintains a Provider dispute resolution process. Physician Group may appeal any aspect of the CalOptima MA Program, including a decision to impose a sanction, terminate this Contract, or take other actions against Physician Group, by filing a complaint pursuant to CalOptima Policies. Physician Group shall exhaust all administrative remedies and any government claims requirements, as applicable, before commencing arbitration.

12.1.2 **Meet and Confer**. For any dispute not subject to or resolved by the provider appeals process, or if either Party has a dispute it seeks to address informally, the Parties shall use reasonable efforts to informally meet and confer to try and resolve the dispute. The Parties shall meet and confer within thirty (30) days of a written request submitted by either Party in an effort to settle any dispute. At each meet-and-confer meeting, each Party shall be represented by persons with final authority to settle the dispute. If either Party fails to meet within the thirty (30)-day period, that Party shall be deemed to have waived the meet-and-confer requirement, and at the other Party's option, the dispute may proceed immediately to arbitration under Section 12.1.3.

12.1.3 **Arbitration**. If the Parties are unable to resolve any dispute arising out of or relating to this Contract under Sections 12.1.1 and 12.1.2, either Party may submit the dispute for resolution exclusively through confidential, binding arbitration, instead of through trial by court or jury, in Orange County, California. The Parties may agree in writing prior to commencing the arbitration on the dispute resolution rules and arbitration service that will be used to resolve the dispute. If the Parties cannot reach such an agreement, the arbitration will be conducted by Judicial Arbitration and Mediation Services ("**JAMS**") in accordance with the commercial dispute rules then in effect for JAMS; provided, however, that this Contract shall control in instances where it conflicts with JAMS's (or the applicable arbitration service's) rules. The arbitration shall be conducted on an expedited basis by a single arbitrator. The Parties prefer that the arbitrator be a retired judge of the California Superior, Appellate, or Supreme Court or of a United States court sitting in California. If no such retired judge is available, the arbitrator may be an attorney with at least fifteen (15) years of experience, including at least five (5) years in managed health care. If the Parties are unable to agree on the arbitrator within thirty (30) days of the date that the arbitration service accepts the arbitration, the arbitrator shall be selected by the arbitration service from a list of four potential arbitrators (all of whom shall be on arbitration services' panel of arbitrators) submitted by the Parties, two from each side; provided, however, that nothing stated in this section shall prevent a Party from disqualifying an arbitrator based on a conflict of interest. In making decisions about discovery and case management, it is the Parties' express agreement and intent that the arbitrator at all times promote efficiency without denying either Party the ability to present relevant evidence. In reaching and issuing decisions, the arbitrator shall have no jurisdiction to make errors of law and/or legal reasoning. The Parties shall share the costs of arbitration equally, and each Party shall bear its own attorneys' fees and costs.

12.1.4 **Exclusive Remedy**. With the exception of any dispute that under Laws may not be settled through arbitration, arbitration under Section 12.1.3 is the exclusive method to resolve a dispute between the Parties arising out of or relating to this Contract that is not resolved through the provider appeals or meet-and-confer processes.

12.1.5 **Waiver**. By agreeing to binding arbitration as set forth in Section 12.1.3, the Parties acknowledge that they are waiving certain substantial rights and protections which otherwise may be available if a dispute between them was determined by litigation in a court, including the right to a jury trial, attorneys' fees, and certain rights of appeal.

12.2 **Interpretation of Contract Language**. CalOptima has the right to final interpretation of the Contract language when disputes arise. Physician Group has the right to appeal disputes concerning Contract language to CalOptima.

12.3 **Waiver**. The waiver by either Party of a breach or violation of any provision of this Contract will not operate as or be construed to be a waiver of any subsequent breach thereof. To be effective, a waiver must in writing signed by the Parties.

12.4 **Assignment**. This Contract and the rights, interests, duties, and obligations hereunder shall not be assigned, transferred, pledged, or hypothecated in any way by Physician Group nor shall the duties and obligations imposed herein be subcontracted or delegated without the prior written consent of CalOptima, which consent may be withheld in CalOptima's sole and absolute discretion for any reason or no reason. Physician Group acknowledges and agrees that CalOptima's consent, if any, to assignment and/or delegation is subject to the approval of CMS. Therefore, any assignment and/or delegation of this Contract, including the rights, interests, duties, and obligations hereunder, shall be void unless prior written consent is obtained from CalOptima and CMS. Physician Group further acknowledges and agrees that CalOptima may require Physician Group and the proposed assignee/sub-delegate to cooperate in due diligence and sub-delegation assessment activities as part of its review of any request for consent to assignment of this Contract and the rights, interests, duties, and obligations hereunder. Physician Group agrees to cooperate and provide such information as requested by CalOptima. Physician Group acknowledges and agrees that (i) CalOptima's due diligence and/or assessment activities related to any proposed assignment may take one hundred eighty (180) days or more; (ii) in no event shall CalOptima's due diligence and/or delegation assessment activities be construed as CalOptima's consent to assignment; and (iii) any consent to assignment by CalOptima must be reflected in a separate writing executed by CalOptima and other relevant parties. CalOptima may, from time to time, establish policies and procedures regarding its processes for initiating review and approval of any proposed assignment of this Contract. For purposes hereof, the term "assignment" shall include any of the following: (i) the change of more than twenty-five percent (25%) of the ownership or equity interest in Physician Group (whether in a single transaction or in a series of transactions); (ii) the change of more than twenty-five percent (25%) of the directors or trustees of Physician Group; (iii) the merger, reorganization, or consolidation of Physician Group with another entity with respect to which Physician is not the surviving entity; and/or (iv) a change in the management of Physician Group from management by persons appointed, elected, or otherwise selected by the governing body of Physician Group (e.g., the Board of Directors) to a third-party management person, company, group, team or other entity.

12.5 **Independent Parties**. None of the provisions of this Contract are intended to create nor will be deemed or construed to create any relationship between the Parties other than that of independent contractors, solely for the purposes of effecting the provisions of the Contract. Neither of the

Parties nor any of their respective officers, directors, or employees shall act as nor be construed to be the agent, the employee, or the representative of the other Party.

12.6 **Integration of Entire Contract**. This Contract contains all of the terms and conditions agreed upon by the Parties regarding the subject matter of this Contract. Any prior agreements, promises, negotiations or representations of or between the Parties, either oral or written, relating to the subject matter of this Contract that are not expressly set forth in this Contract are null and void and of no further force or effect.

12.7 **Invalidity or Unenforceability**. The invalidity or unenforceability of any terms or provisions hereof will in no way affect the validity or enforceability of any other term or provision.

12.8 **Amendment**. CalOptima may amend this Contract immediately upon written notice to Physician Group in the event such amendment is required in order to maintain compliance with Laws. CalOptima may deem all other amendments to the Contract effective after at least forty-five (45) business days' notice or earlier if agreed to by Physician Group. All amendments of this Contract are subject to CMS approval.

12.9 **No Waiver of Immunity or Privilege**. Any information delivered, exchanged, or otherwise provided hereunder shall be delivered, exchanged, or otherwise provided in a manner, which does not constitute a waiver of immunity or privilege under applicable law.

12.10 **Choice of Law; Jurisdiction and Venue**. This Contract shall be governed by and construed in accordance with all State and federal laws and regulations governing the CMS Contract. The Parties consent to the jurisdiction of the California Courts with venue in Orange County California.

12.11 **Force Majeure**. Either Party, upon prompt written notice to the other Party, shall be excused from performance hereunder for any period that it is prevented from meeting the terms of this Contract as a result of a catastrophic occurrence or natural disaster, including, but not limited to, an act of war and excluding labor disputes ("**Force Majeure Event**");

12.12 **No Liability of County of Orange**. As required under Ordinance No. 3896, as amended, of the County of Orange, State of California, CalOptima and the Physician Group hereby acknowledge and agree that the obligations of CalOptima under this Contract are solely the obligations of CalOptima, and the County of Orange, State of California, shall have no obligation or liability therefor.

12.13 **Confidential and Proprietary Information**. Physician Group agrees to maintain confidential the following information (the "**Confidential Information**"): (a) eligibility lists and any other information containing the names, addresses and telephone numbers of CalOptima Enrollees; (b) CalOptima's administrative service manuals and all forms related thereto; (c) the financial arrangements between CalOptima and any Participating Provider; and (d) any other information compiled or created by CalOptima that is proprietary to CalOptima and that CalOptima identifies as proprietary to Physician Group in writing. Physician Group shall not disclose or use the Confidential Information for its own benefit or gain either during the Term or after the date of termination of this Contract. Physician Group may use the Confidential Information to the extent necessary to perform its duties under this Contract or upon express prior written permission of CalOptima. Upon the effective date of termination of this Contract, Physician Group shall promptly return to CalOptima the Confidential Information in its possession, upon CalOptima's notice.

12.14 **Third Party Beneficiaries**. Nothing in this Contract, express or implied, is intended to or shall confer upon any other person or entity, any right, benefit or remedy of any nature whatsoever.

12.15 **Survival**. The terms set forth in the following sections shall survive the expiration or termination of this Contract, whether with or without cause, by rescission or otherwise, as to all Covered Services provided under this Contract prior to termination: Sections 6.2, 6.5, 7.8, Article 8, 9.1, 11.10, 11.11, 12.1, 12.2, 12.3, 12.5, 12.6, 12.7, 12.9, 12.10, 12.12, 12.13, 12.14, and any other sections that, by their terms, are intended to survive termination of the Contract.

12.16 **Recitals and Exhibits**. The recitals, exhibits, and addenda set forth in this Contract are made a part of the Contract by this reference.

12.17 **Without Limitation**. Any reference in the Contract to "include(s)" or "including" means inclusion without limitation, unless otherwise distinguished within the text.

12.18 **Notices**. All notices shall be in writing and shall be deemed to have been duly given on the date of service if personally served on the Party to whom notice is given, or seventy-two (72) hours after mailing by electronic mail transmission, United States priority mail, United States mail first class (Certified Mail or Registered Mail), addressed to the Party to whom notice is to be given and such party's address as set forth below or such other address provided by notice.

To: CalOptima

Attention: Chief Operating Officer
505 City Parkway West
Orange, California 92868

To: Physician Group

_____

_____

_____

XIII. CONDITIONS PRECEDENT TO CONTRACT COMMENCEMENT

13.1 **Contract Effectiveness**. The Contract is subject to CalOptima's determination, in its sole discretion, that the following conditions have been met prior to the Effective Date: (i) Physician Group has successfully met all criteria in CalOptima's readiness assessment, including financial viability and delegated function criteria; Physician Group has signed CalOptima's Business Associate Agreement; and (iii) Physician Group has furnished all required documentation and data requested by CalOptima (e.g., insurance documents, licenses).

13.2 **Additional CalOptima Regulator Requirements**. CalOptima, in its sole discretion, may condition this Contract upon Physician Group's ability to meet other criteria imposed by CalOptima Regulators.

XIV. SIGNATURES

SUBJECT TO (I) THE UNITED STATES GOVERNMENT PROVIDING FUNDS FOR THE TERM OF THIS CONTRACT AND FOR THE PURPOSES WITH RESPECT TO WHICH IT IS ENTERED INTO; AND (II) THE APPROVAL OF THIS CONTRACT BY DMHC AND CMS, THIS

CONTRACT SHALL BECOME EFFECTIVE ON THE EFFECTIVE DATE AND SHALL TERMINATE ON AS PROVIDED IN THIS CONTRACT.

IN WITNESS WHEREOF, CalOptima and Physician Group have executed this Contract as indicated below.

FOR Physician Group:	FOR CALOPTIMA:
_____	_____
SIGNATURE	SIGNATURE
_____	Yunkyung Kim
PRINT NAME	PRINT NAME
_____	Chief Operations Officer
TITLE	TITLE
_____	_____
DATE	DATE

ADDENDUM 1

Entities Comprising the PHC

ATTACHMENT A
DEFINITIONS

1. "**Administrative Services**" means those non-clinical, administrative functions that are the responsibility of the Physician Group as set forth under the Contract and in CalOptima Policies.

2. "**Advance Directive**" means an individual's written directive or instruction, such as a power of attorney for health care or a living will, recognized under state law (whether statutory or as recognized by the courts of the state) for the provision of that individual's health care if the individual is unable to make his or her health care wishes known.

3. "**Appeals**" means an Enrollee's actions, both internal and external to CalOptima, requesting review of the denial, reduction, or termination of benefits or services from CalOptima.

4. "**Authorization/Authorized**" means the approval of CalOptima, or its delegate (which may include Physician Group), for the provision or referral of Covered Services, obtained in accordance with, and as further described in, the Provider Manual and this Contract.

5. "**Behavioral Health**" means the mental health services and substance use disorder services arranged for or provided to Enrollees by a separate Mental Health Plan, CalOptima, or their subcontractors.

6. "**CalOptima Formulary**" means the CalOptima Approved Drug List, the Disposable Medical Equipment/Supplies List, the CalOptima OneCare Formulary, and any additional formularies as may be designated by CalOptima and provided to CalOptima's designated pharmacy benefits manager "PBM". There is no applicable CalOptima Formulary for the PACE program.

7. "**CalOptima Policies**" means CalOptima policies and procedures, including CalOptima's Provider Manual, that are amended from time to time at the sole discretion of CalOptima and incorporated into this Agreement by this reference.

8. "**CalOptima's Regulators**" means those government agencies that regulate and oversee CalOptima's and its FDRs' activities and obligations under this Contract including the Department of Health and Human Services, CMS, and the DMHC and other government agencies that have authority to set standards and oversee the performance of the parties to this Contract, as well as their respective agents and contractors quality improvement organizations.

9. "**Capitation Payment**" means the monthly payment paid to Physician Group by CalOptima for delivery for Covered Services to Enrollees, which is determined by multiplying the applicable Capitation Rate by Physician Group's monthly enrollment.

10. "**Capitation Rate**" means the rate set by CalOptima for the delivery of Covered Services to an Enrollee.

11. "**Care Coordinator**" means a clinician or other trained individual employed by or contracted with Physician Group who is accountable for providing care coordination services for Enrollees, as required by CalOptima Policies and who services on one or more ICTs.

12. "**C.C.R.**" means the California Code of Regulations.

13. "**C.F.R.**" means the Code of Federal Regulations.

14. "**CMS**" means the Center for Medicare & Medicaid Services.

15. "**CMS Contract**" means the agreement between CMS and CalOptima under which CalOptima can establish its MA Program for Enrollees.

16. "**COB**" refers to the coordination of benefits and determination of order of financial responsibility that applies when two or more health benefit plans provide coverage of items and services for an individual.

17. "**Compliance Program**" means the program (including the compliance manual, code of conduct and CalOptima Policies) developed and adopted by CalOptima to promote, monitor, and ensure that CalOptima's operations and practices and the practices of its Board members, employees, contractors, and Providers comply with applicable law and ethical standards. The Compliance Program includes CalOptima's Fraud, Waste and Abuse ("FWA") plan.

18. "**Covered Services**" means those health care items, drugs, and services that an Enrollee is entitled to receive pursuant to a Program applicable to that Enrollee. Covered Services must generally be referred and Authorized in confirming with CalOptima's Policies, including its utilization management program."

19. "**Delegation**" means the process by which CalOptima expressly grants, by formal written agreement to another entity, the authority to carry out a function that would otherwise be required to be performed by CalOptima in order to meet its obligations under the CMS Contract.

20. "**Delegation Agreement**" means the formal written agreement by which CalOptima grants to another entity the authority to carry out a function that would otherwise be required to be performed by CalOptima to meet its obligations under the CMS Contract.

21. "**Delegation Criteria**" means those criteria adopted by CalOptima, for the delegation of activities in the areas of UM, medical records audits, the Office Site Review, 'Enrollee's rights and responsibilities, and credentialing, as set forth in CalOptima Policies.

22. "**DMHC**" means the California Department of Managed Health Care.

23. "**Downstream Entity**" means all Providers and other persons or entities with which Physician Group has entered into a written subcontract (acceptable to CMS) to perform administrative functions and/or health care services to satisfy Physician Group's obligations to CalOptima under this Contract, continuing down to the ultimate provider of services. The term "Physician Group" as used in the terms of this Contract shall also include its subcontractors when such subcontractors are Downstream Entities, even if not expressly referenced in the particular provision.

24. "**Emergency Medical Condition**" means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, with an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in: (i) placing the health of the individual (or with respect to a pregnant woman, the health of the woman and her unborn child) in serious jeopardy; or (ii) serious impairment to bodily functions; or (iii) serious dysfunction of any bodily organ or part.

25. "**Emergency Services**" means those covered inpatient and outpatient services that are (i) furnished by a Provider qualified to furnish Emergency Services; and (ii) needed to evaluate and/or stabilize an Enrollee's Emergency Medical Condition.

26. "**Encounter Data**" means the record of an Enrollee receiving any item(s) or service(s) provided through Medicaid or Medicare under a prepaid, capitated, or any other risk basis payment methodology submitted to CMS. The encounter data record shall incorporate HIPAA security, privacy, and transaction standards and be submitted in ASCX12N 837 or any successor format required by CalOptima's Regulators.

27. "**Enrollee**" means an eligible individual who is enrolled in the CalOptima MA Program.

28. "**Evidence of Coverage**" means the document approved by CalOptima's Regulators and issued by CalOptima to Enrollees that describes Enrollee's benefits under the CalOptima MA Program.

29. "**FDR**" means a party that enters into a written agreement (acceptable to CMS) to provide administrative or health care services to CalOptima and/or its Enrollees that are governed by the CMS Contract.

30. "**FQHC**" means an entity that meets all of the requirements for designation as a federally qualified health center under § 1861(aa)(3) of the Social Security Act and is approved for participation in the MA program.

31. "**Grievance**" means an oral or written expression of dissatisfaction, including any compliant, dispute, request for reconsideration, or appeal, made by an Enrollee.

32. "**Group Physician**" means a Physician who is employed by or under contract with Physician Group to provide physician services.

33. "**Health Network**" means Physician Group, a PHC, or health care service plan (such as an HMO) that is contracted with CalOptima to provide items and services to Enrollees on a capitated basis.

34. "**HEDIS**" means the set of standardized performance measures sponsored and maintained by the NCQA.

35. "**HRA**" means the health risk assessment tool that identifies an Enrollee's primary, acute, LTSS, Behavioral Health, and functional needs.

36. "**HIPAA**" means the Health Insurance Portability and Accountability Act of 1996, Public Law 104-191, the Health Information Technology for Economic and Clinical Health Act, Public Law 111-005, and regulations promulgated thereunder by the U.S. Department of Health and Human Services, including Title 45 of the C.F.R, Parts 160 and 164.

37. "**ICP**" means the plan of care developed by an Enrollee and/or his/her ICT or CalOptima.

38. "**Indian Enrollee**" means an Enrollee who is an Indian (as defined in the Indian Health Care Improvement Act of 1976 [25 U.S.C. §§ 1603(13), 1603 (13 and 23), or 1679(a)] or who has been determined as an Indian under 42 C.F.R. § 136.12.

39. "**Indian Health Care Provider**" means a health care program operated by the Indian Health Services or by an Indian Tribe, Tribal Organization, or Urban Indian Organization, as those terms are defined in Section 4 of the Indian Health Care Improvement Act (25 U.S.C. § 1603).

40. "**ICT**" means an interdisciplinary care team comprised of the primary care provider and Care Coordinator and other Providers at the discretion of the Enrollee that work with the Enrollee to develop, implement, and maintain the ICP.

41. "**Laws**" means any local, State, or federal statute, regulation, rule, or executive or agency order applicable to this Contract.

42. "**LTSS**" means the range of long-term services and supports that help Enrollees meet their daily needs for assistance and improve the quality of their lives and which include: (i) In-Home Supportive Services ("IHSS"); (ii) Community-Based Adult Services ("CBAS"); (iii) Multi-purpose Senior Services Program ("MSSP") services; and (iv) skilled nursing facility services and sub-acute care services.

43. "**Medically Necessary**" or "**Medical Necessity**" means when addressing Covered Services: (i) under Medicare, reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member, or otherwise medically necessary under 42 U.S.C. Section 1395y.

44. "**Medical Record**" means any record kept or required to be kept by any Provider that documents medical services received by the Enrollee, including inpatient, outpatient, emergency care, referral requests, and Authorizations in accordance with applicable laws including Title 28 C.C.R. § 1300.80(b), Title 42 U.S.C. § 1396a(w), 42 C.F.R. § 456.111 and 42 C.F.R. § 456.211 and CalOptima Policies.

45. "**Mental Health Plan**" means the entity that has contracted with DHCS to provide Specialty Mental Health Services to individuals, including Enrollees.

46. "**Model of Care**" means the component of CalOptima's quality improvement framework that is evidence-based, includes certain clinical and non-clinical elements, and is in addition to the comprehensive care coordination requirements specified in CalOptima Policies.

47. "**Non-Covered Services**" means those services that are not benefits under the CalOptima MA Program in accordance with CalOptima's Evidence of Coverage and applicable state and federal laws and regulations.

48. "**Non-Participating Provider**" means an institution, professional, or other Provider of health care services who has not entered into an agreement, either with CalOptima or Physician Group, to provide medical and other services to Enrollees.

49. "**Out-of-Area**" means that area that is outside the Service Area.

50. "**Outpatient Mental Health Services**" means outpatient services that are provided to Enrollees with mild to moderate mental health conditions including: (i) individual/group mental health evaluation and treatment (psychotherapy); (ii) psychological testing when clinically indicated to evaluate a mental health condition; (iii) outpatient services for the purpose of monitoring drug therapy; (iv) psychiatric consultation for mediation management; and (v) outpatient laboratory supplies and supplements.

51. "**Participating Provider**" means an institution, professional, or other provider of health care services who has entered into an agreement, either with CalOptima or Physician Group, to provide health care services to Enrollees.

52. "**PCC**" means the personal care coordinator(s) employed by Physician Group to comply with the CalOptima MOC Program.

53. "**PCC Component to the Model of Care Profile**" means the PCC Components identified in the Model of Care Profile.

54. **"Physician"** means a person with an unrestricted license to practice medicine or osteopathy in the state in which they practice.

55. "**Physician Direct Referral**" means the process whereby a PCP has the authority the decide whether a referral is deemed necessary for an Enrollee and if deemed necessary the PCP will directly refer that Enrollee within said Physician Group to any of the specialties or services specified in CalOptima Policies without requiring the prior Authorization of Physician Group.

56. "**Post-Stabilization Care Services**" means services related to an Emergency Medical Condition that are provided after an Enrollee is Stabilized in order to maintain the Stabilized condition, or under some circumstances, to improve or resolve the condition.

57. "**Preclusion List**" means the CMS-compiled list of providers and prescribers who are precluded from receiving payment for MA items and services or Part D drugs furnished or prescribed to Medicare beneficiaries.

58. "**PCP**" means a primary care physician responsible for supervising, coordinating, and providing initial and primary care to Enrollees; for serving as the medical home; for processing initial referrals for Specialist Physician care; and for maintaining the continuity of patient care.

59. "**Program**" is health care benefit program offered by CalOptima to Enrollees. Programs and their designs are subject to change periodically.

60. "**Provider**" means a physician, nurse, nurse mid-wife, nurse practitioner, medical technician, physician assistant, hospital, laboratory, health maintenance organization ("HMO"), or other person or institution who furnishes health care items or services.

61. "**Provider Manual**" means that comprehensive online document, as amended from time to time, and describes CalOptima's Policies and procedures affecting Physician Group Physicians' services under this Contract.

62. "**Referral**" means the process by which the Participating Provider Physician directs an Enrollee to seek and obtain Covered Services from a health professional or for care at a facility.

63. "**Rural Health Clinic (RHC)**" means an entity that meets all of the requirements for designation as a rural health clinic under § 1861(aa)(1) of the Social Security Act and is approved for participation in the MA program.

64. "**Service Area**" means the geographic area within Orange County, California.

65. "**Specialist Physician**" means any physician who is not a PCP, has the requisite training and education, and meets all other requirements set by CalOptima Policies for specialists.

66. "**Stabilize**" or "**Stabilized**" means, with respect to an Emergency Medical Condition, to provide such medical treatment of the condition to assure within reasonable medical probability that no

material deterioration of the condition is likely to result or occur during the transfer of the individual from a facility, or in the case of a pregnant woman, that the woman has delivered the child and placenta.

67. "**Threshold Language**" means those languages as determined by CalOptima's Regulators from time to time and identified in guidance on translation requirements provided to CalOptima.

68. "**Urgent Care**" means services required to prevent serious deterioration of health following the onset of an unforeseen condition or injury and are medical services required promptly to prevent impairment of health due to symptoms that do not constitute an Emergency Medical Condition but that are the result of an unforeseen illness, injury or condition for which medical services are immediately required.

ATTACHMENT B
CALOPTIMA SENIOR PLAN
MATRIX OF FINANCIAL RESPONSIBILITY
January 1, 2023

	PHYSICIAN GROUP	RESPONSIBLE PARTY	
SERVICES	**GROUP**	**SHARED RISK SERVICES BUDGET (Between Group and Plan)**	**PLAN**
Medicare Part A Services – Not Otherwise Assigned Herein or in Any Agreement Incorporating This Exhibit:			
Inpatient		**X**	
Outpatient		**X**	
Medicare Part B Services Not Otherwise Assigned Herein or in Any Agreement Incorporating This Exhibit	**X**		
Some of the main services and those related to the Risk Sharing Program are listed below:			
Acupuncture (Medicare covered)	**X**		
Allergy			
Testing and Treatment	**X**		
Serum	**X**		
Ambulance – Air and Ground			
Emergency		**X**	
Inter-facility Transfers (all vehicle types)		**X**	
Amniocentesis			
Facility Component			
Outpatient (if not provided in physician office setting)		**X**	
Professional Component	**X**		
Audiologic			
Diagnostic	**X**		
Biofeedback	**X**		
Blood & Blood Products/Blood Transfusions (including professional component)			
Autologous Blood Donation		**X**	
From Blood Bank		**X**	
Cataract Surgery			

SERVICES	GROUP	SHARED RISK SERVICES BUDGET (Between Group and Plan)	PLAN
Professional Component	X		
Facility Component (Hospital Based Outpatient – Including Implanted Lenses)		X	
Facility Component (Ambulatory Surgery Center – Including Implanted Lenses)		X	
Chemical Dependency Rehabilitation and Detox (Medicare Covered)			
Professional Component	X		
Facility Component		X	
Methadone outpatient clinics			X
Chemotherapy			
Drugs – Outpatient (Part B)		X	
Drugs – Outpatient (Part D)			Rx
Professional Component	X		
Facility Component		X	
Chiropractic (Medicare covered)	X		
Dental Services (Medical)			
Professional Component	X		
Facility Component		X	
Facility Component (Non-Hospital) Based	X		
Diabetic Supplies			
Insulin and syringes (Rx Benefit)-see Medication-Outpatient Prescription Drug Benefit			Rx
Home Glucose Monitoring Equipment and Supplies)	X		
Diagnostic Testing			
Technical Component (Outpatient)	X		
Professional Component	X		
Durable Medical Equipment (DME)			
Outpatient	X		
Emergency Room			
Facility Component		X	
Professional Component (including interpretive reports)	X		

SERVICES	GROUP	SHARED RISK SERVICES BUDGET (Between Group and Plan)	PLAN
Endoscopy			
Facility Component		X	
Professional Component	X		
Family Planning			
Therapeutic Abortion Services, Tubal Ligation, Vasectomy, etc.			
Facility Component		X	
Professional Component	X		
Fetal Monitoring			
Facility Component		X	
Professional Component	X		
Genetic Testing/Counseling	X		
Health Education	X		
Hemodialysis/Dialysis			
Outpatient (Includes drugs per Medicare guidelines)		X	
Professional Component	X		
Home Health Care			
Medicare covered home health services (Including home IV therapy, excluding Part D drugs)		X	
Home Health Supplies (see medical supplies)		X	
Hospice	**Medicare FFS has primary responsibility**		
Hospitalization			
Facility Component (Including pre-admission diagnostic services)		X	
Interpretive Reports	X		
Professional Component (Including hospital-based physicians)	X		
Immunization and Inoculations (Part B)	X		
Immunization and Inoculations (Part D)			**Rx**
Infusion Therapy			
Professional Component	X		
Facility Component		X	

SERVICES	GROUP	SHARED RISK SERVICES BUDGET (Between Group and Plan)	PLAN
Part B drugs		X	
Part D drugs			Rx
Injectables -- (Outpatient) (see also Chemotherapy)			
Part B drugs		X	
Part D drugs			Rx
Lithotripsy			
Professional Component	X		
Facility Component		X	
Mammography	X		
Maternity/Obstetrics			
Facility Component		X	
Professional Component	X		
Medical supplies (includes catheters)			
Outpatient	X		
Medication			
Outpatient – Prescription Drug Benefit (Part D)			Rx
Outpatient medications (Part B)		X	
Mental Health			
Facility Component (includes Partial Hospitalization)		X	
Professional Component			X
Nuclear Medicine			
Inpatient, Facility Component (therapeutic)		X	
Outpatient, Facility Component	X		
Professional Component	X		
Nutrition			
Nutritional/Dietetic Counseling (Medicare Covered)	X		
Parenteral Nutrients, Supplies, Kits and Pumps			
Part B		X	
Part D			X
Enteral Nutrients, Supplies, Kits and Pumps			

SERVICES	GROUP	SHARED RISK SERVICES BUDGET (Between Group and Plan)	PLAN
Outpatient			**X**
Organ Transplants			
Pre Evaluation (All Inclusive)	**X**		
Organ Acquisition		**X**	**Medicare FFS for Kidney only**
Transplant Professional Component	**X**		
Transplant Facility Component (includes organ acquisition)		**X**	
Post Transplant (up to one year for transplant related services)			
Professional Component	**X**		
Post Transplant Facility Component (Inpatient)		**X**	
Post Transplant Facility Component (Outpatient – if provided in physician office setting)	**X**		
Orthotics and Prosthetics (Medicare Covered)			
Outpatient (Medicare defined coverage applies)		**X**	
Ostomy Supplies			
Outpatient	**X**		
Out of Area (Emergent and Urgently Needed Services)			
Facility Component		**X**	
Professional Component	**X**		
Outpatient Diagnostic Tests and Services (All Inclusive)	**X**		
Outpatient Surgery			
Facility Component (Hospital Based)		**X**	
Facility Component (Freestanding Ambulatory Surgery Center)		**X**	
Professional Component	**X**		
Cardiac catheterization and Angiograms (Professional)	**X**		
Cardiac catheterization and Angiograms (Facility)		**X**	
Physical Therapy (See Rehabilitation)			
Pain Management			

SERVICES	GROUP	SHARED RISK SERVICES BUDGET (Between Group and Plan)	PLAN
Professional	X		
Facility (if provided in other than physician office setting)		X	
Physician Visits/Consultations (inclusive of all settings)	X		
Podiatry Services (Medicare covered)	X		
Radiation Therapy			
Professional	X		
Facility, outpatient facility		X	
Radiology Services			
Outpatient, Preoperative, and Inpatient Professional Component	X		
Inpatient (facility component)		X	
Rehabilitation (Short Term e.g.: PT, OT, Speech, Cardiac)			
Outpatient Facility Component	X		
Professional Component	X		
Skilled Nursing Facility (SNF)			
Facility Component (All Inclusive)		X	
Professional Component	X		
Social Services – Medical	X		
Surgically Implanted Devices – All Categories		X	
Vision Care			
Annual routine exam			X
Glasses			X
Lenses and Frames incidental to cataract surgery (Medicare covered)	X		
Screening, Physician Office	X		

Notes:

1. **Financial responsibility is based on Medicare benefit interpretations and limitations.**
2. **The symbol "Rx" denotes outpatient prescription drug services.**

Assignment of financial responsibility as outlined in this document is independent of the questions of medical necessity, coverage or benefits.

ATTACHMENT C
CAPITATION RATES AND RISK SHARING

1. **Capitation Allocation**

1.1 **Allocation of Non-Part D CMS Revenue**. Each month, CalOptima shall allocate both the non-Part D related capitation that CalOptima receives from CMS for Enrollees affiliated with Physician Group and any applicable premiums that CalOptima charges Enrollees affiliated with Physician Group (collectively, the "**Total Revenues**") as follows:

- Facility and Other Services ("**Hospital Budget**") xx.x%
- Physician Group Capitation Payment xx.xx%

1.2 **MLR**. In accordance with Section 2.3, "Medical Loss Ratio", of the Contract, Physician Group shall maintain a minimum acceptable loss ratio of eighty-five percent (85%). Should Physician Group not meet the minimum eighty-five percent (85%) MLR, CalOptima reserves the right to require Physician Group to return to CalOptima the difference between eighty-five percent (85%) of Capitation Payments and the allowed medical expenses.

1.3 **Personal Care Coordinator**.

1.3.1 In addition to the amounts described above, and contingent on CalOptima Board of Directors' approval, CalOptima will pay Physician Group, ____dollars and ____cents ($xx.xx), a per Enrollee, per month amount for PCCs. The commencement date, amount, and duration of such PCC capitation payments, if any, will be established by the action of the CalOptima Board of Directors, and will be deemed incorporated herein by reference. Such payments, if any, may be adjusted in accordance with the PCC Reference Manual and are subject to recovery, termination, or offset as provided in this Contract and in the PCC Reference Manual.

1.3.2 Physician Group acknowledges and agrees that CalOptima may adjust and/or terminate the PCC Capitation Payments in the event Physician Group fails to comply with the requirements outlined in the PCC component of the model of care (MOC) profile. Physician Group acknowledges and agrees that CalOptima, in its sole and absolute discretion, may also offset Physician Group's future PCC Capitation Payments in the event CalOptima determines that Physician Group has not complied with the requirements set forth in the PCC component of the MOC Profile.

1.4 **Sequestration**. If CMS reduces payment to CalOptima under the CMS Contract by more than two percent (2%) at any time during the Term, CalOptima may, upon written notice to Physician Group, reduce payment to Physician Group under this Attachment C by the same percentage that CMS reduced payment to CalOptima. This provision applies each time CMS reduces payment to CalOptima by more than two percent (2%) during the Term.

1.5 **Pay-for-Performance Program**. CalOptima will develop a pay-for performance program to provide incentive payments to Physician Group. Payments will be calculated and paid

quarterly and annually based on a per Enrollee, per month rate and reflect achievement of specified program goals, which are determined by CalOptima in its sole discretion.

ATTACHMENT D
CLAIMS PROCESSING AND COMPLIANCE OBLIGATIONS

I. DEFINITIONS

1.1 "**Clean Claim**" means one that can be processed without obtaining additional information from the provider of the service or from a third party. Clean claim shall have the same meaning as "complete claim" as that term is defined in Title 28, CCR Section 1300.71(a)(2). Clean Claim does not include a claim from a Provider who is under investigation for fraud or abuse, or a claim under review for Medical Necessity.

1.2 "**Unclean Claim**" means any claim other than as defined in Section 1.1 of this attachment.

1.3 "**Denied Claim**" means a claim where (a) one or more services will not be paid by Physician Group and (b) payment is the responsibility of the Enrollee. Examples of claims that are not denials and should not be reported, submitted, or presented to CalOptima as Denied Claims include claims:

1.3.1 For patients who remain enrolled with CalOptima but have transferred to another Physician Group and Physician Group is forwarding the claim,

1.3.2 For which payment responsibility belongs to another contracting entity, and Physician Group is forwarding the claim,

1.3.3 That are duplicates,

1.3.4 That are encounter only/capitated claims and no patient liability is involved, and

1.3.5 That involve reduced payment amounts due to contract terms or allowed Medicare fee schedules.

II. GENERAL TERMS

2.1 **Physician Group Claims Processing**. Physician Group shall process claims for Provider services according to all CMS requirements and, as applicable, in accordance with the requirements of the Knox-Keene Act. This Attachment D is intended to comply with all DMHC and CMS standards and requirements. Should this Attachment D be out of compliance with any existing or newly enacted DMHC or CMS standard or requirement, the DMHC and/or CMS standard or requirement will supersede this Attachment D. CalOptima will communicate any changes in requirements to Physician Group in writing.

2.2 If Physician Group enters into a contract with a Downstream Entity whereby the responsibility for claims processing is delegated to that Downstream Entity, Attachment D provisions shall apply. Physician Group will have contractual provisions to ensure such Downstream Entity conforms to all DMHC and CMS requirements and oversight provisions as outlined herein and in CalOptima Policies.

2.3 Physician Group and any applicable Downstream Entity shall be required to have an oversight program for claims processing that includes written policies and procedures, a process for reporting fraudulent or unethical conduct, and an executive accountable for review of claims data and attesting to its accuracy. The oversight program shall include internal auditing of claims functions, and self-reporting as outlined in CalOptima Policies.

III. CLAIMS PROCESSING

3.1 **Timely Provider Payments**.

3.1.1 Physician Group and Downstream Entities, if, and as applicable, must make timely payments to Participating Providers consistent with 42 CFR § 447.45.

3.1.2 Physician Group shall reimburse Clean Claims, or any portion of any Clean Claim, for Covered Services, as soon as practical, but no later than thirty (30) calendar days after receipt of the claim by Physician Group, unless the claim or portion thereof is reasonably contested, in which case the claimant shall be notified in writing that the claim is contested or denied within forty-five (45) business days after receipt of the claim by Physician Group in accordance with CalOptima Policies.

3.1.3 Physician Group must ensure that ninety percent (90%) of claims from Providers who are in individual or group practice, which can be processed without obtaining additional information from the Provider or from a third party, will be paid within thirty (30) days of the date of receipt of the claim.

3.1.4 Physician Group must ensure that ninety-nine percent (99%) of all Clean Claims from Providers for Covered Services will be paid within ninety (90) days of the date of receipt of the claim.

3.1.5 Generally, the date of receipt is the date the Physician Group receives the claim, as indicated by its date stamp on the claim. The date of payment is the date of the check or other form of payment.

3.1.6 **"30-Day" Claim Timeliness**. Physician Group shall adjudicate nine-five percent (95%) of all Clean Claims from Non-Participating Providers or suppliers within thirty (30) calendar days of receiving the claim. Adjudicate a claim shall be deemed to mean to have processed the claim (paid or denied) and mailed the remittance advice by the thirtieth (30^{th}) calendar day since the earliest receipt by Physician Group or CalOptima's contracting Providers.

3.1.7 **"60-Day" Claim Timeliness**. Physician Group shall pay or deny Unclean Claims from Non-Participating Providers or suppliers, claims from Participating Providers or suppliers, and claims from Medicare fiscal intermediaries and carriers within sixty (60) calendar days of receipt of such claims. Processing shall be deemed to mean either to have paid or denied and mailed the remittance advice by the sixtieth (60^{th}) calendar day since the earliest receipt by Physician Group or CalOptima's contracting Providers, or to have denied the claim, and have mailed the denial letter to the Enrollee by the sixtieth (60^{th}) day. In accordance with federal law and CMS regulations, failure to process such claims within sixty (60) calendar days of receipt automatically constitutes an "adverse" initial determination, which the Enrollee may appeal; thus, a denial notice must be mailed to the Enrollee.

3.1.8 **Payment Accuracy**. When paying Non-Participating Providers, Physician Group shall employ only those Medicare fee schedules that MA plans are allowed to use by law and shall comply with 42 CFR § 422.214.

3.1.9 **Denied Claims**. Decisions to deny claims that result in liability for the Enrollee must be made in accordance with CMS guidelines. Whenever such decisions are made, the currently CMS approved Notice of Denial of Payment or Integrated Denial Notice must be

used, including approved denial reasons. Under no circumstances shall Physician Group deny a claim for the second time as a consequence of responding to a request for reconsideration from an Enrollee; instead, Physician Group must direct the Enrollee to submit the request directly to CalOptima as appropriate.

3.2 **Claims for Emergency and Post-Stabilization Services.**

3.2.1 Physician Group shall not retroactively deny a claim for Emergency Services because the condition, which appeared to be an Emergency Medical Condition, turned out to be non-emergency in nature. Physician Group shall ensure that its claims processing actions do not conflict with Hospital actions required to comply with the Emergency Medical Treatment and Active Labor Act ("**EMTALA**").

3.2.2 If there is a disagreement between Physician Group or any Participating Provider and any Non-Participating Provider regarding Medically Necessity of Covered Services in an emergency, the judgment of the attending physician(s) actually caring for the Enrollee at the treating facility shall prevail. Physician Group may establish relationships with treating facility whereby the Physician Group may send a Participating Provider with privileges to assume the attending physician's responsibilities to establish treatment or may arrange to have a Participating Provider under contract with Physician Group agree to accept the transfer of the Enrollee after the Enrollee has been Stabilized.

3.2.3 Physician Group shall ensure that an enrollee with an Emergency Medical Condition will be seen on an emergency basis and that Emergency Services will be available and accessible within the Service Area twenty-four (24) hours a day. Physician Group shall cover Emergency Services without prior Authorization pursuant to Title 28 CCR Section 1300.67(g), Title 22 CCR Section 53216, and Section 1932(b)(2) of the Social Security Act. Physician Group shall coordinate access to Emergency Services in accordance with 42 CFR § 438.114 and the Physician Group's emergency department protocol.

3.2.4 Physician Group may not refuse to cover Emergency Services based on the emergency room Provider, Hospital, or fiscal agent not notifying the Enrollee's PCP managed care organization, prepaid ambulatory health plan, prepaid inpatient health plan or applicable State entity of the Enrollee's screening and treatment within ten (10) calendar days of presentation for Emergency Services. An Enrollee who has an Emergency Medical Condition may not be held liable for payment of subsequent screening and treatment needed to diagnose the specific condition or Stabilize the Enrollee.

3.2.5 Physician Group may not deny payment for treatment obtained under either of the following circumstances: an Enrollee had an Emergency Medical Condition, including cases in which the absence of immediate medical attention would not have had the outcomes specified in the definition of an Emergency Medical Condition; or the Physician Group representative instructs the Enrollee to seek Emergency Services. The attending emergency Physician, or the Provider actually treating the Enrollee, is responsible for determining when the Enrollee is sufficiently Stabilized for transfer or discharge, and that determination is binding on the entities as responsible for coverage and payment.

3.2.6 Physician Group must cover and pay for Post-Stabilization Care Services. Physician Group is financially responsible for Post-Stabilization Care Services obtained within or outside the organization that are pre-approved by a Physician Group Provider or other Physician Group representative. Physician Group is financially responsible for Post-Stabilization

Care Services obtained within or outside the Physician Group organization that are not pre-approved by a Participating Provider or other Physician Group representative, but are administered to maintain the Enrollee's Stabilized condition within one (1) hour of a request to the Physician Group for pre-approval of further Post-Stabilization Care Services. Physician Group is financially responsible for Post-Stabilization Care Services obtained from within or outside the Physician Group that are not pre-approved by a Participating Provider or other Physician Group representative, but administered to maintain, improve, or resolve the Enrollee's Stabilized condition if the Physician Group: does not respond to a request for pre-approval within one (1) hour; cannot be contacted; or the Physician Group representative and the treating physician cannot reach an agreement concerning the Enrollee's care and a Participating Provider is not available for consultation. In this situation, the Physician Group must give the treating Physician the opportunity to consult with a Participating Provider and the treating Physician may continue with care of the Enrollee until a Participating Provider is reached or one criteria in 42 C.F.R. § 113(c)(3) is met. Physician Group must limit charges to Enrollees for Post-Stabilization Care Services to an amount no greater than what the Physician Group would charge the Enrollee if he or she had obtained the services through Physician Group. Physician Group financial responsibility for Post-Stabilization Care Services it has not pre-approved ends when: a Participating Provider with privileges at the treating hospital assumes responsibility for the Enrollee's care; a Participating Provider assumes responsibility for the Enrollee's care through transfer; Physician Group representative and the treating Physician reach an agreement concerning the Enrollee's care; or; the Enrollee is discharged.

3.2.7 Physician Group shall reimburse those Physicians providing Emergency Services and Urgent Care services with whom Physician Group has a contract according to the terms of that contract.

3.2.8 Physician Group must reimburse a Non-Participating Provider for Emergency Services or Urgent Care services at the prevailing Medicare fee-for-service ("**FFS**") rate as applicable for that service. Where the Covered Service would traditionally be covered under Medicare FFS, the Medicare FFS rate applies. Physician Group shall ensure that Enrollees maintain balance billing protections as provided in Section 6.4 of this Contract.

3.2.9 In accordance with CalOptima Policies, Physician Group shall implement the CMS Quality Payment Program known as the Merit-based Incentive Payment System ("**MIPS**"). MIPS adjustments for Part B covered professional services furnished by MIPS-eligible Providers that are not contracted with Physician Group shall be administered in the same manner as any other changes in the applicable Medicare payment schedules. Physician Group shall make positive and negative payment adjustments as identified by CMS based on the CMS MIPS adjustment data files.

3.2.9.1 CalOptima or Physician Group may apply MIPS payment adjustments either at the time the payment is made during the applicable MIPS payment year or as a retrospective adjustment to paid claims.

3.2.9.2 CalOptima or Physician Group are required to demonstrate payment through reporting or attestation by the end of March on an annual basis.

3.3 **Physician Group Financial Responsibility**. If CalOptima receives a claim for Covered Services that are the financial responsibility of Physician Group, CalOptima shall forward such claim to Physician Group for payment, in accordance with the procedures set forth in Title 28 CCR Section

1300.71, "Claims Settlement Practices." CalOptima shall not pay for services that are Physician Group's financial responsibility unless Physician Group fails to make payment within the time allowed by State and federal laws and regulations, and CalOptima is required by law to make such payment. In such cases, CalOptima, after written notice to Physician Group and reasonable opportunity to cure, will make payment, and Physician Group shall reimburse CalOptima for such payments. If Physician Group fails to reimburse CalOptima, CalOptima may offset an uncontested payment(s) against Capitation Payments or other amounts due from CalOptima to Physician Group, if any.

3.4 **Collection of Share of Cost**. Physician Group shall collect Medicare share of cost unless prohibited under this Contract.

3.5 **Capitation Payments**. Physician Group and/or Downstream Entities shall distribute monthly Capitation Payments to capitated Participating Providers within fifteen (15) calendar days following the date on which Physician receives payment from CalOptima.

3.6 **Claims Adjudication**. Except as provided in Section 3.1.1, Physician Group shall accept and adjudicate claims for Covered Services provided to Enrollees in accordance with the provisions of Sections 1371, 1371.1, 1371.2, 1371.22, 1371.35, 1371.36, 1371.37, 1371.38, 1371.4 and 1371.8 of the California Health & Safety Code, and Sections 1300.71, 1300.71.38, 1300.71.4, and 1300.77.4 of Title 28 of the CCR and CalOptima Policies. Waiver of any right or obligation specific to the Health and Safety Code and Title 28 related to claims processing and payment shall be prohibited.

3.7 **Dispute Resolution.** Physician Group shall establish and maintain a fair, fast and cost-effective dispute resolution mechanism to process and resolve provider disputes in accordance with the provisions of Sections 1371, 1371.1, 1371.2, 1371.22, 1371.35, 1371.36, 1371.37, 1371.38, 1371.4 and 1371.8 of the California Health & Safety Code, and Sections 1300.71, 1300.71.38, 1300.71.4, and 1300.77.4 of Title 28 of the CCR and CalOptima Policies.

3.8 **Right of Appeal**. Physician Group shall afford Providers an unconditional right of appeal and de novo review for claims disputes involving issues of Medical Necessity. Any Provider that submits a claim dispute to Physician Group's dispute resolution mechanism involving an issue of Medical Necessity or utilization review shall have an unconditional right of appeal for that claim dispute to CalOptima's dispute resolution process for a de novo review and resolution for a period of sixty (60) working days from Physician's Date of Determination.

3.9 **CalOptima Payment On Behalf Of Physician**. If CalOptima receives a copy of an unpaid Clean Claim as part of a Provider grievance that is thirty (30) working days old or more, CalOptima will follow all notification and acknowledgement procedures pursuant to CalOptima Policies. If Physician Group does not either notify CalOptima that the claim is reasonably contested, as set forth in CalOptima Policies, or pay the Clean Claim within the thirty (30) working day period, CalOptima shall pay the Claim on behalf of Physician, plus interest, as required by the Knox-Keene Act, and deduct the amounts reimbursed, plus processing costs, from the Capitation Payment, in accordance with CalOptima Policies.

3.10 **Quarterly Claims Payment Performance Report.**

3.10.1 Physician Group shall submit, in a format specified by CalOptima Policies, a quarterly claims payment performance report ("**Quarterly Claims Report**") to CalOptima within thirty (30) calendar days of the close of each calendar quarter. The Quarterly Claims Report

shall, at a minimum, disclose Physician Group's compliance status with Sections 1371, 1371.1, 1371.2, 1371.22, 1371.35, 1371.36, 1371.37, 1371.4, and 1371.8 of the California Health and Safety Code and Sections 1300.71, 1300.71.38, 1300.71.4 and 1300.77.4 of Title 28 of the CCR.

3.10.2 Physician Group shall ensure that each Quarterly Claims Report is signed by, and includes the written verification of, a principal officer, as defined by Section 1300.45(o) of Title 28 of the CCR, of Physician Group, stating that the report is true and correct to the best knowledge and belief of the principal officer.

3.10.3 Physician Group's Quarterly Claims Report shall include a tabulated record of each Provider dispute it received, categorized by date of receipt, and including the identification of the Provider, type of dispute, disposition and working days to resolution, as to each Provider dispute received. Each individual dispute contained in a Provider's bundled notice of Provider dispute shall be reported as a separate dispute to CalOptima.

3.11 **Forwarding of Misdirected Claims.**

3.11.1 Physician Group shall have the ability to receive a standard ANSI 837I and ANSI 837P claim file format for retrieving misrouted claims that are the financial responsibility of the Physician Group. Physician Group will receive and forward misdirected claims per CalOptima Policy.

3.11.2 Physician Group shall have the ability to create a standard ANSI 837I and ANSI 837P claim file for forwarding claims that are the financial responsibility of CalOptima within ten (10) working days of receipt of the claim. CalOptima shall receive these files per CalOptima policy and load them into its system to ensure timely claims processing. Physician Group shall forward any claims that are not its payment responsibility to CalOptima within eight (8) calendar days of receipt, so that a total of only ten (10) working days will elapse prior to the claims being in the proper hands.

3.12 **Assumption of Delegated Functions**. In the event that Physician Group fails to timely and accurately reimburse its claims (including the payment of interest and penalties), CalOptima may, at its sole discretion, revoke the delegation and assume responsibility from Physician Group for claims payment, or terminate this Contract as provided for in Article XI. CalOptima's assumption of responsibility for the processing and timely reimbursement of Provider claims may be altered to the extent that Physician Group has established an approved CAP consistent with Section 1375.4 (b)(4) of the Health and Safety Code and Section 11.3 of the Contract.

3.13 **Recoupment for Assumption of Claims Processing Obligations**. CalOptima, in its sole and absolute discretion, may reduce Physician Group's Capitation Payments to recoup additional administrative costs for the assumption of the claims processing obligations of Physician Group, as described in this Article III of Attachment D, as well as any amounts, including interest due, on claims unpaid at the assumption of such obligations by CalOptima.

IV. CLAIMS COMPLIANCE

4.1 **Claims Compliance Monitoring**. Physician Group understands that claims compliance programs are required by CalOptima's Regulators and agrees that delegation is contingent upon Physician Group's compliance with required monitoring and oversight activities, as outlined in CalOptima Policies. Physician Group agrees that CalOptima reserves the right to monitor Physician Group's

claims compliance activities, notwithstanding any other audit, compliance, or contractual issue between Physician Group and CalOptima. In the event Physician Group demonstrates an inability to meet CalOptima's claims payment standards, CalOptima reserves the right to revoke and assume the delegated responsibilities described above.

4.2 **Claims Non-Compliance**. In the event that CalOptima determines that Physician Group is not in ninety-five percent (95%) compliance with any of the requirements of Attachment D the following actions will be applied:

4.2.1 Within thirty (30) days of an audit that documents non-compliance, CalOptima will issue a written warning to Physician Group that describes the non-compliance. Physician Group will respond within fifteen (15) working days of receiving the non-compliance notification with a written CAP to comply. Such CAP will describe the actions to be taken and the schedule by which those actions will be completed. CalOptima will review the CAP and advise Physician Group whether or not actions or time schedules are acceptable within fifteen (15) days of receiving it. CalOptima will conduct a follow-up audit of Physician Group's claims operation within ninety (90) days from the date of serving the non-compliance notification to verify compliance with Attachment D. If CalOptima does not receive a CAP within fifteen (15) calendar days, the consequences outlined in Subsection 4.2.2 of this attachment for continued non-compliance will apply.

4.2.2 If, as a result of CalOptima's follow-up audit, Physician Group is found to still be non-compliant with Attachment D within fifteen (15) calendar days of making that determination, CalOptima will notify Physician Group in writing of the continued non-compliance and may elect to provide consultative or other assistance to help establish, maintain and monitor continued administrative compliance or assume "joint administration" of Physician Group's claims operations, involving itself only with Enrollees' claims and allowing the operation to remain on Physician Group's premises. The Parties agree to meet and develop a mutually agreeable work plan for added staffing and work stations, the cost of which will be Physician Group's sole responsibility. CalOptima will develop a CAP with Physician Group's participation to assure maximum compatibility with Physician Group's ongoing operations. CalOptima will cooperate with Physician Group in implementing changes across all risk claims processed at that site, should Physician Group so request. Within fifteen (15) calendar days of receiving the second notice of non-compliance, Physician Group will provide a written response stating the specific action to be taken to establish compliance with the help of CalOptima. If CalOptima does not receive a CAP within fifteen (15) calendar days, the consequences outlined in Subsection 4.2.3 for continued non-compliance will apply. Within ninety (90) days from the date of serving the second notice of non-compliance, CalOptima will re-audit Physician Group's claims process and documents to determine final compliance or non-compliance.

4.2.3 If, as a result of its second follow-up audit, CalOptima reasonably determines that Physician Group is still non-compliant, CalOptima reserves the right to terminate this Contract for material breach upon ten (10) days' prior written notice and opportunity to cure.

4.2.4 Physician Group may resume sole administrative responsibility for claims processing if CalOptima determines that Physician Group has corrected the deficiencies that caused the non-compliance, and, as a result of resuming responsibility for claims processing,

demonstrates compliance with the timely provider payments requirements set forth in Section 3.1 of this Attachment D.

4.2.5 With respect to the requirements of Attachment D, Physician Group will be subject to regular site-audits conducted by CalOptima to monitor all claims requirements.

V. CLAIMS FORWARDING

Physician Group shall forward any claims that are not its payment responsibility to CalOptima within ten (10) calendar days of receipt.

VI. SELF-MONITORING & REPORTING

Physician Group shall develop, implement and demonstrate upon request, a claims quality assurance process, including regular, scheduled, automated, or manual reports, self-testing procedures, and internal reporting to Physician Group's executive management of timeliness, payment accuracy, and denial accuracy (as required herein). Such self-monitoring and internal reporting shall involve use of industry standard tools and shall measure actual performance against the standards for DMHC and CMS compliance. CalOptima strongly recommends check issuance and mailing occur not less frequently than weekly and that Physician Group's internal reporting intervals match the intervals at which checks are issued, except that weekly reporting would be sufficient if checks are issued more often than weekly. At a point early in the beginning of operations under the Contract and in accordance with industry-wide CMS requirements, CalOptima will require that Physician Group submit monthly reports to CalOptima using the industry-standard Monthly Report of Claims Processing Timeliness and Overall Percent of Denial Accuracy format. Those reports must be received by CalOptima not later than the fifteenth (15th) calendar day of each month.

VII. AUDITS & AUDIT PREPARATION

Article IV, above, provides detailed, specific processes involving claims non-compliance. Even when Physician Group does meet compliance standards and successfully concludes any time periods where denials must be submitted to CalOptima for review, CalOptima will continue to schedule (1) periodic audits, (2) random, focused audits, and (3) focused reviews based on appeals and grievance results to monitor Physician Group's compliance with CMS regulations. Prior to the scheduled arrival of CalOptima's auditor, Physician Group shall retrieve claims and related documents in accordance with instructions provided to Physician Group by CalOptima in its letter confirming the appointment.

VIII. SPECIAL STUDIES

8.1 In the event DMHC and/or CMS requires that CalOptima conduct any special compliance study or effort, Physician Group shall support the study and will be subject to any DMHC and/or CMS specified time schedules or deadlines for corrective actions.

IX. FEDERALLY QUALIFIED HEALTH CENTERS AND RURAL HEALTH CLINICS

9.1 Physician Group shall meet federal requirements for access to FQHC services, including those in 42 U.S.C. § 1396 b(m). Physician Group shall reimburse FQHCs and RHCs in accordance with current Laws. If FQHC and RHCs services are not available in the Provider network, Physician Group shall authorize out-of-network services subject to the prevailing MA payment requirements for out-of-network services.

9.2 Physician Group shall ensure that its payments to FQHCs and RHCs for services to Enrollees are no less than the sum of the level and amount of payment that the Health Network or CalOptima would make for such services if the services had been furnished by an entity providing similar services that was not an FQHC and RHC. The intent of these provisions is to ensure that Physician Group pays FQHCs and RHCs amounts consistent with Medicare managed care policies while preserving the opportunity for FQHCs to separately claim supplemental payments under such policies.

X. INDIAN HEALTH CARE PROVIDERS

10.1 Physician Group shall pay non-network Indian Health Care Providers that are FQHCs for the provision of services to an Indian Enrollee at a rate equal to the rate that Physician Group would pay to a network FQHC that is not an Indian Health Care Provider, including any supplemental payment from the State to make up the difference between the contract amount and what the Indian Health Care Provider would have received FFS.

10.2 When the amount the Participating Provider Indian Health Care Provider receives from the Physician Group is less than the amount the Indian Health Care Providers would receive FFS, the State must make a supplemental payment to the Indian Health Care Provider that the Indian Health Care Provider would receive FFS or the applicable encounter rate.

10.3 Physician Group shall not impose enrollment fees, premiums, or similar charges on Indians served by an Indian Health Care Provider or through referral under contract health services. Physician Group must exempt from all cost-sharing any Indian who is currently receiving or has ever received an item or service furnished by an Indian Health Care Provider or through referral under contract health services.

10.4 Physician Group shall reimburse Indian Health Care Providers promptly who provide Covered Services to Indian Enrollees, who are eligible to receive Covered Services, at the most current and applicable outpatient per-visit rate published in the Federal Register by the Indian Health Service, and Physician Group shall ensure any retroactive outpatient per visit rates are appropriately reimbursed to the Indian Health Care Provider.

ATTACHMENT E
STATUTORY AND REGULATORY COMPLIANCE TERMS

1. **Compliance with State and Federal Laws**. Physician Group acknowledges that CalOptima is subject to certain State and federal laws, regulations, and instructions governing its MA Program. Physician Group shall comply with all Laws and DMHC and CMS administrative bulletins, plan letters and instructions. Physician Group understands that payments made by CalOptima are, in whole or in part, derived from federal funds, and therefore Physician Group and any Downstream Entities are subject to certain laws that are applicable to individuals and entities receiving federal funds, including the following: (i) Title VI of the Civil Rights Act of 1964; (ii) Sections 503 and 504 of the Rehabilitation Act of 1973; (iii) the Age Discrimination Act of 1975; (iv) the Americans with Disabilities Act of 1990; (v) the Vietnam Era Veteran's Readjustment Assistance Act; and (vi) Title IX of the Education Amendments of 1972. Any provision required to be in this Contract by the CMS Contract, the Knox-Keene Act, Title 28 of the California Code of Regulations, Medicare laws and regulations, DMHC or CMS instructions and reporting requirements and other applicable laws, shall bind CalOptima, Physician Group, and Downstream Entities, whether or not specifically set forth in this Contract.

2. **Compliance with CalOptima's Contractual Obligations**. All services and other activities furnished by Physician Group and Downstream Entities must be performed in accordance with CalOptima's contractual obligations to CMS.

3. **Compliance with FWA Requirements**. Physician Group, and its employees, agents and Downstream Entities performing services under this Contract, shall comply with CalOptima's Compliance Program including, its FWA plan. Prior to performing services under this Contract, Physician Group shall complete and submit to CalOptima, any CMS-required training and/or CalOptima-required attestations related to such training and other compliance obligations. Physician Group agrees to comply and will have any Downstream Entity agree to comply with CalOptima standards and policies.

4. **Fraud and Abuse Reporting**. Physician Group shall, in accordance with all Laws, report to CalOptima all cases of suspected fraud and/or abuse relating to the rendering of Covered Services within five (5) days of the date when Physician Group first becomes aware of or is on notice of such activity.

5. **CMS Participation Requirements**. Physician Group represents and warrants that: (i) neither Physician Group nor any of its Group Physician, employees or agents furnishing services under this Contract are excluded from participating in any federal or state healthcare program as defined in 42 U.S.C. Section 1320a-7b(f) ("**Federal Health Care Program(s)**"); (ii) Physician Group has not arranged or contracted (by employment or otherwise) with any employee, contractor or agent that Physician Group knows or should know are excluded or precluded from participation in Federal Health Care Programs; (iii) no action is pending against Physician Group or any of its Group Physicians, employees, or agents performing services under this Contract to suspend or exclude such persons or entities from participation in any Federal Health Care Program; and (iv) Physician Group will immediately notify CalOptima if it learns that it is or has employed or contracted with a person or entity that is excluded from participation in any Federal Health Care Program. If Physician Group fails to comply with this Section 5 of this attachment, CalOptima reserves the right to require Physician Group to pay immediately to CalOptima the amount of any sanctions or other penalties that may be imposed on CalOptima by CMS for violation of this prohibition, and Physician Group shall be responsible for any resulting overpayments. Physician Group shall not make payment for a healthcare item or service furnished by an individual or entity

that is excluded by the Office of the Inspector General or is included on the Preclusion List. Physician Group shall provide written notice to the Enrollee who received the services and the excluded Provider or Provider listed on the Preclusion List that payment will not be made, in accordance with CMS requirements. Physician Group shall ensure that all Participating Providers that provide Covered Services do not appear on the CMS Preclusion List in order to receive reimbursement for claims or otherwise participate in the Medicare program.

6. **Confidentiality of Enrollee Information**. Physician Group, its Downstream Entities, and their employees and agents shall comply with the specific confidentiality obligations set forth below.

6.1 Physician Group, Downstream Entities, and their employees and agents 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 them as a result of services performed under this Contract, except for statistical information not identifying any such person. Physician Group, Downstream Entities, and their employees and agents shall not use such identifying information for any purpose other than carrying out Physician Group's obligations under this Contract.

6.2 Physician Group, Downstream Entities, and their employees and agents shall promptly transmit to CalOptima all requests for disclosure of such identifying information not emanating from the Enrollee. Physician Group shall not disclose, except as otherwise specifically permitted by this Contract or authorized by the Enrollee, any such identifying information to anyone other than CMS, DMHC, 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.

6.3 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*., Welfare and Institutions Code Section 14100.2, and regulations adopted thereunder. For the purpose of this Contract, all information, records, data, and data elements collected and maintained for the operation of the Contract and pertaining to Enrollees shall be protected by Physician Group from unauthorized disclosure. Physician Group may release Medical Records in accordance with Laws pertaining to the release of this type of information. Physician Group is not required to report requests for Medical Records made in accordance with Laws.

6.4 With respect to any identifiable information concerning an Enrollee under this Contract that is obtained by Physician Group or its Downstream Entities from CalOptima's Regulators, Physician Group will, at the termination of this Contract, return all such information to CalOptima's Regulators if required by them, or maintain such information according to written procedures provided to Physician Group by CalOptima and/or CalOptima's Regulators for this purpose.

7. **Offshore Subcontracts**. Physician Group shall provide, and ensure that Downstream Entities provide, to CalOptima information and attestations related to the provision of any services under this Contract in a country other than the United States ("**Offshore Subcontractor**") to enable CalOptima to comply with CMS reporting obligations. Such information shall be submitted to CalOptima prior to engaging any Offshore Subcontractor for purposes of this Contract, and such Offshore Subcontractors are subject to approval by CalOptima.

8. **Required Disclosures**. In accordance with 42 CFR Section 1002.3, Physician Group shall immediately notify CalOptima in the event any sanctioned person (as defined in 42 CFR Section 1001.1001(a)(1)) owns or controls Physician Group.

9. **Equal Opportunity**. Physician Group and Downstream Entities shall comply with the following Equal Opportunity requirements set forth below.

9.1 Physician Group and its Downstream Entities 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. Physician Group and its Downstream Entities will take affirmative action to ensure that qualified applicants are employed, and that employees are treated during employment, without regard to their race, color, religion, sex, national origin, physical or mental handicap, disability, age, or status as a disabled veteran or veteran of the Vietnam era. Such action shall include the following: Employment, upgrading, demotion or transfer; recruitment or recruitment advertising; layoff or termination; rates of pay or other forms of compensation; and career development opportunities and selection for training, including apprenticeship. Physician and its Downstream Entities agree to post in conspicuous places, available to employees and applicants for employment, notices to be provided by the federal government, 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 Physician Group and its Downstream Entities' 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.

9.2 Physician Group and its Downstream Entities will, in all solicitations or advancements for employees placed by or on behalf of Physician Group and its Downstream Entities, 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.

9.3 Physician Group and its Downstream Entities will send to each labor union or representative of workers with which it has a collective bargaining agreement or other contract or understanding a notice, to be provided by the federal government or the State, advising the labor union or workers' representative of Physician Group and its Downstream Entities' commitments under the provisions herein and shall post copies of the notice in conspicuous places available to employees and applicants for employment.

9.4 Physician Group and its Downstream Entities 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.

9.5 Physician Group and its Downstream Entities 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 Physician Group 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.

9.6 In the event of Physician Group and its Downstream Entities' noncompliance with the requirements of the provisions herein or with any federal rules, regulations, or orders which are referenced in this Article IX, this Contract may be cancelled, terminated, or suspended in whole or in part, and Physician Group and its Downstream Entities may be declared ineligible for further State and Federal 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.

9.7 Physician Group and its Downstream Entities will include the provisions of Sections 10.1 through 10.7 of this attachment 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. Section 4212) of the Vietnam Era Veteran's Readjustment Assistance Act, so that such provisions will be binding upon each Downstream Entity. Physician and its Downstream Entities will take such action with respect to any subcontract or purchase order as the Director of the Office of Federal Contract Compliance Programs or CMS may direct as a means of enforcing such provisions, including sanctions for noncompliance; provided, however, that in the event Physician Group and/or its Downstream Entities become involved in, or are threatened with litigation by a other Downstream Entity or vendor as a result of such direction by CMS, Physician Group and its Downstream Entities may request in writing to CMS, 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.

10. **Non-Discrimination**. Physician Group and Downstream Entities shall comply with the non-discrimination requirements set forth below.

10.1 During the performance of this Contract, neither Physician Group nor any Downstream Entities shall unlawfully discriminate, harass, or allow harassment against any employee or applicant for employment because of sex, race, religion, color, national origin, ancestry, religious creed, physical disability, (including Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS), AIDS-Related Complex (ARC)), medical condition (including cancer), mental disability, marital status, age (over 40), or the

use of family and medical care leave and pregnancy disability leave. Physician Group and Downstream Entities shall insure that the evaluation and treatment of their employees and applicants for employment are free of such discrimination and harassment. Physician Group and Downstream Entities shall comply with the provisions of the Fair Employment and Housing Act (Government Code, Section 12900, *et seq*.) and the applicable regulations promulgated thereunder (Title 2 CCR Section 7285.0, *et seq*.). The applicable regulations of the Fair Employment and Housing Commission implementing Government Code, Section 12990, set forth in Chapter 5 of Division 4 of Title 2 of the CCR are incorporated into this Contract by reference and made a part hereof as if set forth in full. Physician Group and Downstream Entities shall give written notice of their obligations under this clause to labor organizations with which they have a collective bargaining or other agreement. Physician Group shall include the non-discrimination and compliance provisions of this Section 10.1 in all Downstream Entity subcontracts to perform work under this Contract.

10.2 Physician Group and all Downstream Entities shall abide by 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 1972 (regarding education programs and activities); Title 45 CFR Part 91 and the Age Discrimination Act of 1975 (discrimination based on age); and all other laws regarding privacy and confidentiality. Neither the Physician nor Downstream Entities shall discriminate against Enrollees because of race, color, creed, religion, ancestry, marital status, sexual orientation, national origin, age, sex, or physical or mental handicap in accordance with Title VI of the Civil Rights Act of 1964, 42 U.S.C., Section 2000d (race, color, national origin); 45 CFR Part 84 (physical or mental handicap); Government Code Section 11135 (ethnic group identification, religion, age, sex, color, physical or mental handicap); Civil Code Section 51 (all types of arbitrary discrimination); rules and regulations promulgated pursuant thereto, or as otherwise provided by Laws.

10.3 For the purpose of this Contract, if based on any of the foregoing criteria, the following constitute unlawful discriminations: (i) denying any Enrollee any Covered Services or availability of a facility; (ii) providing to an Enrollee any Covered Service that is different or is provided in a different manner or at a different time from that provided to other similarly situated Enrollees under this Contract, except where medically indicated; (iii) subjecting an Enrollee to segregation or separate treatment in any manner related to the receipt of any Covered Service; (iv) restricting an Enrollee in any way in the enjoyment of any advantage or privilege enjoyed by others receiving any Covered Service; or (v) treating an Enrollee differently from others similarly situated in determining compliance with admission, enrollment, quota, eligibility, or other requirements or conditions that individuals shall meet in order to be provided any Covered Service or assigning the times or places for the provision of Covered Services.

10.4 Physician Group shall take affirmative action to ensure that all Enrollees are provided Covered Services without unlawful discrimination, except where medically indicated. For the purposes of this Section 10.4, physical handicap includes the carrying of a gene that may, under some circumstances, be associated with disability in that person's offspring, but which causes no adverse effects on the carrier. Such genetic handicap shall include,

but not be limited to, Tay-Sachs trait, sickle cell trait, thalassemia trait, and X-linked hemophilia.

10.5 Physician shall act upon all complaints alleging discrimination against Enrollees in accordance with CalOptima's Policies and shall forward copies of all such grievances to CalOptima within five (5) days of receipt of same.

11. **Smoke Free Workplace**. Public Law 103-227, also known as the Pro Children Act of 1994 ("**Pro Children Act**"), requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health, day care, early childhood development services, education, or library services to children under the age of 18, if the services are funded by federal programs either directly or through state or local governments, by federal grant, contract, loan, or loan guarantee. The law also applies to children's services that are provided in indoor facilities that are constructed, operated, or maintained with such federal funds. The law does not apply to children's services provided in private residences; portions of facilities used for inpatient drug or alcohol treatment; service providers whose sole source of applicable federal funds is Medicare or Medicaid; or facilities where WIC coupons are redeemed. Failure to comply with the provisions of the law may result in the imposition of a civil monetary penalty of up to $1,000 for each violation and/or the imposition of an administrative compliance order on the responsible party. By signing this Contract, Physician Group certifies that it will comply with the requirements of the Pro Children Act and will not allow smoking within any portion of any indoor facility used for the provision of services for children as defined by the Pro Children Act. Physician further agrees that it will insert this certification into any subcontracts entered into that provide for children's services as described in the Pro Children Act.

12. **Air or Water Pollution Requirements**. Any federally funded agreement and/or subcontract in excess of $100,000 must comply with the following provisions unless said agreement is exempt under 40 CFR 15.5. Physician Group 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.

13. **Lobbying Restrictions and Disclosure Certification**. Any federally funded contracts in excess of $100,000 per Section 1352 of the 31, U.S.C. must comply with the following lobby restrictions and disclosures.

13.1 Each person (or recipient) who requests or receives a contract, subcontract, grant, or sub-grant, which is subject to 31 U.S.C. Section 1352 and which exceeds $100,000 at any tier, shall file a certification (in the form set forth in **Attachment E-1**, consisting of one page, entitled "Certification Regarding Lobbying") that the recipient has not made, and will not make, any payment prohibited by Subsection 13.6 of this attachment.

13.2 Each recipient shall file a disclosure (in the form set forth in **Attachment E-2**, entitled "Standard Form-LLL 'Disclosure of Lobbying Activities'") if such recipient has made or has agreed to make any payment using non-appropriated 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 Section 13.6 of this attachment if paid for with appropriated funds.

13.3 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 Section

13.2 of this attachment. An event that materially affects the accuracy of the information reported includes: (i) 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; (ii) a change in the person(s) or individuals(s) influencing or attempting to influence a covered federal action; or (iii) 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.

13.4 Each person (or recipient) who requests or receives, from a person referred to in Section 13.1 of this attachment, a contract, subcontract, grant or sub-grant 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.

13.5 All disclosure forms (but not certifications) shall be forwarded from tier to tier until received by the person referred to in Section 13.1 of this attachment.

13.6 31 U.S.C. Section 1352 provides in part that no appropriated funds may be expended by the recipient of a federal contract, grant, loan, or cooperative agreement to pay any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with any of the following covered federal actions: the awarding of any federal contract, the making of any federal grant, the making of any federal loan, entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any federal contract, grant, loan, or cooperative agreement.

14. **Debarment Certification**. Physician Group agrees to comply with applicable Federal suspension and debarment regulations including 7 CFR § 3017, 45 CFR §76, 40 CFR § 32, or 34 CFR § 85.

14.1 Physician Group certifies to the best of its knowledge and belief, that it and its principals:

(i) Are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded by any Federal department or agency;

(ii) Have not within a three (3)-year period preceding this Contract have been convicted of or had a civil judgment rendered against them for commission of fraud or a criminal offense in connection with obtaining, attempting to obtain, or performing a public (Federal, State or local) transaction or contract under a public transaction; violation of Federal or State antitrust statutes or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, or receiving stolen property;

(iii) Are not presently indicted for or otherwise criminally or civilly charged by a governmental entity (federal, State or local) with commission of any of the offenses enumerated in sub-provision (ii) herein;

(iv) Have not within a three (3)-year period preceding this Contract had one or more public transactions (Federal, State or local) terminated for cause or default;

(v) Shall not knowingly enter into any lower tier covered transaction with a person who is proposed for debarment under Federal regulations (i.e., 48 CFR 9, subpart 9.4), debarred, suspended, declared ineligible, or voluntarily excluded from participation in such transaction, unless authorized by the State; and

(vi) Will include a clause entitled, "Debarment and Suspension Certification'' that essentially sets forth the provisions herein, in all lower tier covered transactions and in all solicitations for lower tier covered transactions.

14.2 If Physician Group is unable to certify to any of the statements in this certification, the Physician shall submit an explanation to CalOptima.

14.3 The terms and definitions in this Section 14 have the meanings set out in the Definitions and Coverage sections of the rules implementing Federal Executive Order 12549.

14.4 If Physician Group knowingly violates this certification, in addition to other remedies available to the federal government, CalOptima may terminate this Contract for cause or default.

15. **Downstream Entity Contracts**. If any services under this Contract are to be provided by a Downstream Entity subcontracted by Physician Group, Physician Group shall ensure that such subcontracts comply with 42 CFR Sections 422.504, 423.505 and 438.6(l). Such subcontracts shall include all language required by CMS as provided in Attachment F**.**

16. **Other Statutory and Compliance Terms**. Physician Group shall not contract with, or otherwise pay for any items or services (other than an emergency item or service, not including items or services furnished in an emergency room of a hospital):

16.1 Furnished by Physician Group by any individual or entity during any period when the individual or entity is excluded from participation under Titles V, XVIII, or XX, or under Title XIX pursuant to sections 1128, 1128A, 1156 or 1842(j)(2);

16.2 Furnished at the medical direction or the prescription of a physician, during the period when such physician is excluded from participation under Titles V, XVIII, or XX, or under Title XIX pursuant to sections 1128, 1128A, 1156, or 1842(j)(2) and when the person furnishing such item or service knew, or had some reason to know, of the exclusion (after a reasonable time period and after reasonable notice has been furnished to the person);

16.3 Furnished by an individual or entity to whom the State has suspended payments to during any period when there is a pending investigation of a credible allegation of fraud against the individual or entity, unless the State determines there is good cause not to suspend such payments;

16.4 Physician Group may not pay for an item or service with respect to any amount expended for which funds may not be used under the Assisted Suicide Funding Restriction Act of 1997

ATTACHMENT E-1
CERTIFICATION REGARDING LOBBYING

STATE OF CALIFORNIA
DEPARTMENT OF HEALTH CARE SERVICES
CERTIFICATIN 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 Physician Group Group	Printed Name of Person Signing for Physician
Contract / Grant Number	Signature of Person Signing for Physician Group
Date	Title

After execution by or on behalf of Physician Group, please return to:

CalOptima
Attn: Regulatory Affairs
505 City Parkway West
Orange, California 92868

ATTACHMENT E-2

CERTIFICATION REGARDING LOBBYING

Approved by OMB

Complete this form to disclose lobbying activities pursuant to 31 U.S.C. 1352
0348-0046 (See reverse for public burden disclosure)

<table>
<tr><td>1. Type of Federal Action:
contract
grant
cooperative agreement loan
loan guarantee
loan insurance</td><td>2. Status of Federal Action:
bid/offer/application initial
award post-award</td><td>3. Report Type:
initial filing
material change

For Material Change Only:
Year _____ quarter_____
date of last report</td></tr>
<tr><td colspan="2">4. Name and Address of Reporting Entity:
Prime Subawardee Tier, if known:</td><td rowspan="2">5. If Reporting Entity in No. 4 is Subawardee, Enter Name and Address of Prime:

Congressional District, If known:</td></tr>
<tr><td colspan="2">Congressional District, If known:</td></tr>
<tr><td colspan="2">6. Federal Department/Agency:</td><td>Federal Program Name/Description:
CDFA Number, if applicable:</td></tr>
<tr><td colspan="2">8. Federal Action Number, if known:</td><td>9. Award Amount, if known:</td></tr>
<tr><td colspan="2">10. a. Name and Address of Lobbying Entity
(If individual, last name, first name, MI):
(attach Continuation Sheets(s)</td><td>b. Name and Address of Lobbying Entity
(If individual, last name, first name, MI):
SF-LLL-A, If necessary)</td></tr>
<tr><td colspan="2">Amount of Payment (check all that apply):
$ actual planned</td><td rowspan="3">13. Type of Payment (check all that apply):
a. retainer
b. one-time fee
c. commission
d. contingent fee
e. deferred
f. other, specify:</td></tr>
<tr><td colspan="2">Form of Payment (check all that apply):
a. cash
b. in-kind, specify: Nature</td></tr>
<tr><td colspan="2">Value</td></tr>
</table>

14. Brief Description of Services Performed or to be Performed and Dates(s) of Service, including Officer(s), Employee(s), or Member(s) Contracted for Payment indicated in item 11: (Attach Continuation Sheet(s) SF-LLL-A, If necessary)	
15. Continuation Sheet(s) SF-LLL-A Attached: Yes No	
16. Information requested through this form is authorized by Title 31, U.S.C., Section 1352. This disclosure of lobbying activities is a material representation of fact upon which reliance was placed by the tier above when this transaction was made or entered into. This disclosure is required pursuant to Title 31, U.S.C., Section 1352. This information will be reported to the Congress semiannually and will be available for public inspection. Any person who fails to file the required disclosure shall be subject to a civil penalty of not less than $19,000 and not more than $100,000 for each such failure.	Signature: Print Name: Title: Telephone No.: Date:
Federal Use Only	

INSTRUCTIONS FOR COMPLETION OF SF-LLL, DISCLOSURE OF LOBBYING ACTIVITIES

This disclosure form shall be completed by the reporting entity, whether subawardee or prime federal recipients at the initiation or receipt of a covered federal action, or a material change to a previous filing, pursuant to Title 31, U.S.C., Section 1352. The filing of a form is required for each payment or agreement to make payment to any lobbying entity for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with a covered federal action. Use the SF-LLL-A Continuation Sheet for additional information if the space on the form is inadequate. Complete all items that apply for both the initial filing and material change report. Refer to the implementing guidance published by the Office of Management and Budget for additional information.

Identify the type of covered federal action for which lobbying activity is and/or has been secured to influence the outcome of a covered federal action.

Identify the status of the covered federal action.

Identify the appropriate classification of this report. If this is a follow-up report caused by a material change to the information previously reported, enter the year and quarter in which the change occurred. Enter the date of the last previously submitted report by this reporting entity for this covered federal action.

Enter the full name, address, city, state, and ZIP code of the reporting entity. Include Congressional District, if known. Check the appropriate classification of the reporting entity that designates if it is, or expects to be, a prime or subaward recipient. Identify the tier of the subawardee, e.g., the first subawardee of the prime is the 1st tier. Subawards include but are not limited to subcontracts, subgrants, and contract awards under grants.

If the organization filing the report in Item 4 checks "Subawardee," then enter the full name, address, city, state, and ZIP code of the prime federal recipient. Include Congressional District, if known.

Enter the name of the federal agency making the award or loan commitment. Include at least one organizational level below agency name, if known. For example, Department of Transportation United States Coast Guard.

Enter the federal program name or description for the covered federal action (Item 1). If known, enter the full Catalog of Federal Domestic Assistance (CDFA) number for grants, cooperative agreements, loans, and loan commitments.

Enter the most appropriate federal identifying number available for the federal action identified in Item 1 (e.g., Request for Proposal (RFP) number; Invitation for Bid (IFB) number; grant announcement number; the contract grant, or loan award number; the application/proposal control number assigned by the federal agency). Include prefixes, e.g., "RFP-DE-90401."

For a covered federal action where there has been an award or loan commitment by the federal agency, enter the federal amount of the award/loan commitment for the prime entity identified in Item 4 or 5.

10. (a) Enter the full name, address, city, state, and ZIP code of the lobbying entity engaged by the reporting entity identified in Item 4 to influence the covered federal action.

10. (b) Enter the full names of the Individual(s) performing services and include full address if different from 10.(a). Enter last name, first name, and middle initial (MI).

Enter the amount of compensation paid or reasonably expected to be paid by the reporting entity (Item 4) to the lobbying entity (Item 10). Indicate whether the payment has been made (actual) or will be made (planned). Check all boxes that apply. If this is a material change report, enter the cumulative amount of payment made or planned to be made.

Check the appropriate box(es). Check all boxes that apply. If payment is made through an in-kind contribution, specify the nature and value of the in-kind payment.

Check the appropriate box(es). Check all boxes that apply. If other, specify nature.

Provide a specific and detailed description of the services that the lobbyist has performed, or will be expected to perform, and the date(s) of any services rendered. Include all preparatory and related activity, not just time spent in actual contact with federal officials, identify the federal official(s) or employee(s) contacted or the officer(s), employee(s), or Member(s) of Congress that were contacted.

Check whether or not a SF-LLL-A Continuation Sheet(s) is attached.

The certifying official shall sign and date the form, print his/her name, title, and telephone number.

Public reporting burden for this collection of information is estimated to average 30 minutes per response, including time for reviewing instruction, searching existing data sources, gathering and maintaining the data needed, and completing and renewing the collection of information. Send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to the Office of Management and Budget, Paperwork Reduction Project, (0348-0046), Washington, DC 20503.

ATTACHMENT F
SUBCONTRACT REGULATORY TERMS

A. **General Terms**: Language addressing the following matters shall be included in Downstream subcontracts:

1. The right of CalOptima's Regulators to monitor, audit, evaluate, inspect and have access to books, records and other information as provided in this Contract.
2. CalOptima's Regulators' right to inspect, evaluate, and audit any pertinent information related to the Contract for a period of ten (10) years from the final date of the contract period or from the date of completion of any audit as provided in this Contract.
3. Prohibitions against holding Enrollees liable for payment of any fees that are the obligation of CalOptima or the Physician Group, as applicable.
4. The services are in accordance with CalOptima's obligations to CMS and applicable CalOptima Policies.
5. The obligations of Downstream Entities to protect Enrollee privacy and confidentiality including health records, as provided in this Contract.
6. The obligation to comply with all federal and state laws, regulations and CMS instructions, including those laws that must be incorporated into such Downstream subcontracts as indicated in this Contract.
7. Language related to the obligations to submit timely and accurate Encounter Data and other data and reports required by CalOptima and CalOptima's Regulators as provided in this Contract and in CalOptima's Policies.
8. All requirements included in Attachment E not expressly addressed herein.

B. **Delegation Terms**. If, and to the extent that sub-delegation is permitted by CalOptima and Physician Group obtains CalOptima's approval as provided in this Contract, Downstream Entity subcontracts must include:

1. Language that specifies (i) the delegated activities and reporting requirements; (ii) that provides for revocation of the delegated activities and other remedies in the event CalOptima or CalOptima's Regulators find that the delegated party as not performed satisfactorily; (iii) that the performance of the parties is monitored by CalOptima on an ongoing basis; and (iv) that CalOptima may impose corrective action as necessary.
2. If the subcontract relates to credentialing of medical providers, language that the credentials of medical professionals affiliated with the party or parties will either be reviewed by CalOptima or the credential process will be reviewed and approved by CalOptima and that CalOptima must audit the process on an ongoing basis.
3. If the subcontract delegates selection of providers it must include language that CalOptima retains the right to approve, suspend or terminate any such arrangement and that CalOptima shall provide a written statement to a provider of the reason or reasons for the termination with cause.

C. **Medical Provider Downstream Subcontract Terms**.

All subcontracts or arrangements with medical providers shall include provisions addressing:

1. The term of the contract, including the beginning and ending dates as well as methods of extension, renegotiation and termination and full disclosure of the method and amount of compensation or other consideration.

2. The obligation to pay contracted medical providers under the terms of the contract and prompt payment provision, the terms of which are developed and agreed to by the parties.

3. The obligations to provide services in a culturally competent manner to all Enrollees, including those with limited English proficiency or reading skills, and diverse culturally and ethnic background and provide interpreter services for Enrollees at all provider sites.

4. The obligation to (i) abide by all federal and state laws and regulations regarding confidentiality and disclosure of medical records, or other health and enrollment information; (ii) to ensure that medical information is released in accordance with applicable federal or state law, or pursuant to court orders or subpoenas; (iii) to maintain Enrollee records and information in an accurate and timely manner; and (iv) to ensure timely access by Enrollees to the records and information that pertain to them.

5. The obligation to hold CalOptima, CalOptima's Regulators and Enrollees harmless in the event that Physician Group cannot or will not pay for services performed by the Downstream Entity and for Medicare Part A and B cost sharing. Specifically, Medicare Parts A and B services must be provided at zero cost-sharing to Enrollees.

6. Medical providers' EMTALA obligations and that they must not create any conflicts with hospital actions required to comply with EMTALA.

7. Language prohibiting providers, including PCPs, from closing or otherwise limiting their acceptance of Enrollees as patients unless the same limitations apply to all commercially insured Enrollees.

8. Language that prohibits the Downstream Entity from refusing to contract or pay an otherwise eligible health care Provider for the provision of Covered Services solely because such Provider has in good faith: (a) Communicated with or advocated on behalf of one or more of his or her prospective, current or former patients regarding the provisions, terms or requirements of the 'Downstream Entity's health benefit plans as they relate to the needs of such Provider's patients; or (b) communicated with one or more of his or her prospective, current or former patients with respect to the method by which such Provider is compensated by the Downstream Entity for services provided to the patient.

9. Language that states the Provider is not required to indemnify the Physician Group for any expenses and liabilities, including judgments, settlements, attorneys' fees, court costs and any associated charges, incurred in connection with any claim or action brought against the Physician Group based on its management decisions, utilization review provisions or other policies, guidelines or actions.

10. The obligation of the medical provider to assist CalOptima in the transfer of care, including in the transfer of care in the event of sub-subcontract termination for any reason.

11. Acknowledgement that assignment or delegation of the subcontract will be void unless prior written approval is obtained from CMS and CalOptima.

12. 'The Provider's right to submit a grievance and a description of the formal process to resolve the Provider's grievances.

13. The obligation to participate and cooperate in Physician Group's Quality Improvement System.

14. Language addressing requirements related to payment of Non-Participating Provider

emergency and post-stabilization services.

ATTACHMENT G
CMS SPECIFIC PROGRAM PERFORMANCE REQUIREMENTS

1. HCC Coding Requirements and Performance Improvement Activities

1.1 CMS pays CalOptima health-based capitation to compensate CalOptima for services rendered to Enrollees. CMS utilizes encounter data to assign Hierarchical Condition Categories ("**HCC**") to Enrollees. The Enrollee's HCC determines the payment amount received by CalOptima accounting for the variation in expenditures for Medicare Enrollees based on an Enrollee's health status.

1.2 Physician Group shall submit Enrollee-specific accurate encounter and service data. Encounters are to be submitted no less than monthly using the ANSI 837P and/or 837I format version 5010 as appropriate, or current format as required by CalOptima.

1.3 Physician Group shall support and aid CalOptima's review of encounters, including to production and/or access of supporting medical records.

1.4 To enhance encounter submission accuracy and completeness, CalOptima has initiated performance improvement activities ("**PIAs**"). These PIAs include Enrollee medical and behavioral health assessments provided in the home or a residential facility.

1.5 Physician Group has the option to perform these PIAs provided Physician Group can demonstrate that Physician Group's PIAs meet all CalOptima standards and guidelines. Should Physician Group not perform the PIAs or Physician Group's PIAs not meet CalOptima standards and guidelines as determined by CalOptima, CalOptima shall perform these activities on behalf of Physician Group and the cost for these PIAs shall be charged to or shared with Physician Group. CalOptima will provide sixty (60) days' notification prior to taking any such action.

2. ESRD Waiver Responsibilities

2.1 Physician Group shall demonstrate to CalOptima that Physician Group administers a CalOptima-approved complex case management program for all End Stage Renal Disease (ESRD) Enrollees, which is in accordance with CMS requirements and CalOptima Policies and standards.

2.2 CalOptima shall advise Physician Group if its ESRD complex case management program does not meet CMS requirements and CalOptima Policies and clinical standards. If Physician Group cannot meet requirements as provided by CalOptima, CalOptima shall have the option to de-delegate the Physician Group for the management of ESRD Enrollees and retain a portion of the Capitation Payment for ESRD Enrollees commensurate with the costs for providing or outsourcing such services.

2.3 CalOptima shall provide notification to Physician Group of the intent to de-delegate. Physician Group shall have the opportunity to submit a corrective action plan to CalOptima in accordance with CalOptima policy.

3. Appeals Rights

Physician Group may appeal CalOptima's decision to take the actions outlined above, by filing a complaint pursuant to CalOptima Policies. If Physician Group is dissatisfied with the result of any appeal; it shall proceed in accordance with CalOptima's legal claims and judicial review policy.

MEDICARE ADVANTAGE – HOSPITAL SERVICES CONTRACT

BETWEEN

ORANGE COUNTY HEALTH AUTHORITY DBA CALOPTIMA

AND

_____

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MEDICARE ADVANTAGE HOSPITAL SERVICES CONTRACT

This Medicare Advantage Hospital Services Contract ("**Contract**") is January 1, 2023 ("**Effective Date**") by and between Orange County Health Authority, a public agency dba CalOptima ("**CalOptima**"), and _____ ("**Hospital**"), a California corporation organized under the laws of the State of California. CalOptima and Hospital may each be referred to herein as a "**Party**" and collectively as the "**Parties**".

RECITALS

A. CalOptima is a County Organized Health System ("**COHS**") organized under Welfare & Institutions Section 14087.54 and Orange County Ordinance No. 3896.

B. CalOptima is licensed as a health care service plan by the California Department of Managed Health Care ("**DMHC**") under the Knox-Keene Health Care Service Plan Act of 1975 and its implementing regulations (collectively the "**Knox-Keene Act**") and authorized to offer a Medicare Advantage ("**MA**") plan pursuant to Title 42 of the United States Code, Chapter 7, Subchapter XVIII, Part C and its implementing regulations for individuals covered under the federal Medicare program.

C. CalOptima, as a dual–eligible special needs plan ("**DSNP**"), may only enroll those dual eligible individuals who meet all applicable Medicare Advantage eligibility requirements, and who are eligible to be enrolled in CalOptima's Medi-Cal Managed Care plan, as described in the contract between CalOptima and the California Department of Health Care Services ("**DHCS**").

D. Hospital is a licensed and experienced in providing hospital services to Medicare beneficiaries.

E. Hospital and the physician groups set forth in Addendum 1 ("**Physician Group**") have affiliated to operate as a physician-hospital consortium ("**PHC**"), which is an arrangement under which Hospital and Physician Group each participate in a risk pool for Covered Services provided to Enrollees as detailed in Section 2.7, for the purpose of providing or arranging for the provision of Covered Services to Enrollees under this Contract and Physician Group's contract with CalOptima ("**Physician Group Contract**"). Hospital and Physician Group may collectively be referred to herein as "**PHC Participants**".

F. Hospital recognizes that in order to comply with the requirements of this Contract, Hospital and Physician Group must operate in a manner that is mutually beneficial to both entities affiliated to operate as a PHC. Accordingly, Hospital agrees under this Contract and Physician Group has agreed under the Physician Contract to collectively and individually coordinate and cooperate with each other and with CalOptima in arranging for and providing Covered Services to Enrollees.

G. CalOptima and Hospital desire to enter into the Contract whereby Hospital will perform delegated administrative services and furnish health care items and services as described herein to certain Enrollees enrolled in CalOptima's MA plan.

F. Unless defined elsewhere in the Contract, the defined terms used in this Contract shall have the meanings set forth in Attachment A.

NOW, THEREFORE, in consideration of the promises and the mutual covenants herein stated, it is agreed by and between the Parties as follows:

I. HOSPITAL SERVICE OBLIGATIONS

1.1 **Covered Services**. Hospital shall provide Covered Services to Enrollees selecting, and assigned to, Hospital in accordance with all provisions of this Contract and CalOptima Policies. The Covered Services that are to be provided by and are the financial responsibility of Hospital are described in Attachment B. Hospital specifically agrees to accept financial risk and responsibility for injectables pursuant to Health & Safety Code Section 1375.8.

1.1.1 Hospital shall provide Covered Services: (i) in the same manner, in accordance with the same standards, and within the same time availability as offered to non-CalOptima patients; (ii) in accordance with professionally recognized standards of practice, (iii) in a culturally competent manner to all Enrollees, including those with limited English proficiency or reading skills and from diverse cultural and ethnic backgrounds; and (iv) not discriminate in the provision of such Covered Services because of an Enrollee's race, ethnicity, color, national origin, religion, sex, sexual orientation, age, medical or claims history, mental or physical disability, genetic information, or source of payment.

1.1.2 Hospital is prohibited from closing or otherwise limiting its acceptance of Enrollees as patients unless the same limitations apply to all of its commercially insured patients.

1.1.3 Hospital shall use its best efforts, where consistent with sound medical practice, to ensure that Covered Services are provided only by Participating Providers, except in cases of Emergency Services or Urgent Care Services, or if no such Participating Provider is available to perform the appropriate Covered Services.

1.1.4 Hospital shall be liable for the provision and payment of all Covered Services notwithstanding a delay in payment of the Capitation Payment.

1.1.5 Hospital acknowledges that the determination of whether a service or supply was/is a Covered Service delegated to Hospital rests with CalOptima, subject to the Evidence of Coverage and Appeals procedures established by the DMHC and CMS.

1.1.6 CalOptima may incorporate any change in Covered Services mandated by Laws into the Contract effective the date the change goes into effect. Whenever possible, CalOptima shall give the Hospital thirty (30) calendar days' prior notice of any such change to the Contract. CalOptima shall determine the effective date of the change in Covered Services. Attachment B shall not be amended during the current Term without mutual consent of the Parties, except as may be required for continued compliance with Laws.

1.1.7 Decisions concerning whether to provide or authorize Covered Services under this Contract shall be based solely on Medical Necessity. Hospital shall not deny Authorization for a Covered Service that the Enrollee or the Provider demonstrates is Medically Necessary. The actual provision of any Covered Service is subject to the professional judgment of the PCP or other physicians and/or Providers participating with Hospital as to the Medical Necessity of the Covered Service, except that each Physician shall provide assessment and evaluation services ordered by a court or legal mandate. Hospital acknowledges that disputes between the Hospital and Enrollees about Medical Necessity can be appealed pursuant to CalOptima Policies and Laws.

1.1.8 Hospital may not arbitrarily deny or reduce the amount, duration, or scope of a required Covered Service solely because of the diagnosis, type of illness, or condition. Hospital may place appropriate limits on a service on the basis of criteria such as Medical Necessity or for utilization control, provided the services furnished can reasonably be expected to achieve their purpose and such a limitation complies with Laws.

1.2 **Confidentiality**. Hospital and CalOptima agree to safeguard the confidentiality of Enrollee information and comply with all Laws (including, but limited to, the Health Insurance Portability and Accountability Act ("HIPAA"), 42 CFR Section 431.300 *et seq*., California Welfare and Institutions Code Section 14100.2, California Civil Code Section 56 *et seq.*, and the California Information Practices Act, Civil Code Section 1798) regarding the confidentiality and disclosure of Enrollee names, health, enrollment and personal information (including medical and Behavioral Health information contained in Medical Records). Hospital shall provide counseling to Enrollees on their right to confidentiality and obtain Enrollee consent prior to releasing confidential information unless such consent is not required pursuant to Title 22 CCR Section 51009.

1.3 **Emergency Services and Urgent Care**. Hospital shall insure that it provides and pays for all Emergency Services and Urgent Care, including those services provided by Non-Participating Providers, without prior Authorization, twenty-four (24) hours each day, seven (7) days a week, in accordance with Laws and CalOptima Policies. Hospital shall coordinate access to Emergency Services in accordance with CalOptima's emergency department protocol. Hospital shall ensure adequate follow-up care for those Enrollees who have been screened in the emergency room and require non-Emergency Services. Hospital may not specify what constitutes an Emergency Medical Condition on the basis of lists of diagnoses or symptoms.

1.4 **Clinical Laboratory Improvement Amendments**. Hospital shall only use laboratories with a Clinical Laboratory Improvement Amendments ("**CLIA**") certificate of waiver or a certificate of registration along with a CLIA identification number.

1.5 **CalOptima Formulary Compliance**. Participating Providers shall comply with the CalOptima Formulary and its associated drug utilization and disease management guidelines and protocols. Requests for items not included in the CalOptima Formulary shall require prior Authorization by CalOptima. The prescribing Physician shall be responsible for obtaining Authorization through CalOptima and/or its designated pharmacy benefit management contractor ("**PBM**"), as appropriate. The prescribing Physician shall provide CalOptima and/or the PBM with all information necessary to process Authorization requests.

1.6 **Enrollee Access**. Hospital and its Downstream Entities shall comply with all Laws and CalOptima Policies governing Enrollee access to Covered Services.

1.6.1 If Hospital is unable to provide necessary Covered Services to a particular Enrollee, Hospital must adequately and timely cover these services with Non-Participating Providers for the Enrollee, for as long as Hospital is unable to provide them. Hospital shall make prior arrangements with Non-Participating Providers for the provision of such services, shall be fully responsible for arranging and paying for such services, and shall comply with all applicable CalOptima Policies with regard to the payment and Authorization of Non-Participating Providers.

1.6.2 Hospital shall ensure that PCPs as well as Specialty Physicians are located so as to assure sufficient geographic and physical access of Enrollees to such providers as required by Laws and CalOptima Policies.

1.6.3 Hospital shall ensure that each Enrollee has a PCP who is available and physically present at the service site for sufficient time to ensure access for the assigned Enrollee when medically required. This requirement does not preclude an appropriately licensed professional from being a substitute for the PCP in the event of the PCP's vacation, illness, or other unforeseen circumstances.

1.6.4 Hospital shall ensure female Enrollees have direct access to a women's health specialist within the network to provide women's routine and preventative health care services. Such access may be in addition to the Enrollee's PCP.

1.6.5 Hospital shall cover family planning services for all Enrollees whether they are provided by a Participating Provider or Non-Participating Provider.

1.6.6 Hospital shall reasonably accommodate Enrollees and ensure programs and services are as accessible (including a sufficient number of Providers and geographic access) to an Enrollee with disabilities as they are to an Enrollee without disabilities in accordance with CalOptima Policies. Hospital's facilities shall comply with the requirements of Title III of the Americans with Disabilities Act of 1990 ("**ADA**") and shall ensure access for the disabled, including, but not limited to, ramps, elevators, restrooms, designated parking spaces, and drinking water provisions. Hospital shall have policies to ensure that physical, communication and programmatic barriers do not inhibit Enrollees with disabilities from obtaining all Covered Services, including addressing reasonable accommodations required by the CMS Contract and CalOptima Policies. Hospital will comply with CalOptima Policies and work plan requirements related to ADA compliance relevant to services under this Contract.

1.7 **Provider Network Maintenance**. Hospital agrees to employ or contract with a sufficient number of hospitals to ensure Enrollees of reasonable access to the full range of Covered Services.

1.7.1 During the Term, all Participating Providers of Covered Services must: (i) be and remain qualified in accordance with current applicable legal, professional, and technical standards; (ii) be and remain appropriately licensed, certified or registered; (iii) be and remain in good standing with Medicare and not be terminated or suspended from participation in the Medicare and/or Medi-Cal programs; and (v) have a valid NPI number, as applicable. Hospital shall ensure that PCPs are located so as to assure sufficient geographic and physical access of Enrollees to such Physicians under Laws and CalOptima Policies.

1.7.2 Hospital shall ensure that Participating Providers have the requisite training and experience in dealing with the medical problems frequently encountered in elderly, disabled, and special needs individuals.

1.7.3 Hospital shall use primary source verification to confirm the board certification in each clinical specialty area for which the Physician is being credentialed if the Physician lists such board certification on credentialing applications.

1.7.4 Hospital acknowledges that the requirements of this Section 1.9 apply to each individual Provider who is affiliated with and/or part of any medical group, independent physician associations ("**IPA**"), and/or other organization or entity that contracts with Hospital to furnish Covered Services to Enrollees.

1.7.5 Hospital will maintain accurate records, including records detailing the status, membership, and qualifications of the Participating Providers in the Hospital's network.

1.7.6 In the event a Provider who seeks to become a Participating Provider is denied a contract with Hospital or a Participating Provider is suspended or terminated for cause, Hospital shall provide the Provider with written notice of the reason for the action, as required by Laws, including any standards and profiling data Hospital used to evaluate the provider, the number and mix of similar health care Providers that Hospital needs (if applicable), and notice of the Provider's right to appeal the action, including notice of the process and timing to request a hearing. In the event Hospital terminates a contract with a Participating Provider for deficiencies in the quality of care provided, Hospital shall give notice of the action to CalOptima, as provided by CalOptima Policies, and to the appropriate licensing and disciplinary bodies, as provided by law.

1.7.7 In the event that a Provider, including a PCP, is terminated or leaves the Hospital for any reason, Hospital shall give written notification of termination of such Provider to CalOptima within fifteen (15) days after receipt or issuance of the termination notice.

1.7.8 In the event that a Provider, including a PCP, is terminated or leaves the Hospital for any reason, Hospital shall ensure that there is no disruption in services provided to Enrollees who are receiving treatment for a chronic or ongoing medical condition in accordance with applicable Laws.

1.7.9 Hospital shall notify CalOptima at least sixty (60) days before any significant change in Hospital's provider network that renders Hospital unable to provide one or more Covered Services within CalOptima's access to care standards. If such notice is not possible because the providers terminate their participation with less than sixty (60) days' notice or Hospital terminates the providers without prior notice as a result of their endangering the health and safety of Enrollees, providers committed criminal or fraudulent acts, or providers engaged in grossly unprofessional conduct, then Hospital shall notify CalOptima immediately upon receipt of notice of the termination, or sending notice to the providers of a Hospital-initiated termination.

1.7.10 Hospital shall ensure that no Provider who fails to meet the requirements of this section furnishes items and/or services to Enrollees, submits claims and/or receives reimbursement for any Covered Services.

1.7.11 Hospital agrees that each Participating Provider with whom Hospital contracts to provide Covered Services will be required to execute a contract with Hospital. Such an agreement will require all Participating Providers to comply with those aspects of this Contract relating to activities of Participating Providers and with Laws, including the standards of accrediting and regulatory agencies governing CalOptima's MA Program, and any and all provisions required by MA regulations. The Hospital agreement with Participating Providers shall be made available to CalOptima and its regulatory agencies for inspection and copying upon request. Hospital shall ensure that all contracts with Participating Providers allow for termination of the contract for failure to meet the requirements of this Section 1.9.

1.8 **Enrollment**. Hospital shall accept as Enrollees all persons indicated as Enrollees by the CalOptima information system and transmitted to Hospital and shall comply with requirements to provide notices to Enrollees in accordance with CalOptima Policies.

1.9 **Care Coordination**. Hospital shall offer care coordination and case management services to all Enrollees, which shall: (i) include coordination of care across the full continuum of service providers as appropriate to Covered Services under this Contract; (ii) ensure that care coordination services reflect a person-centered, outcome-based approach, consistent with the Model of Care and CalOptima Policies; (iii) follow Enrollee direction about level of involvement of his or her caregivers or medical providers; (iv) include the assignment of a qualified Care Coordinator to each Enrollee needing or requesting one; and (v) reflect access to appropriate community resources with a focus on providing services in the least restrictive setting and transitions between the facilities and the community.

1.10 **Model of Care**. Hospital shall furnish Covered Services in compliance with CalOptima's Model of Care. Hospital shall ensure the provision of discharge planning when an Enrollee is admitted to a Hospital or institution and continues into the post-discharge period. Discharge planning shall include ensuring that the necessary care, services, and supports are in place in the community for the Enrollee once he or she is discharged, including scheduling an outpatient appointment and/or conducting follow-up with the Enrollee or caregiver. Hospital shall comply with CalOptima Policies addressing minimum criteria requirements for discharge planning.

1.11 **Behavioral Health Services Referrals**. Hospital shall furnish and/or coordinate Behavioral Health services as specified in CalOptima Policies and this Contract.

1.12 **LTSS Referrals**. Hospital shall refer Enrollees to CalOptima for LTSS pursuant to CalOptima Policies.

1.13 **Facility Site and Medical Record Reviews**. Hospital shall participate in, and comply with requirements for, PCP site and medical reviews, including facility site physical accessibility reviews, in accordance with CalOptima Policies and guidance issued by CalOptima's Regulators, including requirements, if any, related to collaborative programs.

1.14 **Transfers**. Hospital agrees to assist CalOptima in facilitating the transfer of care of Enrollees if determined medically acceptable by attending Physicians and the CalOptima Medical Director. Hospital will be responsible for the cost of Covered Services provided if Hospital refuses to accept such transfer.

1.15 **Delegation by CalOptima to Hospital**. Hospital agrees to accept delegated responsibility for those activities listed in the Delegation Agreement and to perform the delegated activities in a manner consistent with the Delegation Criteria. Hospital warrants that it meets CalOptima's Delegation Criteria and acknowledges that delegation to another entity does not alter Hospital's ultimate obligations and responsibilities set forth in this Contract. Hospital agrees to notify CalOptima of any change in its ability to meet the Delegation Criteria within twenty-four (24) hours from the date it fails to meet such Delegation Criteria. At CalOptima's request, Hospital shall identify the Compliance Officer or other appropriate health network representative to be the liaison expressly responsible for oversight of delegated obligations.

1.15.1 Hospital acknowledges that it is CalOptima's responsibility to oversee, monitor and evaluate Hospital's ongoing eligibility for delegation according to the Delegation Criteria and performance of the delegated activities according to the Delegation Criteria. Hospital agrees to cooperate with CalOptima's oversight, monitoring, and evaluation of Hospital's eligibility and performance of delegated activities, including the provision of reasonable access during regular business hours to the Enrollee inquiry files, credentialing files, clinical and Medical Records of Enrollees, and all other information requested by

CalOptima. Hospital shall comply with corrective actions imposed by CalOptima and/or CalOptima's Regulators in the time and manner required by them.

1.15.2 Hospital acknowledges and agrees that CalOptima retains final authority and responsibility for activities delegated under this Contract. Activities not expressly delegated herein and in the Delegation Agreement by CalOptima or for which delegation is terminated are the responsibility of CalOptima.

1.15.3 Hospital agrees to provide CalOptima with periodic reports on delegated activities performed by Hospital as provided in the Delegation Criteria or specified in CalOptima Policies.

1.15.4 In the event CalOptima, DMHC, or CMS is dissatisfied with the performance of delegated functions and activities by Hospital or its Downstream Entities, CalOptima may, in its sole discretion, modify Hospital's delegated status (in respect to all or a particular delegated activity), including from fully delegated to delegated with corrective action, or may immediately revoke all or part of the delegated activities. In the event Hospital breaches its obligation to perform any delegated obligations, CalOptima shall have all remedies set forth in this Contract, including the right to revoke delegation of such function(s) and impose financial and other penalties. Moreover, CalOptima shall have the right to require Hospital to terminate any Downstream Entity for good cause, including breach of its obligations to perform any delegated duties. Nothing herein is intended to limit CalOptima's remedies as provided for in this Contract or at law.

1.15.5 Hospital acknowledges and agrees that CalOptima, in its sole and absolute discretion, may reduce Hospital's Capitation Payments to recoup additional administrative costs where CalOptima revokes or modifies activities or functions delegated to Hospital under this Contract.

1.16 **Delegation and Subcontracting of Administrative Services by Hospital**. Except as otherwise limited by this Contract and/or CalOptima Policies, Hospital may sub-delegate Administrative Services required of Hospital to a management services organization ("**MSO**"), medical group and/or IPA. Delegation shall not absolve Hospital of oversight responsibilities or its obligations under this Contract. All requests for delegation of Administrative Services (i) must be in writing; (ii) are subject to successful completion of CalOptima's readiness assessment requirements; and (iii) must be approved by CalOptima in advance of undertaking the Administrative Services. Hospital shall obtain written approval of delegation from CalOptima pursuant to the process detailed in CalOptima Policies.

1.17 **Subcontracts**. Hospital is required to inform CalOptima of the name and business addresses of all subcontracted Downstream Entities. Hospital is required to ensure that all such subcontracts are in writing and include all provisions required by this Contract to be incorporated into subcontracts. Hospital acknowledges that CalOptima's FDR subcontracts are subject to the review and approval of CMS.

1.18 **Payment to Providers**. CalOptima hereby delegates claims processing functions to Hospital. Hospital shall review, adjudicate, and pay (as appropriate) all claims in accordance with the benefits set forth in the Evidence of Coverage, the requirements established by Laws, and the terms of this Contract. In making payments to Providers, Hospital shall comply with the provisions of Attachment D, including requirements related to payment of Non-Participating Provider Emergency Services and Urgent Care claims.

1.19 **Documentation and Data Submission Integrity**. Hospital and its Downstream Entities shall not submit false claims or financial reports, encounter data, and other information to CalOptima, CMS or DMHC, whether by commission or omission. Hospital and applicable Downstream Entities shall implement and maintain policies and procedures that address correct completion of claims, financial reports, encounter data, and other documentation requirements and penalties for falsifying such reports and other information that require all new and current employees and/or agents compiling or providing this information to sign a statement of attestation that will acknowledge understanding and compliance with said Hospital policy.

1.20 **Advance Directives**. Hospital shall maintain written policies and procedures related to Advanced Directives in compliance with Laws. Providers shall document Advance Directives in patient records in accordance with Laws. Hospital shall not discriminate against any Enrollee on the basis of that Enrollee's Advance Directive status. Nothing in this Contract shall be interpreted to require an Enrollee to execute an Advance Directive or agree to orders regarding the provision of life-sustaining treatment as a condition of receipt of services.

1.21 **Enrollee Appeals**. Enrollees will be notified of all applicable MA and/or Medicare Appeal rights, the form and content of which is approved by CMS. . Medicare Appeal rights and protections will be maintained and enhanced for Medicare services. Hospital agrees to cooperate with CalOptima in resolving Appeals related to Hospital or Hospital's Participating Providers and will comply with CalOptima Policies related to Appeals.

1.22 **Organization Determination Process**. Hospital agrees to comply with CMS regulations and instructions and CalOptima Policies pertaining to timely organization determination by Hospital with regard to the provision, denial, reduction, or suspension of a Covered Service to an Enrollee. "**Organization determination**" is defined as a decision to provide or deny service based on CMS and CalOptima criteria. Such determinations shall be made in accordance with procedures and instructions set forth in the CalOptima Policies and Laws. Hospital shall immediately notify CalOptima of any request for an expedited initial organization determination and submit to CalOptima on a monthly basis a report which tracks the requests for standard and expedited organization determinations and the timeframe within which Enrollees were informed of decisions made by Hospital.

1.23 **Expedited Review Process**. Hospital shall comply with CMS regulations and CalOptima Policies pertaining to expedited initial organization determinations of Enrollee's medical care and reconsideration (Appeals) thereof in the time sensitive situations. Time sensitive situations are those outlined by CMS which include medical conditions that require initial determinations to be made within seventy-two (72) hours upon Hospital receiving a request for an expedited review from a Provider, Enrollee, or CalOptima.

1.24 **Linguistic and Cultural Sensitivity**. Hospital shall comply with all requirements related to the provision of linguistic and culturally sensitive services in accordance to this Contract, CalOptima's Cultural and Linguistic Services Program, and CalOptima Policies. Hospital shall address the special health needs of Enrollees who are of any minority, are homeless, are disabled (both congenital and acquired disabilities), or are part of other special populations served by the CalOptima MA Program, including the capacity to communicate with Enrollees in languages other than English, when necessary, as well as those Enrollees who are deaf, hard-of-hearing, and/or visually impaired. Physician shall, in policies, administration, and services, practice the values of: (a) honoring the Enrollees' beliefs, traditions and customs; (b) recognizing individual differences within a culture; (c) creating an open, supportive, and responsive organization in which differences are valued, respected and managed; (d) through cultural diversity training, foster in staff and

Participating Providers attitudes and interpersonal communication styles that respect Enrollees' cultural backgrounds and are sensitive to their special needs; and (e) referring Enrollees to linguistically and culturally sensitive programs. Pursuant to CalOptima Policies, Hospital shall provide translation of written materials in the Threshold Languages as provided by CalOptima Policies. Written materials to be translated include, but are not limited to, signage, the Enrollee services guide, Enrollee information, Explanation of Coverage, Enrollee forms, Enrollee notices, and Enrollee welcome packages.

1.25 **Provision of Interpreters**. Oral interpreters, signers, and bilingual Provider services shall be provided in all languages spoken by all MA Enrollees. Hospital shall provide linguistic interpreter/translator services for Enrollees as necessary at all Hospital sites to ensure the availability of effective communication regarding treatment, diagnosis, medical history, and health education to Enrollees. Hospital shall provide twenty-four (24)-hour access to interpreter services for all Enrollees. Upon an Enrollee or Participating Provider request for interpreter services in a specific situation where care is needed, Hospital shall make all reasonable efforts to provide an interpreter in time to assist adequately with all necessary Covered Services, including Urgent Care Services and Emergency Services, as required by Laws. Hospital shall routinely document all such efforts and make this documentation available to CalOptima at its request. Interpreters shall be used where needed where technical, medical, or treatment information is to be discussed. Hospital shall not require an Enrollee to use friends or family as interpreters. However, a family member or friend may be used when the use of the family member or friend: (i) is requested by the Enrollee; (ii) will not compromise the effectiveness of service; (iii) will not violate Enrollee's confidentiality; and (iv) the Enrollee is advised that an interpreter is available at no cost to the Enrollee. Hospital shall maintain a contract with an interpreter service agency that is on "on call" status to provide interpreter services.

1.26 **Identification of Hospital**. Hospital agrees that CalOptima may list the Hospital's name, address, and telephone number and that of its Downstream Entities in CalOptima's roster of Participating Providers that is given to Enrollees and prospective Enrollees, and CalOptima may use such names for advertising/marketing purposes. The use of Hospital's trademarks or logos by CalOptima is prohibited without Hospital's prior written approval.

1.27 **Liaisons**. Hospital shall designate an individual(s) who will assume the day-to-day responsibilities with regard to Hospital's obligations under this Contract and to serve as liaison with CalOptima. Hospital will also designate an individual(s) to be responsible for answering Enrollee inquiries and responding promptly to any Enrollee grievance in accordance with CalOptima's grievance procedures and Laws.

1.28 **Provider Private Contract**. Hospital understands that CalOptima is prohibited by CMS from paying capitation to, or including in its provider network, any provider that has entered into a private contract with a Medicare beneficiary for the provision of Covered Services.

1.29 **Provider Grievance Process**. Hospital shall establish and maintain a Provider dispute resolution process that at all times complies with the requirements of Laws. Hospital shall provide CalOptima with all necessary information and reports regarding the provider dispute resolution process as required by CalOptima to meet its obligations under the CMS Contract and Laws. If Hospital fails to maintain a process that complies with the requirements stated in Laws and CalOptima Policies, then following written notice of such deficiency from CalOptima to Hospital, CalOptima may revoke the delegation and assume responsibility for the administration of Hospital's Provider dispute resolution process.

1.30 **Provider Education**. Hospital acknowledges that CMS requires that CalOptima furnish to Participating Providers certain training, education, and orientation related to the MA Program in order to operate in full compliance with this Contract and Laws. Such training and education may address the MA Program, Enrollee rights, cultural competency and clinical protocols, evidence-based guidelines and cultural awareness and sensitivity instruction. Hospital and its Participating Providers shall participate in such training, education, and orientation programs, as required by CalOptima, and shall attest to compliance with training requirements as required by CalOptima.

1.31 **CalOptima's Regulator Requirements**. The MA Program is subject to oversight by CalOptima's Regulators, which mandate that CalOptima and its FDRs comply with certain terms and conditions in rendering services to Enrollees and that certain terms be incorporated in FDR subcontracts. Hospital acknowledges that it will comply with CalOptima's Regulators' requirements set forth in Attachment E.

1.32 **COB Obligations of Hospital**. Hospital agrees to coordinate with CalOptima for proper determination of COB and to bill and collect from other payers and third-party liens such charges for which the other payer is responsible pursuant to CalOptima Policies. Hospital agrees to establish procedures to effectively identify, at the time of service and as part of its claims payment procedures, individuals and services for which there may be a financially responsible party other than the CalOptima MA Program.

1.33 **CMS Lien Rights.** Hospital shall coordinate benefits either operating a cost avoidance method of paying claims, when the existence of private health coverage is known at the time the claim is processed, or using the method of post-payment recovery of the cost of services, if the coverage is identified retroactively, as set forth in CalOptima Policies. Nothing herein shall be interpreted to, in any manner, impair any lien rights retained by the U.S. Department of Health and Human Services ("**HHS**") through CMS. Hospital shall make no claim for the recovery of the value of Covered Services rendered to an Enrollee when such recovery would result from an action involving tort liability of a third party, recovery from the estate of deceased Enrollee, Workers' Compensation, or casualty liability insurance awards and uninsured motorist coverage. Hospital shall identify and notify CalOptima, within five (5) calendar days of discovery of potential third-party liability ("**TPL**") claims, and provide information relative to potential TPL claims, in accordance with CalOptima Policies.

1.34 **Notification of Inpatient Facility Discharge Appeal Rights**. Hospital and its Downstream Entities shall issue the advance written notice to Enrollees of their Hospital discharge rights upon admission and before discharge from the Hospital.

II. HOSPITAL FINANCIAL OBLIGATIONS

2.1 **Financial Security Requirements**. Hospital must establish and maintain, throughout the Term, financial security reserves, in the form of time certificates of deposit, irrevocable standby letters of credit, surety bonds naming CalOptima as beneficiary, and/or other forms of financial instruments acceptable by CalOptima, as required in CalOptima Policies.

2.2 **Financial Viability Standards and Reporting**. Hospital must establish and maintain a minimum reserve of twenty-five percent (25%) of one month's Capitation Payment. Physician shall have thirty (30) days upon receiving notice from CalOptima to cure any deficit. Hospital shall maintain a cash-to-claims ratio of no less than 0.75 at all times during the Term.

2.3 **Medical Loss Ratio**. Hospital shall ensure that it, as well as the PHC, maintains a minimum acceptable loss ratio (as defined by CalOptima Policies) of eight five percent (85%). Hospital shall comply with CalOptima requirements related to limitations on administrative costs, as set forth in CalOptima Policies.

2.4 **Termination of Hospital Health Network**. If this Contract terminates or expires for any reason, CalOptima may require that Hospital take certain actions and/or CalOptima may take certain actions to ensure that all items and services for which Hospital is delegated financial risk under this Contract are reimbursed by Hospital, including the following: (i) require Hospital to reserve sufficient funds to pay any claims run out; (ii) offset Hospital's future Capitation Payments or other amounts due from CalOptima to Hospital under this Contract or any other agreement, if any, in order to pay Hospital's claims; and/or (iii) withhold or offset Hospital's Capitation Payments or other amounts due from CalOptima to Hospital, including to pay-for-performance, quality incentives, and shared risk pool surpluses, if any, in order to pay amounts owed by Hospital to Providers.

2.5 **Conversion of Health Network Model**. If CalOptima approves a change in the delegated model of Hospital at any time during the Term, CalOptima may require additional financial protections as a condition precedent to such approval, including: (i) require Hospital to reserve sufficient funds to pay any claims run out related to claims which are the financial responsibility of Hospital under the existing delegated relationship; (ii) require Hospital to meet additional financial security requirements, including the maintenance of financial deposits; and/or (iii) withhold or offset Hospital's Capitation Payments or other amounts due from CalOptima to Hospital, including pay-for-performance, quality incentives and shared risk pool surpluses, if any, in order to pay amounts owed by Hospital to Providers.

2.6 **Cooperation with DMHC**. Hospital shall fully cooperate and comply with the DMHC's review and audit process and permit DMHC to obtain and evaluate supplemental financial information related to Hospital. Hospital shall also fully cooperate and participate in DMHC's and CalOptima's Corrective Action Plan process, if necessary.

2.7 **Risk Pools**. PHC in which Hospital and Physician Group participate shall have a risk pool arrangement between Hospital and Physician Group, as detailed in this Section 2.7 and Addendum 1 to this Agreement and the Physician Group Contract. During the Term, Hospital and Physician Group shall annually negotiate and agree upon the terms and conditions of the risk pool arrangement ("**Risk Pool**") and shall submit the Risk Pool to CalOptima by November 30 for the next year. Hospital shall corporate with Physician Group so that Physician Group can submit to CalOptima an attestation signed by an authorized signatory of PHC Participants indicating that both Physician Group's and Hospital's Boards of Directors approved the Risk Pool. CalOptima shall pre-approve the Risk Pool before it may go into effect for the next year beginning January l. The Risk Pool shall include the following:

2.7.1 Covered Services for which PHC Participants will share risk.

2.7.2 If any part of the Risk Pool is based on utilization, the Risk Pool shall additionally include:

(a) The expected utilization of Covered Services for which PHC Participants will share risk. Recommended measures are bed days/per 1,000 Enrollees for inpatient services and $ [insert amount] per Enrollee per month for other Covered Services.

(b) The price or value for each Covered Service for which PHC Participants will share risk. These are the amounts that each unit of service will be valued at and charged against the portion of Hospital's capitation payment that the Hospital receives under the Contract and uses to fund to the Risk Pool. Inpatient rates should be listed as per diem rates, while other Covered Services should be priced by fee schedules or as a percentage of billed charges.

(c) A pro forma settlement calculation, which shall state the amount of surplus that is expected to result if Hospital and/or Physician Group achieve their utilization targets and the agreed-upon pricing model employed for the Risk Pool.

(d) A description of audit and/or other procedures required to ensure the accuracy of the surplus or deficit calculations related to the cost and volume of services rendered under the Risk Pool and other revenues and expenses, including interest income, reinsurance premiums, and reinsurance recoveries associated with risk sharing.

(e) Defined responsibilities should deficits occur under the Risk Pool.

(f) Timing and documentation requirements for interim or final surplus distributions from the Risk Pool by Hospital, as agreed upon between the PHC Participants.

2.7.3 Physician Group shall submit [insert requirement for when these should be submitted] to CalOptima interim and final settlement calculations and attestations from all PHC Participants stating that (i) PHC Participants have met all the requirements of this Section 2.7, (ii) PHC Participants have performed all audit and reconciliation procedures, and (iii) the distribution amount to each PHC Participant is consistent with the terms of the Risk Pool, which (as approved by CalOptima annually during the Term) is incorporated into this Contract by this reference.

III. CALOPTIMA OBLIGATIONS

3.1 **CalOptima Services**. CalOptima agrees to provide certain Enrollee and Administrative Services, including processing Enrollee applications, maintaining eligibility records and a system of verifying eligibility, processing enrollments and dis-enrollments, responding to Enrollee complaints and grievances, informing Enrollees of CalOptima Policies, providing Enrollees with membership cards and informational material, and informing Enrollees of Health Networks.

3.2 **Enrollment**. CalOptima agrees to process all enrollment applications and ensure that each Enrollee selects or is assigned to Health Networks in accordance with CalOptima Policies. CalOptima reserves the right to assign Enrollees to a Health Networks other than that selected by Enrollee.

3.3 **Authorization Process**. CalOptima shall provide a written Authorization process for Covered Services pursuant to CalOptima Policies.

3.4 **Enrollee Grievance Process**. CalOptima will inform Enrollees that they may file a grievance through CalOptima or the CMS Ombudsman Program for complaints related to Medicare-covered benefits and services. Enrollees may also file a grievance through 1-800 Medicare.

3.5 **Enrollee Appeals**. Enrollees will be notified of all applicable MA Medicare Appeal rights through a single notice prior approved by CMS.

3.6 **CalOptima Formulary**. CalOptima shall publish and maintain the CalOptima Formulary pursuant to CalOptima Policies.

3.7 **Training and Education**. CalOptima agrees to provide Participating Provider education, training, and orientation in accordance with CMS requirements, including training regarding the CalOptima MA Program, Enrollee rights, clinical protocols, evidence-based practice guidelines, and CalOptima's cultural awareness and sensitivity instruction and cultural competency training, as applicable.

3.8 **Marketing**. Hospital acknowledges that CalOptima will be responsible for marketing the CalOptima MA Program to Medicare beneficiaries. Hospital acknowledges that it shall not conduct any marketing activities except as expressly approved in advance and in writing by CalOptima.

3.9 **Administration of Funds**. CalOptima will administer the funds and payments called for in this Contract to Hospital in accordance with provisions outlined in Article VI.

3.10 **No Refusal to Pay or Contract Based on Hospital Communications with Enrollees**. CalOptima will not refuse to contract or pay an otherwise eligible health care Provider for the provision of Covered Services solely because such Provider has, in good faith, communicated with or advocated on behalf of one or more of his or her prospective, current, or former patients regarding: (i) the provisions, terms or requirements of CalOptima's health care plans as they relate to the needs of such Provider's Enrollees; or (ii) the method by which such Provider is compensated by CalOptima for Covered Services rendered to the Enrollee.

3.11 **CalOptima Policies**. CalOptima will provide Hospital with CalOptima Policies as necessary for Group to provide Covered Services to Enrollees. Those CalOptima Policies shall describe all benefit plans, including copayments, limitations, and exclusions offered by CalOptima to Enrollees. The Provider Manual will be made available to Hospital to disseminate to Physicians.

3.12 **Listing of CalOptima**. CalOptima agrees that Hospital may list its name, address, telephone number, and a description of the CalOptima MA Program, along with CalOptima's name, in Hospital's promotional materials and advertisements. The use of CalOptima's trademarks and logos by Hospital is prohibited without CalOptima's prior written approval.

3.13 **CalOptima Oversight**. CalOptima shall monitor Hospital's performance under this Contract on an ongoing basis. CalOptima may conduct regularly scheduled audits as well as an annual evaluation of the delegated functions to determine Hospital's continued compliance with the Delegation Criteria. CalOptima may impose corrective action plans on Hospital and/or its Downstream Entities, as necessary.

3.14 **CalOptima Accountability**. The delegation of the functions and responsibilities stated in this Contract and the Delegation Agreement does not relieve CalOptima of any of its accountability to CMS and obligations to its Enrollees under Laws. CalOptima is authorized to perform and remains liable for the performance of such obligations, notwithstanding any delegation of some or all of those obligations to Hospital.

3.15 **COB Obligations of CalOptima**. CalOptima will cooperate in providing COB information to Hospital by collecting appropriate data from the Enrollee at the point of enrollment and supplying such data to Hospital.

3.16 **Enrollee Rights**. CalOptima shall ensure that Enrollee rights are fully respected and observed in accordance with Laws and CalOptima Policies. CalOptima shall notify Enrollees of their rights and protections at least annually and in a manner that accounts for cultural considerations, functional status, and language needs.

3.17 **Enrollee Grievances**. CalOptima retains responsibility for the Enrollee grievance process. Hospital will comply with CalOptima Policies related to Enrollee grievances, including timely reporting to CalOptima and resolution of Enrollee grievances. Enrollees may file an internal Enrollee grievance at any time with CalOptima or Hospital, including grievances related to reasonable accommodations and access to services under the ADA.

IV. QUALITY IMPROVEMENT PROGRAM AND CREDENTIALING

4.1 **CalOptima's Quality Improvement Program**. Hospital shall comply with, and participate in, CalOptima's Quality Improvement Program ("**QIP**"). Hospital shall immediately notify CalOptima of those Enrollees and cases that fall within the catastrophic and targeted case management guidelines and shall cooperate with CalOptima's case management program for catastrophic and targeted cases. Hospital and its Downstream Entities shall fully cooperate with CalOptima with regard to the HEDIS measurements and HEDIS audits, guideline development, preventive services utilization, disease/risk management, clinical service monitoring, and quality improvement studies and initiatives. Hospital shall comply with and accept as final the decisions of the CalOptima QIP and, pending resolution of any dispute through the dispute resolution process, comply with the decisions of the CalOptima Quality Improvement Committee.

4.2 **Quality Improvement Functions – Delegation to Hospital**. Hospital shall adopt a detailed written Quality Improvement ("**QI**") program, which shall include: (i) well defined goals and objectives; (ii) a well-defined scope that considers all different types and levels of care and service provided to Enrollees; and (iii) clearly defined accountability and responsibility for the QI program.

4.3 **Quality Improvement and Credentialing Program**. CalOptima delegates health delivery organization credentialing requirements to Hospital as provided in the Delegation Agreement. Hospital agrees to comply with CalOptima Policies regarding credentialing standards. In order to ascertain Hospital's continuous compliance with CalOptima standards, CalOptima retains the right to oversee Hospital's credentialing processes and to mandate changes thereto.

4.3.1 At least annually, Hospital shall provide CalOptima with a written credentialing program for the purpose of review and approval by CalOptima. Hospital shall also allow CalOptima, after reasonable prior notice, to conduct an on-site audit and review a sample of physician credentialing files to determine that delegation of the credentialing process is appropriate.

4.3.2 Hospital's credentialing program shall comply with the requirements specified in 42 CFR Sections 422.504, 423.505 and 438.214, as applicable, which include requirements addressing selection and retention of providers, credentialing and re-credentialing requirements, and nondiscrimination. Hospital's credentialing program shall include procedures used for credentialing and re-credentialing Participating Provider's according to current NCQA standards, in addition to procedures used for reducing, suspending or terminating Participating Provider's participation in the organization for reasons relating to quality of care, competence, professional conduct, or service-related issues; procedures for reporting to appropriate authorities serious quality deficiencies that could result in

suspension or termination of a Participating Provider's participation; and procedures for provider appeal, as afforded by Hospital's fair hearing plan and corrective actions.

4.3.3 Hospital shall make best efforts to notify CalOptima within thirty (30) days of any changes involving the rules, regulations, authorities, and responsibilities of the credentialing program. In accordance with CMS requirements, CalOptima also retains the right, based on quality-of-care and service issues, to approve, suspend, or terminate arrangements with practitioners, providers, and sites. In the event that this occurs, CalOptima will notify the Hospital of the quality-of-care and/or service issue, and Hospital shall take appropriate action, report to appropriate authorities any serious quality deficiencies in accordance with Laws, and provide all due process as afforded by the Hospital's fair hearing plan and Laws.

4.3.4 If CalOptima exercises its right to terminate a Provider's participation in the CalOptima MA program, CalOptima shall give the Provider a written statement of the reason or reasons for termination with cause and comply with the procedures required by Laws, if any.

4.4 **Release of Performance Information and Data**. Hospital acknowledges that the CalOptima MA Program focuses on improving the coordination and quality of medical, Behavioral Health, LTSS, and other services for Enrollees, and, in that regard, CalOptima's Regulators will implement capitation withholds to ensure performance consistent with established quality thresholds. Hospital acknowledges and agrees that CalOptima may release information and data related to the performance of Hospital under this Contract to CalOptima Regulators, Providers, Enrollees, and others without further notice to Hospital. The performance data will be used for purposes, including quality improvement activities, and public reporting to consumers, as identified in CalOptima Policies.

V. UTILIZATION MANAGEMENT PROGRAM

5.1 **CalOptima's Utilization Management Program**. CalOptima has implemented, and continuously updates, a UM program to ensure appropriate processes are used to review and approve the provision of Medically Necessary Covered Services to Enrollees in the timeframes required by CalOptima's Regulators. Hospital and its Downstream Entities shall comply with and cooperate in CalOptima's UM program, as established in CalOptima Policies and the CalOptima UM plan, regardless of CalOptima's delegation to Hospital under Section 5.2.

5.2 **UM Program Responsibility—Delegation to Hospital**. CalOptima is hereby delegating to Hospital the process of monitoring and evaluating on a prospective, concurrent, and retrospective basis, the utilization and Medical Necessity of Covered Services provided to Hospital's Enrollees.

5.2.1 Hospital's UM process shall include performing case management activities, referral management and discharge planning, and managing the denial sanction process, as well as conducting peer review for Medical Necessity and appropriateness. Hospital (and its Downstream Entities) shall ensure that its UM program complies with all criteria as set forth in CalOptima Policies and required by CalOptima's Regulators.

5.2.2 In accordance with 42 CFR §§ 438.6(h) and 422.208, compensation to individuals or entities that conduct UM activities must not be structured so as to provide incentives for Hospital or Downstream Entities to deny, limit, or discontinue Medically Necessary Covered Services to any Enrollee.

5.2.3 In the event Hospital (or its Downstream Entities) fails to comply with CalOptima standards and Laws and fails to correct deficiencies within the stated time required by those provisions, CalOptima retains the right to revoke delegation of UM activities.

5.3 **Utilization Management Plan**. Hospital will provide to CalOptima initially upon execution of this Contract, and annually thereafter, a written UM plan for review and approval by CalOptima.

5.3.1 Hospital shall notify CalOptima within thirty (30) days of any changes involving the rules, regulations, authorities, and responsibilities for the UM plan, which shall be subject to reasonable approval by CalOptima. CalOptima approval will be assumed unless Hospital is notified otherwise by CalOptima. Hospital shall comply with and accept as final, the decisions of CalOptima's UM program and, pending resolution of any dispute through the dispute resolution process, comply with the decisions of CalOptima's UM program.

5.3.2 The UM plan shall include procedures approved by CalOptima to identify, assess, establish, and implement a treatment plan for Enrollees with complex or serious medical conditions. The UM plan shall also contain procedures for direct access of Enrollees to services as mandated by CMS regulations and instructions. All Hospital denial letters shall provide Enrollees with timely notice and shall contain appropriate Enrollee appeals rights as approved by CMS and CalOptima. Hospital agrees to cooperate with CalOptima in furnishing the required reports identified in CalOptima' Policies

5.4 **Utilization Management Committee**. Hospital shall establish a UM committee that shall review and document the quality, appropriateness, level of care, and utilization of health care services provided to Enrollees. CalOptima's Medical Director and/or CalOptima staff may attend Hospital UM committee meetings.

5.5 **Process and Timeframes for Authorization**. Hospital (and its Downstream Entities) shall ensure that its process for initial and continuing Authorizations complies with CalOptima Policies, the UM plan and requirements established by CalOptima's Regulators, including timeframes for, and manner of, Authorization.

5.6 **No Prior Authorization**. Hospital (and its Downstream Entities) shall not require prior Authorization for the following services: (i) any services for Emergency Medical Conditions (which include emergency Behavioral Health care); (ii) Urgent Care sought outside the Service Area: (iii) Urgent Care under unusual or extraordinary circumstances provided in the Service Area when the Participating Provider is unavailable or inaccessible; (iv) preventative services; (v) family planning services; (vi) Out-of-Area renal dialysis services; (vii) basic prenatal care; (viii) sexually transmitted disease services; and (ix) HIV testing.

5.7 Second Opinions**. Hospital (and Downstream Entities) shall ensure that Enrollees have the right to second opinions from qualified health professionals at no cost to the Enrollee.**.

VI. COMPENSATION

6.1 **Hospital Compensation**. CalOptima shall compensate Hospital for Covered Services and Administrative Services delegated to Hospital, as set forth in Attachment C. Such Capitation Payments shall be payment in full for Covered Services and Administrative Services, except for amounts recovered through collection of Enrollee's Share of Cost, COBs, and Stop Loss Program, if applicable. Capitation Payment shall be sent on a monthly basis by the twentieth (20th) calendar day of the month, or if such day falls on a weekend or national holiday, on the first business day

thereafter, for all Enrollees eligible from the first (1st) of the month, and on whose behalf payment has been received by CalOptima from CMS by the nineteenth (19th) calendar day of the month. In the event CalOptima receives payment from CMS after the nineteenth (19th) calendar day of the month, capitation payment to Hospital will be made within five (5) working days of receipt of the monthly payment by CalOptima.

6.2 **Disputes Regarding Payments or Enrollment**. Any and all disputes related to Capitation Payments and/or enrollments shall be reported to CalOptima within ninety (90) calendar days of payment, and each dispute shall be clearly defined and include supporting documentation. Failure to dispute within the established time frame indicates acceptance of the Capitation Payment by Hospital.

6.3 **Capitation Rate Adjustments**. The Capitation Rates may be adjusted by CalOptima during the Contract period to reflect implementation of State of California ("**State**") or federal laws or regulations, changes in the CMS Contract or CMS policy, and/or changes in Covered Services. If CalOptima receives advance notice of adjustment from CalOptima's Regulators, CalOptima shall provide notice thereof to Hospital as soon as practicable. Capitation Rates may also be adjusted in the event of de-delegation of any function delegated under this Contract.

6.4 **Enrollee Non-Liability and Hold Harmless Requirements.** Hospital and its Downstream Entities shall accept CalOptima's payment as described in this Contract as payment in full. Hospital and its Downstream Entities for all Covered Services and Administrative Services under this Contract and shall not hold Enrollees liable to the Hospital or Providers for any sums owed to Hospital by CalOptima or owed to Providers by Hospital.

6.4.1 Hospital and its Downstream Entities shall hold harmless CMS, CalOptima, and Enrollees in the event Hospital and/or Downstream Entities cannot or will not pay for services performed by Hospital or Downstream Entities pursuant to this Contract or subcontract, as applicable.

6.4.2 Hospital and its Downstream Entities shall ensure that Enrollees will not be held liable for Medicare Part A and B cost sharing when the State is responsible for paying such amounts and that the Hospital will (i) accept Capitation Payment as payment in full under the Contract, or (ii) bill the appropriate State source, as required at 42 CFR §422.504(g)(1)(iii). Such services must be provided at zero cost-sharing to Enrollees.

6.4.3 Hospital shall not hold an Enrollee liable for the following: (i) debts of Hospital, in the event of 'Hospital's insolvency; (ii) Covered Services provided to the Enrollee in the event that CalOptima or Hospital fails to receive payment from CMS for such services; or (iii) payments to a clinical FDR or Downstream Entity in excess of the amount that would be owed by the Enrollee if Hospital had directly provided the services.

6.4.4 Hospital and its Downstream Entities shall not charge Enrollees coinsurance, co-payments, deductibles, financial penalties, or any other amount in full or part, for any service provided under this Contract, except as otherwise permitted under this Contract.

6.4.5 Hospital and its Downstream Entities shall not deny any service provided under this Contract to an Enrollee for Enrollee's (or any entity responsible for making payment on Enrollee's behalf) failure or inability to pay any applicable charge or shall not deny any service provided under this Contract to an Enrollee who, prior to becoming eligible, incurred a bill that has not been paid.

6.5 **Overpayments Discovered by Hospital**. Hospital shall disclose and return all overpayments to CalOptima within sixty (60) days of when Hospital identified the overpayment or should have identified the overpayment through the exercise of reasonable diligence.

6.6 **Recoupment for Ineligibility; Conlan Reimbursements**. CalOptima shall recoup payments made to Hospital when CMS has determined that an individual was not eligible for the MA Program and retroactively terminates the individual, including recouping any payments made for a deceased Enrollee. CalOptima may also recoup overpayments to Hospital owed by Hospital to Enrollees, including offsetting any such amounts owed against Hospital's Capitation Payments or other amounts due from CalOptima to Hospital under this Contract or any other agreement between the parties, if any. This Section 6.6 shall not be construed to limit CalOptima's right to recoup payment made to Hospital on any other basis for which recoupment is appropriate.

6.7 **CalOptima Right to Recover**.

6.7.1 Overpayments. Hospital acknowledges and agrees that, in the event that CalOptima determines that an amount has been overpaid or paid in duplicate, or that funds were paid which were not due under this Contract to Hospital, CalOptima shall have the right to recover such amounts from Hospital by recoupment or offset from current or future amounts due from CalOptima to Hospital under this Contract or any other agreement between the parties, after giving Hospital notice and an opportunity to return/pay such amounts.

6.7.2 Shared Risk Pool Payments Upon Termination. If this Contract terminates or expires for any reason and Hospital is responsible for a deficit under any shared risk program under this Contract based on the final shared risk pool report results ("**Deficit**"), such Deficit shall be due to CalOptima as follows, as allowed by Laws: CalOptima may elect to recoup such Deficit by either (1) offsetting such Deficit amounts, upon notice to Physician Group, from any current or future amounts owed by CalOptima to Physician Group under the Contract or any other agreement between the Parties, including capitation payments, financial security withholds, pay-for-performance amounts, quality incentives, and shared risk pool surpluses; or (2) sending an invoice to Physician Group that payment for such Deficits are due to CalOptima within thirty (30) days of Physician Group's receipt of the CalOptima invoice.

6.7.3 Regulator Recoupment Upon Termination. If following the termination or expiration of this Contract, CalOptima's Regulators find that Physician Group (or its Downstream Entities) has failed to comply with the requirements governing physician incentive plans and CalOptima's Regulators offset, recoup and/or otherwise seek recovery of FFP, as described in Section 1.33, CalOptima may elect to recoup such FFP amounts, as allowed by Laws, by either: (1) offsetting such FFP amounts, upon notice to Physician Group, from any current or future amounts owed by CalOptima to Physician Group under the Contract or any other agreement between the Parties, including capitation payments, financial security withholds, pay-for-performance amounts, quality incentives, or shared risk pool surpluses; or (2) sending an invoice to Physician Group that payment for such FFP amounts are due to CalOptima within thirty (30) days of Physician Group's receipt of the CalOptima invoice.

6.7.4 Dispute Resolution. Physician Group may use CalOptima's provider dispute resolution procedure, as described under CalOptima's Policies, and/or the dispute resolution procedures under this Contract to resolve any disputes related to the calculation or payment of such Deficits or FFP amounts.

6.7.5 Survival. This Section 6.7 shall survive the termination or expiration of the Contract.

6.8 **Retroactive Cancellation**. CalOptima will discourage retroactive cancellation of any Enrollee. However, CalOptima may make exceptions as required by CMS or due to legitimate administrative processing requirements of CMS. CalOptima may make retroactive additions or cancellations of Enrollees, as necessary for administrative or business reasons, and such retroactive additions or cancellations of Enrollees shall not exceed ninety (90) days.

VII. REPORTING REQUIREMENTS

7.1 **Data Reporting Requirements**. Hospital shall comply with the data reporting requirements set forth in this Contract, including the requirements specified in Standard Reporting Requirements set forth in CalOptima Policies and guidelines (referred to as the Timely and Appropriate Submission requirements). Hospital shall provide such additional data and modify the form, content, instructions, and timetables for the collection and reporting of data, as may be required by CalOptima Policies.

7.2 **Eligibility Reports**. CalOptima will maintain, update, and distribute monthly Enrollee eligibility reports for each month in which the persons included on such list are eligible for CalOptima MA Program. This report will identify the Hospital, PCP selected by the Enrollee, and the Enrollee's coverage. The report will be sent to Hospital and PCPs by the tenth (10th) of each month, identifying eligible Enrollees from the first (1st) of the month.

7.3 **Utilization Data**. Hospital shall, upon request, provide CalOptima with information on the utilization and cost of Covered Services provided to Enrollees in such detail as to allow CalOptima to conduct analysis of costs as required by CMS, as dictated by sound business practices and for the conduct of quality management and UM activities by CalOptima. Such information to be provided by Hospital will not include information beyond that customarily provided on a claim form (such as Form CMS-1500) and shall be provided in the form of a paper report, computer disc, computer tape, or electronic file, as agreed by the parties. Required data will be delivered by Hospital to CalOptima not later than forty-five (45) days following written request by CalOptima.

7.4 **Submission of Electronic Encounter Data**. Hospital must meet any claims, diagnosis, and Encounter Data reporting requirements, as determined from time to time by CalOptima and CalOptima's Regulators.

7.4.1 Hospital agrees to furnish CalOptima with complete, timely, reasonable, and accurate Encounter Data for Covered Services rendered to Enrollees. The Encounter Data will be furnished to CalOptima through Electronic Data Interchange (EDI) or a mutually acceptable format and shall be received by CalOptima per the Policy and Encounter Requirements Manual. Hospital also agrees to furnish Medical Records that may be required to obtain any additional information or corroborate the Encounter Data. Hospital further agrees to have its Chief Executive Officer (CEO) attest and certify the completeness and truthfulness of the Encounter Data submitted.

7.4.2 Hospital shall be subject to financial penalties and/or sanctions if CalOptima determines that Physician is reporting to CalOptima less than all professional encounters in the CalOptima required format and timelines. Financial penalties or sanctions shall be assessed upon Hospital should CalOptima determine that Hospital is not meeting the

standards defined in CalOptima Policies. This Section 7.4.2 shall survive the expiration or termination of this Contract, whether with or without cause, by rescission or otherwise, as to all Covered Services provided under this Contract prior to termination. Based on CalOptima's quarterly determinations and following thirty (30) days' prior notice to Hospital, CalOptima may withhold three (3%) percent of Capitation Payment if CalOptima determines that the monthly Encounter Data that Hospital must provide has not been received by CalOptima within the prior quarter. If at the quarterly determination following such withhold, CalOptima determines that Hospital has satisfactorily delivered to CalOptima the previously non-delivered Encounter Data; such withheld Capitation Payment shall be paid to Hospital, without interest. In the event that Hospital does not deliver such Encounter Data to CalOptima prior to such quarterly determination, CalOptima shall be entitled to retain such withheld Capitation Payment and may withhold three (3%) percent from each quarter's Capitation Payment until CalOptima receives the Encounter Data.

7.5 **Financial Statements**. Hospital agrees to provide CalOptima annually with a copy of Hospital's audited financial statements, including letters to management for the most recent fiscal year end along with an opinion letter on these statements from the accounting firm that completed an audit on these financial statements. Financial statements shall be presented in a form specified by CalOptima that clearly shows the financial position of Hospital as related to Enrollees. Hospital shall allow representatives of CalOptima, upon written request, to verify the financial reports. In the event audited statements are unavailable, Hospital agrees to provide CalOptima with the unaudited financial statements at Hospital's fiscal year end. The unaudited financial statements will include: balance sheets, income statement and statement of cash flows, notes to the financial statement, name of the person preparing these statements, and representation letters from the senior financial executives of the Hospital, attesting that these financial statements were prepared in accordance with GAAP and fairly present the financial condition of the Hospital.

7.6 **Reports Regarding Disclosure of Confidential Enrollee Information**. If Hospital, or any of its officers, employees, agents, or Downstream Entities, becomes aware of the unauthorized disclosure of confidential Enrollee information or of "personal information", within the meaning of California Civil Code Section 1798.3, Hospital shall report said unauthorized disclosure to CalOptima's Privacy Officer immediately upon discovery of said disclosure, providing information on the information disclosed and how the disclosure occurred. For purposes of this section, "unauthorized disclosure" includes any unauthorized access, whether such access was through inadvertence, mistake, theft, or other means, and whether or not Hospital had reasonable control to avoid the disclosure. Nothing herein is intended to limit or replace Hospital's separate obligations under the Business Associate Agreement and Laws.

7.7 **Additional Information Required by CalOptima's Regulators**. Hospital and Downstream Entities shall, at the request of CalOptima or CalOptima's Regulators, provide the following: (i) all information related to the performance of CalOptima's responsibilities, including non-medical information for the purposes of research and evaluation, to CalOptima's Regulators; (ii) any information required to comply with all Laws; and (iii) any information required for external rapid cycle evaluation, including program expenditures, service utilization rates, rebalancing from institutional to community settings, Enrollee satisfaction, Enrollee complaints and Appeals, and enrollment/disenrollment rates.

VIII. RECORD RETENTION, ACCESS AND CONFIDENTIALITY

8.1 **Disclosure of Records**. Hospital and its Downstream Entities agree to maintain and make available contracts, books, documents, records, and electronic systems, including, Medical Records, (collectively, the "**Records**") to CalOptima, HHS, CMS, the Comptroller General, the U.S. Government Accountability Office, any Quality Improvement Organization, or accrediting organizations, including NCQA, their designees, and other representatives of regulatory or accrediting organizations, for inspection, evaluation, and auditing. For purposes of utilization management, quality improvement, and other CalOptima administrative purposes, CalOptima and CalOptima's Regulators shall have access to, and copies of, at reasonable time upon request, the Medical Records, books, charts, and papers relating to the provision of health care services to Enrollees, the cost of such services, and payments received by Hospital or any of its Downstream Entities from Enrollees (or from others on their behalf). Copies of the Medical Record shall be provided at no charge to CalOptima. Unless a longer time is required under applicable law, the records described herein shall be maintained for at least ten (10) years from the final date of the Contract or from the completion of any audit, whichever is later.

8.2 **Medical Records**. Hospital will require that all Downstream Entities establish and maintain in an accurate and timely manner, for each Enrollee who has obtained Covered Services from a Group Provider or Downstream Entity, a legible Medical Record which shall be kept in detail consistent with good medical and professional practice in accordance with Laws and CalOptima Policies. Such Medical Records shall include a historical record of diagnostic and therapeutic services recommended or provided by, or under the direction of, the Provider. Such Medical Records shall be in such a form as to allow trained health professionals, other than the Provider, to readily determine the nature and extent of the Enrollee's medical problem and the services provided and permit peer review of the care provided. Hospital shall ensure that medical information is released in accordance with applicable Laws, or pursuant to valid court orders or subpoenas, subject to compliance with applicable privacy laws. Hospital shall ensure than an individual is delegated the responsibility of securing and maintaining Medical Records at each Hospital or Downstream Entity site.

8.3 **Right to Inspection**. Medical Records referred to in Section 8.2 above will be and remain the property of Hospital or Downstream Entities and will not be removed or transferred from their offices except in accordance with Laws. CalOptima or its designated representatives will have the right, in accordance with this Article 8, to inspect, review, and make copies of such records at Hospital's expense upon request to facilitate CalOptima's obligation to conduct quality management, utilization monitoring, and peer review activities.

8.4 **Records Related to Recovery for Litigation**. Upon request by CalOptima, Hospital and its Downstream Entities shall timely gather, preserve, and provide to CalOptima, in the form and manner specified by CalOptima, any information specified by CalOptima, subject to any lawful privileges, in Hospital's or its Downstream Entities' possession, relating to threatened or pending litigation by or against CalOptima, HHS, and CMS. If Hospital asserts that any requested documents are covered by a privilege, Hospital shall: (1) identify such privileged documents with sufficient particularity to reasonably identify the document while retaining the privilege; and (2) state the privilege being claimed that supports withholding production of the document. Such request shall include a response to a request for documents submitted by any party in any litigation by or against CalOptima. Hospital acknowledges that time may be of the essence in responding to such request. Hospital shall use all reasonable efforts to immediately notify CalOptima of any subpoenas, document production requests, or requests for records received by Hospital or its Downstream Entities related to this Contract or subcontracts entered into under this Contract.

8.5 **State and Federal Site Visits**. Hospital agrees to permit CalOptima, the DMHC, HHS, and/or CMS to conduct a site evaluation of Hospital and its facilities in accordance with Laws and to comply with the agencies' recommendations, if any.

8.6 **Enrollee Access to Records**. Hospital (including Hospital Providers) and its Downstream Entities shall ensure that Enrollees have access to their Medical Records in accordance with the requirements of Laws. An Enrollee shall be provided a copy of his or her Medical Records, upon request, and shall have the right to request corrections or amendments to their Medical Records as specified in 45 CFR Part 164. Hospital and Downstream Entities shall furnish a copy of the Enrollee's Medical Records to another treating or consulting Provider regardless of whether the requesting Provider is a Participating Provider, at no cost to CalOptima or the Enrollee when (i) such a transfer of Medical Records facilitates the continuity of that Enrollee's care; (ii) the Enrollee is transferring from one Provider to another for treatment; and (iii) an Enrollee seeks to obtain a second opinion on the diagnosis or treatment of a medical condition.

IX. INSURANCE AND LIABILITY

9.1 **Indemnification**. Each Party agrees to defend, indemnify, and the other Party and the State and CMS harmless, with respect to any and all claims, costs, damages, and expenses, including reasonable attorney's fees, that are related to or arise out of the negligent or willful performance or non-performance by the indemnifying Party, or any functions, duties, or obligations of such Party. Neither termination of the Contract nor completion of the acts to be performed under this Contract shall release either Party from its obligation to indemnify as to any claims or cause of action asserted so long as the event(s) upon which such claims or cause of action is predicated shall have occurred prior to the effective date of termination or completion. CalOptima and Hospital agree to promptly notify the other Party of any claims or demands that arise and for which indemnification hereunder is sought.

9.2 **Insurance Requirements**.

9.2.1 **Hospital and Downstream Entity Insurance**. Hospital agrees to procure and maintain, at its own expense, the insurance policies required by this Section 9.2 and Laws as necessary to insure it and its employees, agents, and representatives against any claim or claims for damages arising by reason of: (a) personal injuries or death occasioned in connection with the performance of any Covered Services provided hereunder; (b) the use of any property and Facilities of the Hospital; and (c) activities performed in connection with this Contract. Hospital shall require its Downstream Entities to maintain similar policies of insurance where Hospital's insurance does not cover its Downstream Entities.

9.2.2 **Professional/Medical Malpractice**. Hospital shall maintain a professional liability (medical malpractice) insurance policy with minimum limits of ten million dollars ($10,000,000) per incident and twenty million dollars ($20,000,000) in the aggregate per year.

9.2.3 **Commercial General Liability/Commercial Automobile Liability**. Hospital and each Participating Provider who has entered into a contract with Hospital to provide Covered Services under this Contract shall maintain a Commercial General Liability insurance policy and a Commercial Automobile Liability insurance policy with minimum limits as follows:

- Commercial General Liability: One million dollars ($1,000,000) per occurrence and three million dollars ($3,000,000) in the aggregate.

- Commercial Automobile Liability: One million, two hundred thousand dollars ($1,200,000) combined single limit for bodily injury or property damage covering any automobile, whether owned, leased, hired, or rented, on an ISO form CA 0001 or equivalent.

CalOptima must be named as an additional insured on Comprehensive General Liability and Commercial Automobile Liability insurance policies with respect to performance under this Contract.

9.2.4 **Workers' Compensation**. Hospital shall maintain a Workers' Compensation Insurance policy that provides statutory coverage with minimum limits as follows:

- Employers' Liability Insurance:
  - One million dollars ($1,000,000) Bodily Injury by Accident - each accident.
  - One million dollars ($1,000,000) Bodily Injury by Disease - policy limit
  - One million dollars ($1,000,000) Bodily Injury by Disease - each employee

9.2.5 **Managed Care Errors and Omissions**. Physician shall maintain a Managed Care Errors and Omissions Insurance policy with minimum limits as follows:

- Managed Care Errors and Omissions: Ten million dollars ($10,000,000) each claim/ten million dollars ($10,000,000) aggregate

9.2.6 **Electronic and Computer Crimes Insurance**. Hospital and its Downstream Entities shall maintain electronic and computer crimes insurance and employee fidelity insurance with limits of at least one million dollars ($1,000,000) if Hospital and/or its Downstream Entities will be paying claims or receiving funds on behalf of CalOptima, or will be storing, transmitting, and/or receiving personally identifiable and/or protected health information on a regular basis in carrying out its obligations under this Contract.

9.2.7 **Insurer Ratings**. Insurance required under this Article IX shall be provided by an insurer:

(a) Rated by A.M. Best with a rating of A V or better; and

(b) "Admitted" to do business in California or an insurer approved to do business in California by the California Department of Insurance and listed on the Surplus Lines Association of California List of Eligible Surplus Lines Insurers (LESLI); or

(c) An Unincorporated Interindemnity Trust Arrangement as authorized by the California Insurance Code 12180.7

9.2.8 **Captive Risk Retention Group/Self Insured**. Where any of the insurance(s) mentioned in this Article IX is provided by a captive risk retention group or self-insured, insurer ratings requirements above may be waived at the sole discretion of CalOptima, but only

after review of the captive risk retention group's or self-insured's audited financial statements.

9.2.9 **Cancellation or Material Change**. Hospital shall not of its own initiative cause such insurance as addressed in this Article IX to be cancelled or materially changed during the Term.

9.2.10 **Proof of Insurance**. Certificates of Insurance of the insurance policies and/or evidence of self-insurance required under this Article IX shall be provided to CalOptima prior to Effective Date, annually thereafter, and upon request.

X. COOPERATION

10.1 **Non-Interference**. Hospital and Downstream Entities may not prohibit of otherwise restrict a health care professional, acting within the lawful scope of practice, from freely communicating with Enrollees about their treatment and the following, regardless of benefit coverage limitations:

10.1.1 The Enrollee's health status, medical care, or treatment options (including any alternative treatments that may be self-administered), including the provision of sufficient information to provide an opportunity for the Enrollee to decide among all relevant treatment options;

10.1.2 The risks, benefits, and consequences of treatment or non-treatment; or

10.1.3 The opportunity for the Enrollee to refuse treatment and to express preferences about future treatment decisions.

10.2 **No Counseling to Dis-enroll**. Hospital will not, during the Term, provide advice to or counsel any Enrollee to dis-enroll from CalOptima, and Hospital will not solicit such Enrollee to become enrolled with any other health maintenance organization, preferred provider organization, or any other similar hospitalization, medical payment plan or insurance program.

10.3 **Cooperation**. CalOptima and Hospital agree that, to the extent compatible with the separate and independent management of each, they will at all times maintain an effective liaison and close cooperation with each other to provide maximum benefits to Enrollees at the most reasonable cost, consistent with quality standards of hospital and physician care.

10.4 **Signs**. Hospital agrees that CalOptima may post notices, mutually acceptable as to size, content and form in a prominent place instructing Enrollees as to proper procedures and limitations on coverage.

10.5 **Free Exchange of Information**. No provision of this Contract shall be construed to prohibit, nor shall any provision in any contract between Hospital and its employees or Downstream Entities, prohibit, the free, open, and unrestricted exchange of any and all information of any kind between Providers and Enrollees regarding the nature of the Enrollee's medical condition, the health care treatment options and alternatives available and their relative risks and benefits, whether or not covered or excluded under the Enrollee's Evidence of Coverage, and the Enrollee's right to appeal any adverse decision made by Hospital or CalOptima regarding coverage of treatment which has been recommended or rendered. Hospital and CalOptima agree not to penalize nor sanction any Provider in any way for engaging in such free, open, and unrestricted communication with an Enrollee nor for advocating for a particular service on an Enrollee's behalf.

XI. TERM AND TERMINATION

11.1 **Term of Contract**. The term of this Contract shall become effective on the Effective Date and continue in effect for five (5) years through _____ ("Initial Term") and five (5) additional one-year automatic extensions except as directed otherwise by the Board.

11.2 **Sanctions and Terminations for Cause**. If Hospital fails to fulfill any of its duties and obligations under this Contract, including: (i) committing acts to discriminate against Enrollees; (ii) engaging in any practice that would reasonably be expected to have the effect of denying or discouraging enrollment with the Hospital by Enrollees whose medical condition or history indicated a need for substantial future medical services; (iii) not providing Covered Services in the scope or manner required under this Contract; (iv) engaging in prohibited marketing activities; (v) failing to comply with CalOptima's compliance and fraud, waste and abuse programs; (vi) failing to meet financial requirements in Article II; (vii) committing fraud, waste or abuse relating to Covered Services or any and all obligations, duties, and responsibilities under this Contract; (viii) failure to enforce claims payment prohibitions on Providers who are denied the right to submit claims and/or receive reimbursement for services furnished to Enrollees; (ix) failure to comply with pharmacy requirements as determined by CalOptima; (x) failure to submit Encounter Data or comply with other reporting requirements pursuant to this Contract and CalOptima Policies; and/or (xi) failure to take corrective action related to any such obligation or duty in the time or manner required by CalOptima, CalOptima may take any one or more of the actions described in this Article XI.

11.3 **Corrective Action Plans**. CalOptima may require a Corrective Action Plan ("**CAP**") in the event that any report, audit, survey, site review or investigation indicates that the Hospital or any Downstream Entity is not in compliance with any provision of this Contract.

11.3.1 A CAP shall be required if CalOptima receives a substantiated complaint or grievance related to the standard of care provided by the Hospital or any Downstream Entities. CalOptima shall issue a written notice of deficiency and shall require that a CAP to be submitted within thirty (30) calendar days following the date of notice unless otherwise stated. The CAP shall include the time and manner in which the deficiency shall be corrected. CAPs are subject to approval by CalOptima, which may be approved as submitted, accepted with specific modifications, or rejected. CalOptima may extend or reduce the time allowed for completion of the CAP depending upon the nature of the deficiency.

11.3.2 Notwithstanding any request for a CAP, CalOptima may impose monetary penalties, suspend enrollment, reduce maximum enrollment, or impose other sanctions when the Hospital is not in compliance with the provisions of this Contract, CalOptima Policies, and minimum performance requirements as established by CalOptima. All monetary fines are payable to CalOptima within thirty (30) calendar days of receipt of written notice, unless otherwise stated in the notice. Failure to submit payment to CalOptima for any monetary fines within the thirty (30) calendar day period shall result in CalOptima deducting the penalty plus administrative fees from the Hospital's Capitation Payment.

11.3.3 CalOptima may apply sanctions pursuant to this Contract and CalOptima Policies to all PHC Participants independent of the PHC Participant whose action(s) caused sanctions to be applied by CalOptima.

11.4 **CalOptima Termination for Cause**. Notwithstanding and in addition to any other provisions of this Contract, CalOptima may terminate this Contract for cause effective upon thirty (30) calendar

days' written notice; cause shall include, but shall not be limited to, the actions set forth in Section 11.2. CalOptima's rights and remedies provided in this provision shall not be exclusive and are in addition to any other rights and remedies provided by law or this Contract.

11.5 **Hospital Termination for Cause**. Hospital may terminate this Contract for cause only upon thirty (30) calendar days' written notice and only in the event that CalOptima fails to make payments due under this Contract within fifteen (15) calendar days of when such amounts are due and payable.

11.6 **Immediate Terminations**. In addition to all other sanction and termination rights, CalOptima may terminate Contract immediately upon delivery of written notice to Hospital if:

11.6.1 Hospital and/or its Downstream Entities are unable to secure the necessary governmental licenses, approvals, and/or certificates required for the performance of their duties;

11.6.2 CalOptima determines that the health, safety, or welfare of Enrollees is jeopardized by continuation of this Contract;

11.6.3 Hospital commits fraud, waste, or abuse; or

11.6.4 CMS fails to authorize or reauthorize CalOptima to operate a MA Program for a period that overlaps the Term.

11.6.5 This Contract shall terminate upon the termination of the Physician Group Contract. Notification of termination to any PHC Participant shall constitute notification of termination to all PHC Participants.

11.7 **Without Cause Termination**. Following the Initial Term, either Party may terminate this Contract for convenience, without cause, by giving written notice to the other Party of at least one hundred and eighty (180) calendar days' prior to the effective date of such termination.

11.8 **Bankruptcy**. If during the Term there is filed by or against Hospital in any court pursuant to any statute of the United States or any state, a petition in bankruptcy or insolvency or for reorganization or for the appointment of a receiver or trustee or conservator of all or a portion of Hospital's assets, or if Hospital makes an assignment for the benefit of creditors, or if Hospital becomes unable, admits in writing its inability, or fails generally to pay its debts as they become due, this Contract may, at the option of CalOptima, be canceled and terminated. In the event of the filing of a petition for bankruptcy by or against Hospital, Hospital shall assure that all of Hospital's functions and duties related to the Contract are performed in accordance with the terms of the Contract. CalOptima shall have the right to withhold any and all amounts otherwise due to Hospital until Hospital fully discharges its obligations under the Contract. CalOptima shall also have the immediate right of offset by permanently retaining any and all withheld amounts as necessary to ensure that all Hospital obligations have been met.

11.9 **Termination of CMS Contract.** In the event the CMS Contract with CalOptima is terminated or not renewed, the provisions of this Contract shall automatically terminate unless otherwise specified by CalOptima and subject to any provisions that survive termination. Any term provided in the Contract is subject to CMS's continuing approval of CalOptima's MA Program. Hospital agrees to assist CalOptima with such transfer of care requirements mandated by CMS in the event of termination of the CMS Contract.

11.10 **Continuation of Benefits**. Hospital and its Downstream Entities agree that, in the event of CalOptima's insolvency or cessation of operations, benefits to Enrollees will continue through the period for which capitation has been paid or until the discharge of Enrollee from an inpatient facility, whichever time is greater. Covered Services to an Enrollee confined in an inpatient facility on the date of insolvency or other cessation of operations will continue until their appropriate discharge.

11.11 **Hospital Obligations Following Termination**. In the event of termination of this Contract, at CalOptima's sole option, Hospital will continue to provide Covered Services, and CalOptima shall reimburse for such services per the Medicare fee schedule, to Enrollees until CalOptima has made arrangements with alternative Providers to render care to Enrollees. Hospital shall cooperate and assist CalOptima in the transfer of Enrollee care in the event this Contract or any relevant Downstream Entity subcontract is terminated for any reason. Hospital shall provide a plan for the orderly termination of services under this Contract, in form and substance acceptable to CalOptima.

11.12 **Prohibition on Use of Certain Providers**. Hospital agrees that CalOptima reserves the right to require Hospital, upon notification from CalOptima, to prohibit any Provider or Downstream Entity from providing services, whether Covered Services or otherwise, to Enrollees when CalOptima deems such prohibition to be in the best interests of the Enrollees, provided that imposition of the foregoing prohibition shall not terminate this Contract.

11.13 **PHC Primary Hospital Usage Requirement**. In order to qualify as a PHC, PHC Participants must ensure that, during every annual contract year period during the Term, at least seventy percent (70%) of the bed days for those Enrollees assigned to the PHC who require inpatient hospitalization during the previous calendar year must have occurred at Hospital or within the same hospital system as Hospital, except as otherwise provided under CalOptima Policies. For purposes of calculating the bed day percentage, only bed days in Orange County hospitals shall count. Failure to meet this requirement shall be cause for termination by CalOptima under Section 11.4 of this Contract. Termination as a result of breaching this Section 11.13 shall have no effect on any fee-for-service contract between CalOptima and Hospital. In the event of termination under the equivalent of this section in the Physician Group Contract, Physician Group shall be offered the opportunity to continue be a Participating Provider through a separate risk-sharing arrangement with CalOptima, subject to meeting all applicable financial, operational, and other criteria for such an arrangement.

XII. GENERAL PROVISIONS

12.1 **Dispute Resolution**.

12.1.1 **Provider Appeals Process**. CalOptima maintains a Provider dispute resolution process. Hospital may appeal any aspect of the CalOptima MA Program, including a decision to impose a sanction, terminate this Contract, or take other actions against Hospital, by filing a complaint pursuant to CalOptima Policies. Hospital shall exhaust all administrative remedies and any government claims requirements, as applicable, before commencing arbitration.

12.1.2 **Meet and Confer**. For any dispute not subject to or resolved by the provider appeals process, or if either Party has a dispute it seeks to address informally, the Parties shall use reasonable efforts to informally meet and confer to try and resolve the dispute. The Parties shall meet and confer within thirty (30) days of a written request submitted by either Party in an effort to settle any dispute. At each meet-and-confer meeting, each Party shall be represented by persons with final authority to settle the dispute. If either Party fails to meet

within the thirty (30)-day period, that Party shall be deemed to have waived the meet-and-confer requirement, and at the other Party's option, the dispute may proceed immediately to arbitration under Section 12.1.3.

12.1.3 **Arbitration**. If the Parties are unable to resolve any dispute arising out of or relating to this Contract under Sections 12.1.1 and 12.1.2, either Party may submit the dispute for resolution exclusively through confidential, binding arbitration, instead of through trial by court or jury, in Orange County, California. The Parties may agree in writing prior to commencing the arbitration on the dispute resolution rules and arbitration service that will be used to resolve the dispute. If the Parties cannot reach such an agreement, the arbitration will be conducted by Judicial Arbitration and Mediation Services ("**JAMS**") in accordance with the commercial dispute rules then in effect for JAMS; provided, however, that this Contract shall control in instances where it conflicts with JAMS's (or the applicable arbitration service's) rules. The arbitration shall be conducted on an expedited basis by a single arbitrator. The Parties prefer that the arbitrator be a retired judge of the California Superior, Appellate, or Supreme Court or of a United States court sitting in California. If no such retired judge is available, the arbitrator may be an attorney with at least fifteen (15) years of experience, including at least five (5) years in managed health care. If the Parties are unable to agree on the arbitrator within thirty (30) days of the date that the arbitration service accepts the arbitration, the arbitrator shall be selected by the arbitration service from a list of four potential arbitrators (all of whom shall be on arbitration services' panel of arbitrators) submitted by the Parties, two from each side; provided, however, that nothing stated in this section shall prevent a Party from disqualifying an arbitrator based on a conflict of interest. In making decisions about discovery and case management, it is the Parties' express agreement and intent that the arbitrator at all times promote efficiency without denying either Party the ability to present relevant evidence. In reaching and issuing decisions, the arbitrator shall have no jurisdiction to make errors of law and/or legal reasoning. The Parties shall share the costs of arbitration equally, and each Party shall bear its own attorneys' fees and costs.

12.1.4 **Exclusive Remedy**. With the exception of any dispute that under Laws may not be settled through arbitration, arbitration under Section 12.1.3 is the exclusive method to resolve a dispute between the Parties arising out of or relating to this Contract that is not resolved through the provider appeals or meet-and-confer processes.

12.1.5 **Waiver**. By agreeing to binding arbitration as set forth in Section 12.1.3, the Parties acknowledge that they are waiving certain substantial rights and protections which otherwise may be available if a dispute between them was determined by litigation in a court, including the right to a jury trial, attorneys' fees, and certain rights of appeal.

12.2 **Interpretation of Contract Language**. CalOptima has the right to final interpretation of the Contract language when disputes arise. Hospital has the right to appeal disputes concerning Contract language to CalOptima.

12.3 **Waiver**. The waiver by either Party of a breach or violation of any provision of this Contract will not operate as or be construed to be a waiver of any subsequent breach thereof. To be effective, a waiver must in writing signed by the Parties.

12.4 **Assignment**. This Contract and the rights, interests, duties, and obligations hereunder shall not be assigned, transferred, pledged, or hypothecated in any way by Hospital nor shall the duties and obligations imposed herein be subcontracted or delegated without the prior written consent of

CalOptima, which consent may be withheld in CalOptima's sole and absolute discretion for any reason or no reason. Hospital acknowledges and agrees that CalOptima's consent, if any, to assignment and/or delegation is subject to the approval of CMS. Therefore, any assignment and/or delegation of this Contract, including the rights, interests, duties, and obligations hereunder, shall be void unless prior written consent is obtained from CalOptima and CMS. Hospital further acknowledges and agrees that CalOptima may require Hospital and the proposed assignee/sub-delegate to cooperate in due diligence and sub-delegation assessment activities as part of its review of any request for consent to assignment of this Contract and the rights, interests, duties, and obligations hereunder. Hospital agrees to cooperate and provide such information as requested by CalOptima. Hospital acknowledges and agrees that (i) CalOptima's due diligence and/or assessment activities related to any proposed assignment may take one hundred eighty (180) days or more; (ii) in no event shall CalOptima's due diligence and/or delegation assessment activities be construed as CalOptima's consent to assignment; and (iii) any consent to assignment by CalOptima must be reflected in a separate writing executed by CalOptima and other relevant parties. CalOptima may, from time to time, establish policies and procedures regarding its processes for initiating review and approval of any proposed assignment of this Contract. For purposes hereof, the term "**assignment**" shall include any of the following: (i) the change of more than twenty-five percent (25%) of the ownership or equity interest in Hospital (whether in a single transaction or in a series of transactions); (ii) the change of more than twenty-five percent (25%) of the directors or trustees of Hospital; (iii) the merger, reorganization, or consolidation of Hospital with another entity with respect to which Physician is not the surviving entity; and/or (iv) a change in the management of Hospital from management by persons appointed, elected, or otherwise selected by the governing body of Hospital (e.g., the Board of Directors) to a third-party management person, company, group, team or other entity.

12.5 **Independent Parties**. None of the provisions of this Contract are intended to create nor will be deemed or construed to create any relationship between the Parties other than that of independent contractors, solely for the purposes of effecting the provisions of the Contract. Neither of the Parties nor any of their respective officers, directors, or employees shall act as nor be construed to be the agent, the employee, or the representative of the other Party.

12.6 **Integration of Entire Contract**. This Contract contains all of the terms and conditions agreed upon by the Parties regarding the subject matter of this Contract. Any prior agreements, promises, negotiations or representations of or between the Parties, either oral or written, relating to the subject matter of this Contract that are not expressly set forth in this Contract are null and void and of no further force or effect.

12.7 **Invalidity or Unenforceability**. The invalidity or unenforceability of any terms or provisions hereof will in no way affect the validity or enforceability of any other term or provision.

12.8 **Amendment**. CalOptima may amend this Contract immediately upon written notice to Hospital in the event such amendment is required in order to maintain compliance with Laws. CalOptima may deem all other amendments to the Contract effective after at least forty-five (45) business days' notice or earlier if agreed to by Hospital. All amendments of this Contract are subject to CMS approval.

12.9 **No Waiver of Immunity or Privilege**. Any information delivered, exchanged, or otherwise provided hereunder shall be delivered, exchanged, or otherwise provided in a manner, which does not constitute a waiver of immunity or privilege under applicable law.

12.10 **Choice of Law; Jurisdiction and Venue**. This Contract shall be governed by and construed in accordance with all State and federal laws and regulations governing the CMS Contract. The Parties consent to the jurisdiction of the California Courts with venue in Orange County California.

12.11 **Force Majeure**. Either Party, upon prompt written notice to the other Party, shall be excused from performance hereunder for any period that it is prevented from meeting the terms of this Contract as a result of a catastrophic occurrence or natural disaster, including, but not limited to, an act of war and excluding labor disputes ("**Force Majeure Event**");

12.12 **No Liability of County of Orange**. As required under Ordinance No. 3896, as amended, of the County of Orange, State of California, CalOptima and the Hospital hereby acknowledge and agree that the obligations of CalOptima under this Contract are solely the obligations of CalOptima, and the County of Orange, State of California, shall have no obligation or liability therefor.

12.13 **Confidential and Proprietary Information**. Hospital agrees to maintain confidential the following information (the "**Confidential Information**"): (a) eligibility lists and any other information containing the names, addresses and telephone numbers of CalOptima Enrollees; (b) CalOptima's administrative service manuals and all forms related thereto; (c) the financial arrangements between CalOptima and any Participating Provider; and (d) any other information compiled or created by CalOptima that is proprietary to CalOptima and that CalOptima identifies as proprietary to Hospital in writing. Hospital shall not disclose or use the Confidential Information for its own benefit or gain either during the Term or after the date of termination of this Contract. Hospital may use the Confidential Information to the extent necessary to perform its duties under this Contract or upon express prior written permission of CalOptima. Upon the effective date of termination of this Contract, Hospital shall promptly return to CalOptima the Confidential Information in its possession, upon CalOptima's notice.

12.14 **Third Party Beneficiaries**. Nothing in this Contract, express or implied, is intended to or shall confer upon any other person or entity, any right, benefit or remedy of any nature whatsoever.

12.15 **Survival**. The terms set forth in the following sections shall survive the expiration or termination of this Contract, whether with or without cause, by rescission or otherwise, as to all Covered Services provided under this Contract prior to termination: Sections 6.2, 6.5, 7.8, Article 8, 9.1, 11.10, 11.11, 12.1, 12.2, 12.3, 12.5, 12.6, 12.7, 12.9, 12.10, 12.12, 12.13, 12.14, and any other sections that, by their terms, are intended to survive termination of the Contract.

12.16 **Recitals and Exhibits**. The recitals, exhibits, and addenda set forth in this Contract are made a part of the Contract by this reference.

12.17 **Without Limitation**. Any reference in the Contract to "include(s)" or "including" means inclusion without limitation, unless otherwise distinguished within the text.

12.18 **Notices**. All notices shall be in writing and shall be deemed to have been duly given on the date of service if personally served on the Party to whom notice is given, or seventy-two (72) hours after mailing by electronic mail transmission, United States priority mail, United States mail first class (Certified Mail or Registered Mail), addressed to the Party to whom notice is to be given and such party's address as set forth below or such other address provided by notice.

To: CalOptima

Attention: Chief Operating Officer

505 City Parkway West
Orange, California 92868

To: Hospital

_____

_____

_____

XIII. CONDITIONS PRECEDENT TO CONTRACT COMMENCEMENT

13.1 **Contract Effectiveness**. The Contract is subject to CalOptima's determination, in its sole discretion, that the following conditions have been met prior to the Effective Date: (i) Hospital has successfully met all criteria in CalOptima's readiness assessment, including financial viability and delegated function criteria; Hospital has signed CalOptima's Business Associate Agreement; and (iii) Hospital has furnished all required documentation and data requested by CalOptima (e.g., insurance documents, licenses).

13.2 **Additional CalOptima Regulator Requirements**. CalOptima, in its sole discretion, may condition this Contract upon Hospital's ability to meet other criteria imposed by CalOptima Regulators.

XIV. SIGNATURES

SUBJECT TO (I) THE UNITED STATES GOVERNMENT PROVIDING FUNDS FOR THE TERM OF THIS CONTRACT AND FOR THE PURPOSES WITH RESPECT TO WHICH IT IS ENTERED INTO; AND (II) THE APPROVAL OF THIS CONTRACT BY DMHC AND CMS, THIS CONTRACT SHALL BECOME EFFECTIVE ON THE EFFECTIVE DATE AND SHALL TERMINATE ON AS PROVIDED IN THIS CONTRACT.

IN WITNESS WHEREOF, CalOptima and Hospital have executed this Contract as indicated below.

FOR Hospital:	FOR CALOPTIMA:
_____	_____
SIGNATURE	SIGNATURE
_____	Yunkyung Kim
PRINT NAME	PRINT NAME
_____	Chief Operations Officer
TITLE	TITLE
_____	_____
DATE	DATE

ADDENDUM 1

Entities Comprising the PHC

ATTACHMENT A
DEFINITIONS

1. "**Administrative Services**" means those non-clinical, administrative functions that are the responsibility of the Hospital as set forth under the Contract and in CalOptima Policies.

2. "**Advance Directive**" means an individual's written directive or instruction, such as a power of attorney for health care or a living will, recognized under state law (whether statutory or as recognized by the courts of the state) for the provision of that individual's health care if the individual is unable to make his or her health care wishes known.

3. "**Appeals**" means an Enrollee's actions, both internal and external to CalOptima, requesting review of the denial, reduction, or termination of benefits or services from CalOptima.

4. "**Authorization/Authorized**" means the approval of CalOptima, or its delegate (which may include Hospital), for the provision or referral of Covered Services, obtained in accordance with, and as further described in, the Provider Manual and this Contract.

5. "**Behavioral Health**" means the mental health services and substance use disorder services arranged for or provided to Enrollees by a separate Mental Health Plan, CalOptima, or their subcontractors.

6. "**CalOptima Formulary**" means the CalOptima Approved Drug List, the Disposable Medical Equipment/Supplies List, the CalOptima OneCare Formulary, and any additional formularies as may be designated by CalOptima and provided to CalOptima's designated pharmacy benefits manager "**PBM**". There is no applicable CalOptima Formulary for the PACE program.

7. "**CalOptima Policies**" means CalOptima policies and procedures, including CalOptima's Provider Manual, that are amended from time to time at the sole discretion of CalOptima and incorporated into this Agreement by this reference.

8. "**CalOptima's Regulators**" means those government agencies that regulate and oversee CalOptima's and its FDRs' activities and obligations under this Contract including the Department of Health and Human Services, CMS, and the DMHC and other government agencies that have authority to set standards and oversee the performance of the parties to this Contract, as well as their respective agents and contractors quality improvement organizations.

9. "**Capitation Payment**" means the monthly payment paid to Hospital by CalOptima for delivery for Covered Services to Enrollees, which is determined by multiplying the applicable Capitation Rate by Hospital's monthly enrollment.

10. "**Capitation Rate**" means the rate set by CalOptima for the delivery of Covered Services to an Enrollee.

11. "**Care Coordinator**" means a clinician or other trained individual employed by or contracted with Hospital who is accountable for providing care coordination services for Enrollees, as required by CalOptima Policies and who services on one or more ICTs.

12. "**C.C.R.**" means the California Code of Regulations.

13. "**C.F.R.**" means the Code of Federal Regulations.

14. "**CMS**" means the Center for Medicare & Medicaid Services.

15. "**CMS Contract**" means the agreement between CMS and CalOptima under which CalOptima can establish its MA Program for Enrollees.

16. "**COB**" refers to the coordination of benefits and determination of order of financial responsibility that applies when two or more health benefit plans provide coverage of items and services for an individual.

17. "**Compliance Program**" means the program (including the compliance manual, code of conduct and CalOptima Policies) developed and adopted by CalOptima to promote, monitor, and ensure that CalOptima's operations and practices and the practices of its Board members, employees, contractors, and Providers comply with applicable law and ethical standards. The Compliance Program includes CalOptima's Fraud, Waste and Abuse ("**FWA**") plan.

18. "**Covered Services**" means those health care items, drugs, and services that an Enrollee is entitled to receive pursuant to a Program applicable to that Enrollee. Covered Services must generally be referred and Authorized in confirming with CalOptima's Policies, including its utilization management program."

19. "**Delegation**" means the process by which CalOptima expressly grants, by formal written agreement to another entity, the authority to carry out a function that would otherwise be required to be performed by CalOptima in order to meet its obligations under the CMS Contract.

20. "**Delegation Agreement**" means the formal written agreement by which CalOptima grants to another entity the authority to carry out a function that would otherwise be required to be performed by CalOptima to meet its obligations under the CMS Contract.

21. "**Delegation Criteria**" means those criteria adopted by CalOptima, for the delegation of activities in the areas of UM, medical records audits, the Office Site Review, 'Enrollee's rights and responsibilities, and credentialing, as set forth in CalOptima Policies.

22. "**DMHC**" means the California Department of Managed Health Care.

23. "**Downstream Entity**" means all Providers and other persons or entities with which Hospital has entered into a written subcontract (acceptable to CMS) to perform administrative functions and/or health care services to satisfy Hospital's obligations to CalOptima under this Contract, continuing down to the ultimate provider of services. The term "Hospital" as used in the terms of this Contract shall also include its subcontractors when such subcontractors are Downstream Entities, even if not expressly referenced in the particular provision.

24. "**Emergency Medical Condition**" means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, with an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in: (i) placing the health of the individual (or with respect to a pregnant woman, the health of the woman and her unborn child) in serious jeopardy; or (ii) serious impairment to bodily functions; or (iii) serious dysfunction of any bodily organ or part.

25. "**Emergency Services**" means those covered inpatient and outpatient services that are (i) furnished by a Provider qualified to furnish Emergency Services; and (ii) needed to evaluate and/or stabilize an Enrollee's Emergency Medical Condition.

26. "**Encounter Data**" means the record of an Enrollee receiving any item(s) or service(s) provided through Medicaid or Medicare under a prepaid, capitated, or any other risk basis payment methodology submitted to CMS. The encounter data record shall incorporate HIPAA security, privacy, and transaction standards and be submitted in ASCX12N 837 or any successor format required by CalOptima's Regulators.

27. "**Enrollee**" means an eligible individual who is enrolled in the CalOptima MA Program.

28. "**Evidence of Coverage**" means the document approved by CalOptima's Regulators and issued by CalOptima to Enrollees that describes Enrollee's benefits under the CalOptima MA Program.

29. "**FDR**" means a party that enters into a written agreement (acceptable to CMS) to provide administrative or health care services to CalOptima and/or its Enrollees that are governed by the CMS Contract.

30. "**FQHC**" means an entity that meets all of the requirements for designation as a federally qualified health center under § 1861(aa)(3) of the Social Security Act and is approved for participation in the MA program.

31. "**Grievance**" means an oral or written expression of dissatisfaction, including any compliant, dispute, request for reconsideration, or appeal, made by an Enrollee.

32. "**Health Network**" means Hospital, a PHC, or health care service plan (such as an HMO) that is contracted with CalOptima to provide items and services to Enrollees on a capitated basis.

33. "**HEDIS**" means the set of standardized performance measures sponsored and maintained by the NCQA.

34. "**HRA**" means the health risk assessment tool that identifies an Enrollee's primary, acute, LTSS, Behavioral Health, and functional needs.

35. "**HIPAA**" means the Health Insurance Portability and Accountability Act of 1996, Public Law 104-191, the Health Information Technology for Economic and Clinical Health Act, Public Law 111-005, and regulations promulgated thereunder by the U.S. Department of Health and Human Services, including Title 45 of the C.F.R, Parts 160 and 164.

36. "**ICP**" means the plan of care developed by an Enrollee and/or his/her ICT or CalOptima.

37. "**Indian Enrollee**" means an Enrollee who is an Indian (as defined in the Indian Health Care Improvement Act of 1976 [25 U.S.C. §§ 1603(13), 1603 (13 and 23), or 1679(a)] or who has been determined as an Indian under 42 C.F.R. § 136.12.

38. "**Indian Health Care Provider**" means a health care program operated by the Indian Health Services or by an Indian Tribe, Tribal Organization, or Urban Indian Organization, as those terms are defined in Section 4 of the Indian Health Care Improvement Act (25 U.S.C. § 1603).

39. "**ICT**" means an interdisciplinary care team comprised of the primary care provider and Care Coordinator and other Providers at the discretion of the Enrollee that work with the Enrollee to develop, implement, and maintain the ICP.

40. "**Laws**" means any local, State, or federal statute, regulation, rule, or executive or agency order applicable to this Contract.

41. "**LTSS**" means the range of long-term services and supports that help Enrollees meet their daily needs for assistance and improve the quality of their lives and which include: (i) In-Home Supportive Services ("**IHSS**"); (ii) Community-Based Adult Services ("**CBAS**"); (iii) Multi-purpose Senior Services Program ("**MSSP**") services; and (iv) skilled nursing facility services and sub-acute care services.

42. "**Medically Necessary**" or "**Medical Necessity**" means when addressing Covered Services: (i) under Medicare, reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member, or otherwise medically necessary under 42 U.S.C. Section 1395y.

43. "**Medical Record**" means any record kept or required to be kept by any Provider that documents medical services received by the Enrollee, including inpatient, outpatient, emergency care, referral requests, and Authorizations in accordance with applicable laws including Title 28 C.C.R. § 1300.80(b), Title 42 U.S.C. § 1396a(w), 42 C.F.R. § 456.111 and 42 C.F.R. § 456.211 and CalOptima Policies.

44. "**Mental Health Plan**" means the entity that has contracted with DHCS to provide Specialty Mental Health Services to individuals, including Enrollees.

45. "**Model of Care**" means the component of CalOptima's quality improvement framework that is evidence-based, includes certain clinical and non-clinical elements, and is in addition to the comprehensive care coordination requirements specified in CalOptima Policies.

46. "**Non-Covered Services**" means those services that are not benefits under the CalOptima MA Program in accordance with CalOptima's Evidence of Coverage and applicable state and federal laws and regulations.

47. "**Non-Participating Provider**" means an institution, professional, or other Provider of health care services who has not entered into an agreement, either with CalOptima or Hospital, to provide medical and other services to Enrollees.

48. "**Out-of-Area**" means that area that is outside the Service Area.

49. "**Participating Provider**" means an institution, professional, or other provider of health care services who has entered into an agreement, either with CalOptima or Hospital, to provide health care services to Enrollees.

50. **"Physician"** means a person with an unrestricted license to practice medicine or osteopathy in the state in which they practice.

51. "**Post-Stabilization Care Services**" means services related to an Emergency Medical Condition that are provided after an Enrollee is Stabilized in order to maintain the Stabilized condition, or under some circumstances, to improve or resolve the condition.

52. "**Preclusion List**" means the CMS-compiled list of providers and prescribers who are precluded from receiving payment for MA items and services or Part D drugs furnished or prescribed to Medicare beneficiaries.

53. "**PCP**" means a primary care physician responsible for supervising, coordinating, and providing initial and primary care to Enrollees; for serving as the medical home; for processing initial referrals for Specialist Physician care; and for maintaining the continuity of patient care.

54. "**Program**" is health care benefit program offered by CalOptima to Enrollees. Programs and their designs are subject to change periodically.

55. "**Provider**" means a physician, nurse, nurse mid-wife, nurse practitioner, medical technician, physician assistant, hospital, laboratory, health maintenance organization ("**HMO**"), or other person or institution who furnishes health care items or services.

56. "**Provider Manual**" means that comprehensive online document, as amended from time to time, and describes CalOptima's Policies and procedures affecting Hospital Physicians' services under this Contract.

57. "**Referral**" means the process by which the Participating Provider Physician directs an Enrollee to seek and obtain Covered Services from a health professional or for care at a facility.

58. "**Rural Health Clinic (RHC)**" means an entity that meets all of the requirements for designation as a rural health clinic under § 1861(aa)(1) of the Social Security Act and is approved for participation in the MA program.

59. "**Service Area**" means the geographic area within Orange County, California.

60. "**Specialist Physician**" means any physician who is not a PCP, has the requisite training and education, and meets all other requirements set by CalOptima Policies for specialists.

61. "**Stabilize**" or "**Stabilized**" means, with respect to an Emergency Medical Condition, to provide such medical treatment of the condition to assure within reasonable medical probability that no material deterioration of the condition is likely to result or occur during the transfer of the individual from a facility, or in the case of a pregnant woman, that the woman has delivered the child and placenta.

62. "**Threshold Language"** means those languages as determined by CalOptima's Regulators from time to time and identified in guidance on translation requirements provided to CalOptima.

63. "**Urgent Care**" means services required to prevent serious deterioration of health following the onset of an unforeseen condition or injury and are medical services required promptly to prevent impairment of health due to symptoms that do not constitute an Emergency Medical Condition but that are the result of an unforeseen illness, injury or condition for which medical services are immediately required.

ATTACHMENT B
CALOPTIMA SENIOR PLAN
MATRIX OF FINANCIAL RESPONSIBILITY
January 1, 2023

HOSPITAL	RESPONSIBLE PARTY		
SERVICES	**GROUP**	**HOSPITAL**	**PLAN**
Medicare Part A Services – Not Otherwise Assigned Herein or in Any Agreement Incorporating This Exhibit:			
Inpatient		**X**	
Outpatient		**X**	
Medicare Part B Services Not Otherwise Assigned Herein or in Any Agreement Incorporating This Exhibit	**X**		
Some of the main services and those related to the Risk Sharing Program are listed below:			
Acupuncture (Medicare covered)	**X**		
Allergy			
Testing and Treatment	**X**		
Serum	**X**		
Ambulance – Air and Ground			
Emergency		**X**	
Inter-facility Transfers (all vehicle types)		**X**	
Amniocentesis			
Facility Component			
Outpatient (if not provided in physician office setting)		**X**	
Professional Component	**X**		
Audiologic			
Diagnostic	**X**		
Biofeedback	**X**		
Blood & Blood Products/Blood Transfusions (including professional component)			
Autologous Blood Donation		**X**	
From Blood Bank		**X**	
Cataract Surgery			
Professional Component	**X**		
Facility Component (Hospital Based Outpatient – Including Implanted Lenses)		**X**	
Facility Component (Ambulatory Surgery Center – Including Implanted Lenses)		**X**	

SERVICES	GROUP	HOSPITAL	PLAN
Chemical Dependency Rehabilitation and Detox (Medicare Covered)			
Professional Component	**X**		
Facility Component		**X**	
Methadone outpatient clinics			**X**
Chemotherapy			
Drugs – Outpatient (Part B)		**X**	
Drugs – Outpatient (Part D)			**Rx**
Professional Component	**X**		
Facility Component		**X**	
Chiropractic (Medicare covered)	**X**		
Dental Services (Medical)			
Professional Component	**X**		
Facility Component		**X**	
Facility Component (Non-Hospital) Based	**X**		
Diabetic Supplies			
Insulin and syringes (Rx Benefit)-see Medication-Outpatient Prescription Drug Benefit			**Rx**
Home Glucose Monitoring Equipment and Supplies)	**X**		
Diagnostic Testing			
Technical Component (Outpatient)	**X**		
Professional Component	**X**		
Durable Medical Equipment (DME)			
Outpatient	**X**		
Emergency Room			
Facility Component		**X**	
Professional Component (including interpretive reports)	**X**		
Endoscopy			
Facility Component		**X**	
Professional Component	**X**		
Family Planning			
Therapeutic Abortion Services, Tubal Ligation, Vasectomy, etc.			
Facility Component		**X**	
Professional Component	**X**		
Fetal Monitoring			
Facility Component		**X**	

SERVICES	GROUP	HOSPITAL	PLAN
Professional Component	X		
Genetic Testing/Counseling	X		
Health Education	X		
Hemodialysis/Dialysis			
Outpatient (Includes drugs per Medicare guidelines)		X	
Professional Component	X		
Home Health Care			
Medicare covered home health services (Including home IV therapy, excluding Part D drugs)		X	
Home Health Supplies (see medical supplies)		X	
Hospice	**Medicare FFS has primary responsibility**		
Hospitalization			
Facility Component (Including pre-admission diagnostic services)		X	
Interpretive Reports	X		
Professional Component (Including hospital-based physicians)	X		
Immunization and Inoculations (Part B)	X		
Immunization and Inoculations (Part D)			**Rx**
Infusion Therapy			
Professional Component	X		
Facility Component		X	
Part B drugs		X	
Part D drugs			**Rx**
Injectables -- (Outpatient) (see also Chemotherapy)			
Part B drugs		X	
Part D drugs			**Rx**
Lithotripsy			
Professional Component	X		
Facility Component		X	
Mammography	X		
Maternity/Obstetrics			
Facility Component		X	
Professional Component	X		
Medical supplies (includes catheters)			

SERVICES	GROUP	HOSPITAL	PLAN
Outpatient	X		
Medication			
Outpatient – Prescription Drug Benefit (Part D)			**Rx**
Outpatient medications (Part B)		X	
Mental Health			
Facility Component (includes Partial Hospitalization)		X	
Professional Component			X
Nuclear Medicine			
Inpatient, Facility Component (therapeutic)		X	
Outpatient, Facility Component	X		
Professional Component	X		
Nutrition			
Nutritional/Dietetic Counseling (Medicare Covered)	X		
Parenteral Nutrients, Supplies, Kits and Pumps			
Part B		X	
Part D			X
Enteral Nutrients, Supplies, Kits and Pumps			
Outpatient			X
Organ Transplants			
Pre Evaluation (All Inclusive)	X		
Organ Acquisition		X	**Medicare FFS for Kidney only**
Transplant Professional Component	X		
Transplant Facility Component (includes organ acquisition)		X	
Post Transplant (up to one year for transplant related services)			
Professional Component	X		
Post Transplant Facility Component (Inpatient)		X	
Post Transplant Facility Component (Outpatient – if provided in physician office setting)	X		
Orthotics and Prosthetics (Medicare Covered)			
Outpatient (Medicare defined coverage applies)		X	
Ostomy Supplies			
Outpatient	X		

SERVICES	GROUP	HOSPITAL	PLAN
Out of Area (Emergent and Urgently Needed Services)			
Facility Component		X	
Professional Component	X		
Outpatient Diagnostic Tests and Services (All Inclusive)	X		
Outpatient Surgery			
Facility Component (Hospital Based)		X	
Facility Component (Freestanding Ambulatory Surgery Center)		X	
Professional Component	X		
Cardiac catheterization and Angiograms (Professional)	X		
Cardiac catheterization and Angiograms (Facility)		X	
Physical Therapy (See Rehabilitation)			
Pain Management			
Professional	X		
Facility (if provided in other than physician office setting)		X	
Physician Visits/Consultations (inclusive of all settings)	X		
Podiatry Services (Medicare covered)	X		
Radiation Therapy			
Professional	X		
Facility, outpatient facility		X	
Radiology Services			
Outpatient, Preoperative, and Inpatient Professional Component	X		
Inpatient (facility component)		X	
Rehabilitation (Short Term e.g.: PT, OT, Speech, Cardiac)			
Outpatient Facility Component	X		
Professional Component	X		
Skilled Nursing Facility (SNF)			
Facility Component (All Inclusive)		X	
Professional Component	X		
Social Services – Medical	X		
Surgically Implanted Devices – All Categories		X	
Vision Care			
Annual routine exam			X
Glasses			X
Lenses and Frames incidental to cataract surgery (Medicare covered)	X		
Screening, Physician Office	X		

SERVICES	GROUP	HOSPITAL	PLAN
Notes:			
1. Financial responsibility is based on Medicare benefit interpretations and limitations.			
2. The symbol "Rx" denotes outpatient prescription drug services.			
Assignment of financial responsibility as outlined in this document is independent of the questions of medical necessity, coverage or benefits.			

ATTACHMENT C
CAPITATION RATES AND RISK SHARING

1. **Capitation Allocation**

1.1 **Allocation of Non-Part D CMS Revenue**. Each month, CalOptima shall allocate both the non-Part D related capitation that CalOptima receives from CMS for Enrollees affiliated with Hospital and any applicable premiums that CalOptima charges Enrollees affiliated with Hospital (collectively, the "**Total Revenues**") as follows:

- Facility and Other Services ("**Hospital Budget**") xx.x%
- Physician Group Capitation Fees xx.xx%

1.2 **MLR**. In accordance with Section 2.3, "Medical Loss Ratio", of the Contract, Hospital shall maintain a minimum acceptable loss ratio of eighty-five percent (85%). Should Hospital not meet the minimum eighty-five percent (85%) MLR, CalOptima reserves the right to require Hospital to return to CalOptima the difference between eighty-five percent (85%) of Capitation Payments and the allowed medical expenses.

1.3 **Sequestration**. If CMS reduces payment to CalOptima under the CMS Contract by more than two percent (2%) at any time during the Term, CalOptima may, upon written notice to Hospital, reduce payment to Hospital under this Attachment C by the same percentage that CMS reduced payment to CalOptima. This provision applies each time CMS reduces payment to CalOptima by more than two percent (2%) during the Term.

ATTACHMENT D
CLAIMS PROCESSING AND COMPLIANCE OBLIGATIONS

I. DEFINITIONS

1.1 "**Clean Claim**" means one that can be processed without obtaining additional information from the provider of the service or from a third party. Clean claim shall have the same meaning as "complete claim" as that term is defined in Title 28, CCR Section 1300.71(a)(2). Clean Claim does not include a claim from a Provider who is under investigation for fraud or abuse, or a claim under review for Medical Necessity.

1.2 "**Unclean Claim**" means any claim other than as defined in Section 1.1 of this attachment.

1.3 "**Denied Claim**" means a claim where (a) one or more services will not be paid by Hospital and (b) payment is the responsibility of the Enrollee. Examples of claims that are not denials and should not be reported, submitted, or presented to CalOptima as Denied Claims include claims:

1.3.1 For patients who remain enrolled with CalOptima but have transferred to another Hospital and Hospital is forwarding the claim,

1.3.2 For which payment responsibility belongs to another contracting entity, and Hospital is forwarding the claim,

1.3.3 That are duplicates,

1.3.4 That are encounter only/capitated claims and no patient liability is involved, and

1.3.5 That involve reduced payment amounts due to contract terms or allowed Medicare fee schedules.

II. GENERAL TERMS

2.1 **Hospital Claims Processing**. Hospital shall process claims for Provider services according to all CMS requirements and, as applicable, in accordance with the requirements of the Knox-Keene Act. This Attachment D is intended to comply with all DMHC and CMS standards and requirements. Should this Attachment D be out of compliance with any existing or newly enacted DMHC or CMS standard or requirement, the DMHC and/or CMS standard or requirement will supersede this Attachment D. CalOptima will communicate any changes in requirements to Hospital in writing.

2.2 If Hospital enters into a contract with a Downstream Entity whereby the responsibility for claims processing is delegated to that Downstream Entity, Attachment D provisions shall apply. Hospital will have contractual provisions to ensure such Downstream Entity conforms to all DMHC and CMS requirements and oversight provisions as outlined herein and in CalOptima Policies.

2.3 Hospital and any applicable Downstream Entity shall be required to have an oversight program for claims processing that includes written policies and procedures, a process for reporting fraudulent or unethical conduct, and an executive accountable for review of claims data and attesting to its accuracy. The oversight program shall include internal auditing of claims functions, and self-reporting as outlined in CalOptima Policies.

III. CLAIMS PROCESSING

3.1 **Timely Provider Payments**.

3.1.1 Hospital and Downstream Entities, if, and as applicable, must make timely payments to Participating Providers consistent with 42 CFR § 447.45.

3.1.2 Hospital shall reimburse Clean Claims, or any portion of any Clean Claim, for Covered Services, as soon as practical, but no later than thirty (30) calendar days after receipt of the claim by Hospital, unless the claim or portion thereof is reasonably contested, in which case the claimant shall be notified in writing that the claim is contested or denied within forty-five (45) business days after receipt of the claim by Hospital in accordance with CalOptima Policies.

3.1.3 Hospital must ensure that ninety percent (90%) of claims from Providers who are in individual or group practice, which can be processed without obtaining additional information from the Provider or from a third party, will be paid within thirty (30) days of the date of receipt of the claim.

3.1.4 Hospital must ensure that ninety-nine percent (99%) of all Clean Claims from Providers for Covered Services will be paid within ninety (90) days of the date of receipt of the claim.

3.1.5 Generally, the date of receipt is the date the Hospital receives the claim, as indicated by its date stamp on the claim. The date of payment is the date of the check or other form of payment.

3.1.6 **"30-Day" Claim Timeliness**. Hospital shall adjudicate nine-five percent (95%) of all Clean Claims from Non-Participating Providers or suppliers within thirty (30) calendar days of receiving the claim. Adjudicate a claim shall be deemed to mean to have processed the claim (paid or denied) and mailed the remittance advice by the thirtieth (30^{th}) calendar day since the earliest receipt by Hospital or CalOptima's contracting Providers.

3.1.7 **"60-Day" Claim Timeliness**. Hospital shall pay or deny Unclean Claims from Non-Participating Providers or suppliers, claims from Participating Providers or suppliers, and claims from Medicare fiscal intermediaries and carriers within sixty (60) calendar days of receipt of such claims. Processing shall be deemed to mean either to have paid or denied and mailed the remittance advice by the sixtieth (60^{th}) calendar day since the earliest receipt by Hospital or CalOptima's contracting Providers, or to have denied the claim, and have mailed the denial letter to the Enrollee by the sixtieth (60^{th}) day. In accordance with federal law and CMS regulations, failure to process such claims within sixty (60) calendar days of receipt automatically constitutes an "adverse" initial determination, which the Enrollee may appeal; thus, a denial notice must be mailed to the Enrollee.

3.1.8 **Payment Accuracy**. When paying Non-Participating Providers, Hospital shall employ only those Medicare fee schedules that MA plans are allowed to use by law and shall comply with 42 CFR § 422.214.

3.1.9 **Denied Claims**. Decisions to deny claims that result in liability for the Enrollee must be made in accordance with CMS guidelines. Whenever such decisions are made, the currently CMS approved Notice of Denial of Payment or Integrated Denial Notice must be used, including approved denial reasons. Under no circumstances shall Hospital deny a claim for the second time as a consequence of responding to a request for reconsideration from an Enrollee; instead, Hospital must direct the Enrollee to submit the request directly

to CalOptima as appropriate.

3.2 **Claims for Emergency and Post-Stabilization Services.**

3.2.1 Hospital shall not retroactively deny a claim for Emergency Services because the condition, which appeared to be an Emergency Medical Condition, turned out to be non-emergency in nature. Hospital shall ensure that its claims processing actions do not conflict with Hospital actions required to comply with the Emergency Medical Treatment and Active Labor Act ("**EMTALA**").

3.2.2 If there is a disagreement between Hospital or any Participating Provider and any Non-Participating Provider regarding Medically Necessity of Covered Services in an emergency, the judgment of the attending physician(s) actually caring for the Enrollee at the treating facility shall prevail.

3.2.3 Hospital shall ensure that an enrollee with an Emergency Medical Condition will be seen on an emergency basis and that Emergency Services will be available and accessible within the Service Area twenty-four (24) hours a day. Hospital shall cover Emergency Services without prior Authorization pursuant to Title 28 CCR Section 1300.67(g), Title 22 CCR Section 53216, and Section 1932(b)(2) of the Social Security Act. Hospital shall coordinate access to Emergency Services in accordance with 42 CFR § 438.114 and the Hospital's emergency department protocol.

3.2.4 An Enrollee who has an Emergency Medical Condition may not be held liable for payment of subsequent screening and treatment needed to diagnose the specific condition or Stabilize the Enrollee.

3.2.5 Hospital may not deny payment for treatment obtained under either of the following circumstances: an Enrollee had an Emergency Medical Condition, including cases in which the absence of immediate medical attention would not have had the outcomes specified in the definition of an Emergency Medical Condition; or the Hospital representative instructs the Enrollee to seek Emergency Services. The attending emergency Physician, or the Provider actually treating the Enrollee, is responsible for determining when the Enrollee is sufficiently Stabilized for transfer or discharge, and that determination is binding on the entities as responsible for coverage and payment.

3.2.6 Hospital must cover and pay for Post-Stabilization Care Services. Hospital is financially responsible for Post-Stabilization Care Services obtained within or outside the organization that are pre-approved by a Physician Group Provider or other Hospital representative. Hospital is financially responsible for Post-Stabilization Care Services obtained within or outside the Hospital organization that are not pre-approved by a Participating Provider or other Hospital representative, but are administered to maintain the Enrollee's Stabilized condition within one (1) hour of a request to the Hospital for pre-approval of further Post-Stabilization Care Services. Hospital is financially responsible for Post-Stabilization Care Services obtained from within or outside the Hospital that are not pre-approved by a Participating Provider or other Hospital representative, but administered to maintain, improve, or resolve the Enrollee's Stabilized condition if the Hospital: does not respond to a request for pre-approval within one (1) hour; cannot be contacted; or the Hospital representative and the treating physician cannot reach an agreement concerning the Enrollee's care and a Participating Provider is not available for consultation. In this situation, the Hospital must give the treating Physician the opportunity to consult with a

Participating Provider and the treating Physician may continue with care of the Enrollee until a Participating Provider is reached or one criteria in 42 C.F.R. § 113(c)(3) is met. Hospital must limit charges to Enrollees for Post-Stabilization Care Services to an amount no greater than what the Hospital would charge the Enrollee if he or she had obtained the services through Hospital. Hospital financial responsibility for Post-Stabilization Care Services it has not pre-approved ends when: a Participating Provider with privileges at the treating hospital assumes responsibility for the Enrollee's care; a Participating Provider assumes responsibility for the Enrollee's care through transfer; Hospital representative and the treating Physician reach an agreement concerning the Enrollee's care; or; the Enrollee is discharged.

3.2.7 Hospital shall reimburse those hospitals providing Emergency Services and Urgent Care services with which Hospital has a contract according to the terms of that contract.

3.2.8 Hospital must reimburse a Non-Participating Provider for Emergency Services or Urgent Care services at the prevailing Medicare fee-for-service ("**FFS**") rate as applicable for that service. Where the Covered Service would traditionally be covered under Medicare FFS, the Medicare FFS rate applies. Hospital shall ensure that Enrollees maintain balance billing protections as provided in Section 6.4 of this Contract.

3.3 **Hospital Financial Responsibility**. If CalOptima receives a claim for Covered Services that are the financial responsibility of Hospital, CalOptima shall forward such claim to Hospital for payment, in accordance with the procedures set forth in Title 28 CCR Section 1300.71, "Claims Settlement Practices." CalOptima shall not pay for services that are Hospital's financial responsibility unless Hospital fails to make payment within the time allowed by State and federal laws and regulations, and CalOptima is required by law to make such payment. In such cases, CalOptima, after written notice to Hospital and reasonable opportunity to cure, will make payment, and Hospital shall reimburse CalOptima for such payments. If Hospital fails to reimburse CalOptima, CalOptima may offset an uncontested payment(s) against Capitation Payments or other amounts due from CalOptima to Hospital, if any.

3.4 **Collection of Share of Cost**. Hospital shall collect Medicare share of cost unless prohibited under this Contract.

3.5 **Capitation Payments**. Hospital and/or Downstream Entities shall distribute monthly Capitation Payments to capitated Participating Providers within fifteen (15) calendar days following the date on which Physician receives payment from CalOptima.

3.6 **Claims Adjudication**. Except as provided in Section 3.1.1, Hospital shall accept and adjudicate claims for Covered Services provided to Enrollees in accordance with the provisions of Sections 1371, 1371.1, 1371.2, 1371.22, 1371.35, 1371.36, 1371.37, 1371.38, 1371.4 and 1371.8 of the California Health & Safety Code, and Sections 1300.71, 1300.71.38, 1300.71.4, and 1300.77.4 of Title 28 of the CCR and CalOptima Policies. Waiver of any right or obligation specific to the Health and Safety Code and Title 28 related to claims processing and payment shall be prohibited.

3.7 **Dispute Resolution.** Hospital shall establish and maintain a fair, fast and cost-effective dispute resolution mechanism to process and resolve provider disputes in accordance with the provisions of Sections 1371, 1371.1, 1371.2, 1371.22, 1371.35, 1371.36, 1371.37, 1371.38, 1371.4 and 1371.8 of the California Health & Safety Code, and Sections 1300.71, 1300.71.38, 1300.71.4, and 1300.77.4 of Title 28 of the CCR and CalOptima Policies.

3.8 **Right of Appeal**. Hospital shall afford Providers an unconditional right of appeal and de novo review for claims disputes involving issues of Medical Necessity. Any Provider that submits a claim dispute to Hospital's dispute resolution mechanism involving an issue of Medical Necessity or utilization review shall have an unconditional right of appeal for that claim dispute to CalOptima's dispute resolution process for a de novo review and resolution for a period of sixty (60) working days from Physician's Date of Determination.

3.9 **CalOptima Payment On Behalf Of Physician**. If CalOptima receives a copy of an unpaid Clean Claim as part of a Provider grievance that is thirty (30) working days old or more, CalOptima will follow all notification and acknowledgement procedures pursuant to CalOptima Policies. If Hospital does not either notify CalOptima that the claim is reasonably contested, as set forth in CalOptima Policies, or pay the Clean Claim within the thirty (30) working day period, CalOptima shall pay the Claim on behalf of Physician, plus interest, as required by the Knox-Keene Act, and deduct the amounts reimbursed, plus processing costs, from the Capitation Payment, in accordance with CalOptima Policies.

3.10 **Quarterly Claims Payment Performance Report.**

3.10.1 Hospital shall submit, in a format specified by CalOptima Policies, a quarterly claims payment performance report ("**Quarterly Claims Report**") to CalOptima within thirty (30) calendar days of the close of each calendar quarter. The Quarterly Claims Report shall, at a minimum, disclose Hospital's compliance status with Sections 1371, 1371.1, 1371.2, 1371.22, 1371.35, 1371.36, 1371.37, 1371.4, and 1371.8 of the California Health and Safety Code and Sections 1300.71, 1300.71.38, 1300.71.4 and 1300.77.4 of Title 28 of the CCR.

3.10.2 Hospital shall ensure that each Quarterly Claims Report is signed by, and includes the written verification of, a principal officer, as defined by Section 1300.45(o) of Title 28 of the CCR, of Hospital, stating that the report is true and correct to the best knowledge and belief of the principal officer.

3.10.3 Hospital's Quarterly Claims Report shall include a tabulated record of each Provider dispute it received, categorized by date of receipt, and including the identification of the Provider, type of dispute, disposition and working days to resolution, as to each Provider dispute received. Each individual dispute contained in a Provider's bundled notice of Provider dispute shall be reported as a separate dispute to CalOptima.

3.11 **Forwarding of Misdirected Claims.**

3.11.1 Hospital shall have the ability to receive a standard ANSI 837I and ANSI 837P claim file format for retrieving misrouted claims that are the financial responsibility of the Hospital. Hospital will receive and forward misdirected claims per CalOptima Policy.

3.11.2 Hospital shall have the ability to create a standard ANSI 837I and ANSI 837P claim file for forwarding claims that are the financial responsibility of CalOptima within ten (10) working days of receipt of the claim. CalOptima shall receive these files per CalOptima policy and load them into its system to ensure timely claims processing. Hospital shall forward any claims that are not its payment responsibility to CalOptima within eight (8) calendar days of receipt, so that a total of only ten (10) working days will elapse prior to the claims being in the proper hands.

3.12 **Assumption of Delegated Functions**. In the event that Hospital fails to timely and accurately reimburse its claims (including the payment of interest and penalties), CalOptima may, at its sole discretion, revoke the delegation and assume responsibility from Hospital for claims payment, or terminate this Contract as provided for in Article XI. CalOptima's assumption of responsibility for the processing and timely reimbursement of Provider claims may be altered to the extent that Hospital has established an approved CAP consistent with Section 1375.4 (b)(4) of the Health and Safety Code and Section 11.3 of the Contract.

3.13 **Recoupment for Assumption of Claims Processing Obligations**. CalOptima, in its sole and absolute discretion, may reduce Hospital's Capitation Payments to recoup additional administrative costs for the assumption of the claims processing obligations of Hospital, as described in this Article III of Attachment D, as well as any amounts, including interest due, on claims unpaid at the assumption of such obligations by CalOptima.

IV. CLAIMS COMPLIANCE

4.1 **Claims Compliance Monitoring**. Hospital understands that claims compliance programs are required by CalOptima's Regulators and agrees that delegation is contingent upon Hospital's compliance with required monitoring and oversight activities, as outlined in CalOptima Policies. Hospital agrees that CalOptima reserves the right to monitor Hospital's claims compliance activities, notwithstanding any other audit, compliance, or contractual issue between Hospital and CalOptima. In the event Hospital demonstrates an inability to meet CalOptima's claims payment standards, CalOptima reserves the right to revoke and assume the delegated responsibilities described above.

4.2 **Claims Non-Compliance**. In the event that CalOptima determines that Hospital is not in ninety-five percent (95%) compliance with any of the requirements of Attachment D the following actions will be applied:

4.2.1 Within thirty (30) days of an audit that documents non-compliance, CalOptima will issue a written warning to Hospital that describes the non-compliance. Hospital will respond within fifteen (15) working days of receiving the non-compliance notification with a written CAP to comply. Such CAP will describe the actions to be taken and the schedule by which those actions will be completed. CalOptima will review the CAP and advise Hospital whether or not actions or time schedules are acceptable within fifteen (15) days of receiving it. CalOptima will conduct a follow-up audit of Hospital's claims operation within ninety (90) days from the date of serving the non-compliance notification to verify compliance with Attachment D. If CalOptima does not receive a CAP within fifteen (15) calendar days, the consequences outlined in Subsection 4.2.2 of this attachment for continued non-compliance will apply.

4.2.2 If, as a result of CalOptima's follow-up audit, Hospital is found to still be non-compliant with Attachment D within fifteen (15) calendar days of making that determination, CalOptima will notify Hospital in writing of the continued non-compliance and may elect to provide consultative or other assistance to help establish, maintain and monitor continued administrative compliance or assume "joint administration" of Hospital's claims operations, involving itself only with Enrollees' claims and allowing the operation to remain on Hospital's premises. The Parties agree to meet and develop a mutually agreeable work plan for added staffing and work stations, the cost of which will be Hospital's sole responsibility. CalOptima will develop a CAP with Hospital's participation to assure maximum compatibility with Hospital's ongoing operations. CalOptima will cooperate

with Hospital in implementing changes across all risk claims processed at that site, should Hospital so request. Within fifteen (15) calendar days of receiving the second notice of non-compliance, Hospital will provide a written response stating the specific action to be taken to establish compliance with the help of CalOptima. If CalOptima does not receive a CAP within fifteen (15) calendar days, the consequences outlined in Subsection 4.2.3 for continued non-compliance will apply. Within ninety (90) days from the date of serving the second notice of non-compliance, CalOptima will re-audit Hospital's claims process and documents to determine final compliance or non-compliance.

4.2.3 If, as a result of its second follow-up audit, CalOptima reasonably determines that Hospital is still non-compliant, CalOptima reserves the right to terminate this Contract for material breach upon ten (10) days' prior written notice and opportunity to cure.

4.2.4 Hospital may resume sole administrative responsibility for claims processing if CalOptima determines that Hospital has corrected the deficiencies that caused the non-compliance, and, as a result of resuming responsibility for claims processing, demonstrates compliance with the timely provider payments requirements set forth in Section 3.1 of this Attachment D.

4.2.5 With respect to the requirements of Attachment D, Hospital will be subject to regular site-audits conducted by CalOptima to monitor all claims requirements.

V. CLAIMS FORWARDING

Hospital shall forward any claims that are not its payment responsibility to CalOptima within ten (10) calendar days of receipt.

VI. SELF-MONITORING & REPORTING

Hospital shall develop, implement and demonstrate upon request, a claims quality assurance process, including regular, scheduled, automated, or manual reports, self-testing procedures, and internal reporting to Hospital's executive management of timeliness, payment accuracy, and denial accuracy (as required herein). Such self-monitoring and internal reporting shall involve use of industry standard tools and shall measure actual performance against the standards for DMHC and CMS compliance. CalOptima strongly recommends check issuance and mailing occur not less frequently than weekly and that Hospital's internal reporting intervals match the intervals at which checks are issued, except that weekly reporting would be sufficient if checks are issued more often than weekly. At a point early in the beginning of operations under the Contract and in accordance with industry-wide CMS requirements, CalOptima will require that Hospital submit monthly reports to CalOptima using the industry-standard Monthly Report of Claims Processing Timeliness and Overall Percent of Denial Accuracy format. Those reports must be received by CalOptima not later than the fifteenth (15th) calendar day of each month.

VII. AUDITS & AUDIT PREPARATION

Article IV, above, provides detailed, specific processes involving claims non-compliance. Even when Hospital does meet compliance standards and successfully concludes any time periods where denials must be submitted to CalOptima for review, CalOptima will continue to schedule (1) periodic audits, (2) random, focused audits, and (3) focused reviews based on appeals and grievance results to monitor Hospital's compliance with CMS regulations. Prior to the scheduled arrival of CalOptima's auditor, Hospital shall retrieve claims and related documents in accordance with instructions provided to Hospital by CalOptima in its letter confirming the appointment.

VIII. SPECIAL STUDIES

8.1 In the event DMHC and/or CMS requires that CalOptima conduct any special compliance study or effort, Hospital shall support the study and will be subject to any DMHC and/or CMS specified time schedules or deadlines for corrective actions.

IX. FEDERALLY QUALIFIED HEALTH CENTERS AND RURAL HEALTH CLINICS

9.1 Hospital shall meet federal requirements for access to FQHC services, including those in 42 U.S.C. § 1396 b(m). Hospital shall reimburse FQHCs and RHCs in accordance with current Laws. If FQHC and RHCs services are not available in the Provider network, Hospital shall authorize out-of-network services subject to the prevailing MA payment requirements for out-of-network services.

9.2 Hospital shall ensure that its payments to FQHCs and RHCs for services to Enrollees are no less than the sum of the level and amount of payment that the Health Network or CalOptima would make for such services if the services had been furnished by an entity providing similar services that was not an FQHC and RHC. The intent of these provisions is to ensure that Hospital pays FQHCs and RHCs amounts consistent with Medicare managed care policies while preserving the opportunity for FQHCs to separately claim supplemental payments under such policies.

X. INDIAN HEALTH CARE PROVIDERS

10.1 Hospital shall pay non-network Indian Health Care Providers that are FQHCs for the provision of services to an Indian Enrollee at a rate equal to the rate that Hospital would pay to a network FQHC that is not an Indian Health Care Provider, including any supplemental payment from the State to make up the difference between the contract amount and what the Indian Health Care Provider would have received FFS.

10.2 When the amount the Participating Provider Indian Health Care Provider receives from the Hospital is less than the amount the Indian Health Care Providers would receive FFS, the State must make a supplemental payment to the Indian Health Care Provider that the Indian Health Care Provider would receive FFS or the applicable encounter rate.

10.3 Hospital shall not impose enrollment fees, premiums, or similar charges on Indians served by an Indian Health Care Provider or through referral under contract health services. Hospital must exempt from all cost-sharing any Indian who is currently receiving or has ever received an item or service furnished by an Indian Health Care Provider or through referral under contract health services.

10.4 Hospital shall reimburse Indian Health Care Providers promptly who provide Covered Services to Indian Enrollees, who are eligible to receive Covered Services, at the most current and applicable outpatient per-visit rate published in the Federal Register by the Indian Health Service, and Hospital shall ensure any retroactive outpatient per visit rates are appropriately reimbursed to the Indian Health Care Provider.

ATTACHMENT E
STATUTORY AND REGULATORY COMPLIANCE TERMS

1. **Compliance with State and Federal Laws**. Hospital acknowledges that CalOptima is subject to certain State and federal laws, regulations, and instructions governing its MA Program. Hospital shall comply with all Laws and DMHC and CMS administrative bulletins, plan letters and instructions. Hospital understands that payments made by CalOptima are, in whole or in part, derived from federal funds, and therefore Hospital and any Downstream Entities are subject to certain laws that are applicable to individuals and entities receiving federal funds, including the following: (i) Title VI of the Civil Rights Act of 1964; (ii) Sections 503 and 504 of the Rehabilitation Act of 1973; (iii) the Age Discrimination Act of 1975; (iv) the Americans with Disabilities Act of 1990; (v) the Vietnam Era Veteran's Readjustment Assistance Act; and (vi) Title IX of the Education Amendments of 1972. Any provision required to be in this Contract by the CMS Contract, the Knox-Keene Act, Title 28 of the California Code of Regulations, Medicare laws and regulations, DMHC or CMS instructions and reporting requirements and other applicable laws, shall bind CalOptima, Hospital, and Downstream Entities, whether or not specifically set forth in this Contract.

2. **Compliance with CalOptima's Contractual Obligations**. All services and other activities furnished by Hospital and Downstream Entities must be performed in accordance with CalOptima's contractual obligations to CMS.

3. **Compliance with FWA Requirements**. Hospital, and its employees, agents and Downstream Entities performing services under this Contract, shall comply with CalOptima's Compliance Program including, its FWA plan. Prior to performing services under this Contract, Hospital shall complete and submit to CalOptima, any CMS-required training and/or CalOptima-required attestations related to such training and other compliance obligations. Hospital agrees to comply and will have any Downstream Entity agree to comply with CalOptima standards and policies.

4. **Fraud and Abuse Reporting**. Hospital shall, in accordance with all Laws, report to CalOptima all cases of suspected fraud and/or abuse relating to the rendering of Covered Services within five (5) days of the date when Hospital first becomes aware of or is on notice of such activity.

5. **CMS Participation Requirements**. Hospital represents and warrants that: (i) neither Hospital nor any of its Downstream Entities, employees or agents furnishing services under this Contract are excluded from participating in any federal or state healthcare program as defined in 42 U.S.C. Section 1320a-7b(f) ("**Federal Health Care Program(s)**"); (ii) Hospital has not arranged or contracted (by employment or otherwise) with any employee, contractor or agent that Hospital knows or should know are excluded or precluded from participation in Federal Health Care Programs; (iii) no action is pending against Hospital or any of its Downstream Entities, employees, or agents performing services under this Contract to suspend or exclude such persons or entities from participation in any Federal Health Care Program; and (iv) Hospital will immediately notify CalOptima if it learns that it is or has employed or contracted with a person or entity that is excluded from participation in any Federal Health Care Program. If Hospital fails to comply with this Section 5 of this attachment, CalOptima reserves the right to require Hospital to pay immediately to CalOptima the amount of any sanctions or other penalties that may be imposed on CalOptima by CMS for violation of this prohibition, and Hospital shall be responsible for any resulting overpayments. Hospital shall not make payment for a healthcare item or service furnished by an individual or entity that is excluded by the Office of the Inspector General or is included on the Preclusion List. Hospital shall provide written notice to the Enrollee who received the services and the excluded Provider or Provider listed on the Preclusion List that payment will not be made, in

accordance with CMS requirements. Hospital shall ensure that all Participating Providers that provide Covered Services do not appear on the CMS Preclusion List in order to receive reimbursement for claims or otherwise participate in the Medicare program.

6. **Confidentiality of Enrollee Information**. Hospital, its Downstream Entities, and their employees and agents shall comply with the specific confidentiality obligations set forth below.

6.1 Hospital, Downstream Entities, and their employees and agents 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 them as a result of services performed under this Contract, except for statistical information not identifying any such person. Hospital, Downstream Entities, and their employees and agents shall not use such identifying information for any purpose other than carrying out Hospital's obligations under this Contract.

6.2 Hospital, Downstream Entities, and their employees and agents shall promptly transmit to CalOptima all requests for disclosure of such identifying information not emanating from the Enrollee. Hospital shall not disclose, except as otherwise specifically permitted by this Contract or authorized by the Enrollee, any such identifying information to anyone other than CMS, DMHC, 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.

6.3 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*., Welfare and Institutions Code Section 14100.2, and regulations adopted thereunder. For the purpose of this Contract, all information, records, data, and data elements collected and maintained for the operation of the Contract and pertaining to Enrollees shall be protected by Hospital from unauthorized disclosure. Hospital may release Medical Records in accordance with Laws pertaining to the release of this type of information. Hospital is not required to report requests for Medical Records made in accordance with Laws.

6.4 With respect to any identifiable information concerning an Enrollee under this Contract that is obtained by Hospital or its Downstream Entities from CalOptima's Regulators, Hospital will, at the termination of this Contract, return all such information to CalOptima's Regulators if required by them, or maintain such information according to written procedures provided to Hospital by CalOptima and/or CalOptima's Regulators for this purpose.

7. **Offshore Subcontracts**. Hospital shall provide, and ensure that Downstream Entities provide, to CalOptima information and attestations related to the provision of any services under this Contract in a country other than the United States ("**Offshore Subcontractor**") to enable CalOptima to comply with CMS reporting obligations. Such information shall be submitted to CalOptima prior to engaging any Offshore Subcontractor for purposes of this Contract, and such Offshore Subcontractors are subject to approval by CalOptima.

8. **Required Disclosures**. In accordance with 42 CFR Section 1002.3, Hospital shall immediately notify CalOptima in the event any sanctioned person (as defined in 42 CFR Section 1001.1001(a)(1)) owns or controls Hospital.

9. **Equal Opportunity**. Hospital and Downstream Entities shall comply with the following Equal Opportunity requirements set forth below.

9.1 Hospital and its Downstream Entities 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. Hospital and its Downstream Entities will take affirmative action to ensure that qualified applicants are employed, and that employees are treated during employment, without regard to their race, color, religion, sex, national origin, physical or mental handicap, disability, age, or status as a disabled veteran or veteran of the Vietnam era. Such action shall include the following: Employment, upgrading, demotion or transfer; recruitment or recruitment advertising; layoff or termination; rates of pay or other forms of compensation; and career development opportunities and selection for training, including apprenticeship. Physician and its Downstream Entities agree to post in conspicuous places, available to employees and applicants for employment, notices to be provided by the federal government, 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 Hospital and its Downstream Entities' 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.

9.2 Hospital and its Downstream Entities will, in all solicitations or advancements for employees placed by or on behalf of Hospital and its Downstream Entities, 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.

9.3 Hospital and its Downstream Entities will send to each labor union or representative of workers with which it has a collective bargaining agreement or other contract or understanding a notice, to be provided by the federal government or the State, advising the labor union or workers' representative of Hospital and its Downstream Entities' commitments under the provisions herein and shall post copies of the notice in conspicuous places available to employees and applicants for employment.

9.4 Hospital and its Downstream Entities 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.

9.5 Hospital and its Downstream Entities 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 Hospital 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.

9.6 In the event of Hospital and its Downstream Entities' noncompliance with the requirements of the provisions herein or with any federal rules, regulations, or orders which are referenced in this Article IX, this Contract may be cancelled, terminated, or suspended in whole or in part, and Hospital and its Downstream Entities may be declared ineligible for further State and Federal 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.

9.7 Hospital and its Downstream Entities will include the provisions of Sections 10.1 through 10.7 of this attachment 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. Section 4212) of the Vietnam Era Veteran's Readjustment Assistance Act, so that such provisions will be binding upon each Downstream Entity. Physician and its Downstream Entities will take such action with respect to any subcontract or purchase order as the Director of the Office of Federal Contract Compliance Programs or CMS may direct as a means of enforcing such provisions, including sanctions for noncompliance; provided, however, that in the event Hospital and/or its Downstream Entities become involved in, or are threatened with litigation by a other Downstream Entity or vendor as a result of such direction by CMS, Hospital and its Downstream Entities may request in writing to CMS, 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.

10. **Non-Discrimination**. Hospital and Downstream Entities shall comply with the non-discrimination requirements set forth below.

10.1 During the performance of this Contract, neither Hospital nor any Downstream Entities shall unlawfully discriminate, harass, or allow harassment against any employee or applicant for employment because of sex, race, religion, color, national origin, ancestry, religious creed, physical disability, (including Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS), AIDS-Related Complex (ARC)), medical condition (including cancer), mental disability, marital status, age (over 40), or the use of family and medical care leave and pregnancy disability leave. Hospital and

Downstream Entities shall insure that the evaluation and treatment of their employees and applicants for employment are free of such discrimination and harassment. Hospital and Downstream Entities shall comply with the provisions of the Fair Employment and Housing Act (Government Code, Section 12900, *et seq*.) and the applicable regulations promulgated thereunder (Title 2 CCR Section 7285.0, *et seq*.). The applicable regulations of the Fair Employment and Housing Commission implementing Government Code, Section 12990, set forth in Chapter 5 of Division 4 of Title 2 of the CCR are incorporated into this Contract by reference and made a part hereof as if set forth in full. Hospital and Downstream Entities shall give written notice of their obligations under this clause to labor organizations with which they have a collective bargaining or other agreement. Hospital shall include the non-discrimination and compliance provisions of this Section 10.1 in all Downstream Entity subcontracts to perform work under this Contract.

10.2 Hospital and all Downstream Entities shall abide by 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 1972 (regarding education programs and activities); Title 45 CFR Part 91 and the Age Discrimination Act of 1975 (discrimination based on age); and all other laws regarding privacy and confidentiality. Neither the Physician nor Downstream Entities shall discriminate against Enrollees because of race, color, creed, religion, ancestry, marital status, sexual orientation, national origin, age, sex, or physical or mental handicap in accordance with Title VI of the Civil Rights Act of 1964, 42 U.S.C., Section 2000d (race, color, national origin); 45 CFR Part 84 (physical or mental handicap); Government Code Section 11135 (ethnic group identification, religion, age, sex, color, physical or mental handicap); Civil Code Section 51 (all types of arbitrary discrimination); rules and regulations promulgated pursuant thereto, or as otherwise provided by Laws.

10.3 For the purpose of this Contract, if based on any of the foregoing criteria, the following constitute unlawful discriminations: (i) denying any Enrollee any Covered Services or availability of a facility; (ii) providing to an Enrollee any Covered Service that is different or is provided in a different manner or at a different time from that provided to other similarly situated Enrollees under this Contract, except where medically indicated; (iii) subjecting an Enrollee to segregation or separate treatment in any manner related to the receipt of any Covered Service; (iv) restricting an Enrollee in any way in the enjoyment of any advantage or privilege enjoyed by others receiving any Covered Service; or (v) treating an Enrollee differently from others similarly situated in determining compliance with admission, enrollment, quota, eligibility, or other requirements or conditions that individuals shall meet in order to be provided any Covered Service or assigning the times or places for the provision of Covered Services.

10.4 Hospital shall take affirmative action to ensure that all Enrollees are provided Covered Services without unlawful discrimination, except where medically indicated. For the purposes of this Section 10.4, physical handicap includes the carrying of a gene that may, under some circumstances, be associated with disability in that person's offspring, but which causes no adverse effects on the carrier. Such genetic handicap shall include, but not be limited to, Tay-Sachs trait, sickle cell trait, thalassemia trait, and X-linked hemophilia.

10.5 Physician shall act upon all complaints alleging discrimination against Enrollees in accordance with CalOptima's Policies and shall forward copies of all such grievances to CalOptima within five (5) days of receipt of same.

11. **Smoke Free Workplace**. Public Law 103-227, also known as the Pro Children Act of 1994 ("**Pro Children Act**"), requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health, day care, early childhood development services, education, or library services to children under the age of 18, if the services are funded by federal programs either directly or through state or local governments, by federal grant, contract, loan, or loan guarantee. The law also applies to children's services that are provided in indoor facilities that are constructed, operated, or maintained with such federal funds. The law does not apply to children's services provided in private residences; portions of facilities used for inpatient drug or alcohol treatment; service providers whose sole source of applicable federal funds is Medicare or Medicaid; or facilities where WIC coupons are redeemed. Failure to comply with the provisions of the law may result in the imposition of a civil monetary penalty of up to $1,000 for each violation and/or the imposition of an administrative compliance order on the responsible party. By signing this Contract, Hospital certifies that it will comply with the requirements of the Pro Children Act and will not allow smoking within any portion of any indoor facility used for the provision of services for children as defined by the Pro Children Act. Physician further agrees that it will insert this certification into any subcontracts entered into that provide for children's services as described in the Pro Children Act.

12. **Air or Water Pollution Requirements**. Any federally funded agreement and/or subcontract in excess of $100,000 must comply with the following provisions unless said agreement is exempt under 40 CFR 15.5. Hospital 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.

13. **Lobbying Restrictions and Disclosure Certification**. Any federally funded contracts in excess of $100,000 per Section 1352 of the 31, U.S.C. must comply with the following lobby restrictions and disclosures.

13.1 Each person (or recipient) who requests or receives a contract, subcontract, grant, or sub-grant, which is subject to 31 U.S.C. Section 1352 and which exceeds $100,000 at any tier, shall file a certification (in the form set forth in **Attachment E-1**, consisting of one page, entitled "Certification Regarding Lobbying") that the recipient has not made, and will not make, any payment prohibited by Subsection 13.6 of this attachment.

13.2 Each recipient shall file a disclosure (in the form set forth in **Attachment E-2**, entitled "Standard Form-LLL 'Disclosure of Lobbying Activities'") if such recipient has made or has agreed to make any payment using non-appropriated 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 Section 13.6 of this attachment if paid for with appropriated funds.

13.3 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 Section 13.2 of this attachment. An event that materially affects the accuracy of the information reported includes: (i) 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; (ii)

a change in the person(s) or individuals(s) influencing or attempting to influence a covered federal action; or (iii) 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.

13.4 Each person (or recipient) who requests or receives, from a person referred to in Section 13.1 of this attachment, a contract, subcontract, grant or sub-grant 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.

13.5 All disclosure forms (but not certifications) shall be forwarded from tier to tier until received by the person referred to in Section 13.1 of this attachment.

13.6 31 U.S.C. Section 1352 provides in part that no appropriated funds may be expended by the recipient of a federal contract, grant, loan, or cooperative agreement to pay any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with any of the following covered federal actions: the awarding of any federal contract, the making of any federal grant, the making of any federal loan, entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any federal contract, grant, loan, or cooperative agreement.

14. **Debarment Certification**. Hospital agrees to comply with applicable Federal suspension and debarment regulations including 7 CFR § 3017, 45 CFR §76, 40 CFR § 32, or 34 CFR § 85.

14.1 Hospital certifies to the best of its knowledge and belief, that it and its principals:

(i) Are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded by any Federal department or agency;

(ii) Have not within a three (3)-year period preceding this Contract have been convicted of or had a civil judgment rendered against them for commission of fraud or a criminal offense in connection with obtaining, attempting to obtain, or performing a public (Federal, State or local) transaction or contract under a public transaction; violation of Federal or State antitrust statutes or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, or receiving stolen property;

(iii) Are not presently indicted for or otherwise criminally or civilly charged by a governmental entity (federal, State or local) with commission of any of the offenses enumerated in sub-provision (ii) herein;

(iv) Have not within a three (3)-year period preceding this Contract had one or more public transactions (Federal, State or local) terminated for cause or default;

(v) Shall not knowingly enter into any lower tier covered transaction with a person who is proposed for debarment under Federal regulations (i.e., 48 CFR 9, subpart 9.4), debarred, suspended, declared ineligible, or voluntarily excluded from participation in such transaction, unless authorized by the State; and

(vi) Will include a clause entitled, "Debarment and Suspension Certification'' that essentially sets forth the provisions herein, in all lower tier covered transactions and in all solicitations for lower tier covered transactions.

14.2 If Hospital is unable to certify to any of the statements in this certification, the Physician shall submit an explanation to CalOptima.

14.3 The terms and definitions in this Section 14 have the meanings set out in the Definitions and Coverage sections of the rules implementing Federal Executive Order 12549.

14.4 If Hospital knowingly violates this certification, in addition to other remedies available to the federal government, CalOptima may terminate this Contract for cause or default.

15. **Downstream Entity Contracts**. If any services under this Contract are to be provided by a Downstream Entity subcontracted by Hospital, Hospital shall ensure that such subcontracts comply with 42 CFR Sections 422.504, 423.505 and 438.6(l). Such subcontracts shall include all language required by CMS as provided in Attachment F**.**

16. **Other Statutory and Compliance Terms**. Hospital shall not contract with, or otherwise pay for any items or services (other than an emergency item or service, not including items or services furnished in an emergency room of a hospital):

16.1 Furnished by Hospital by any individual or entity during any period when the individual or entity is excluded from participation under Titles V, XVIII, or XX, or under Title XIX pursuant to sections 1128, 1128A, 1156 or 1842(j)(2);

16.2 Furnished at the medical direction or the prescription of a physician, during the period when such physician is excluded from participation under Titles V, XVIII, or XX, or under Title XIX pursuant to sections 1128, 1128A, 1156, or 1842(j)(2) and when the person furnishing such item or service knew, or had some reason to know, of the exclusion (after a reasonable time period and after reasonable notice has been furnished to the person);

16.3 Furnished by an individual or entity to whom the State has suspended payments to during any period when there is a pending investigation of a credible allegation of fraud against the individual or entity, unless the State determines there is good cause not to suspend such payments;

16.4 Hospital may not pay for an item or service with respect to any amount expended for which funds may not be used under the Assisted Suicide Funding Restriction Act of 1997

ATTACHMENT E-1
CERTIFICATION REGARDING LOBBYING

STATE OF CALIFORNIA
DEPARTMENT OF HEALTH CARE SERVICES
CERTIFICATIN 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 Hospital	Printed Name of Person Signing for Hospital
Contract / Grant Number	Signature of Person Signing for Hospital
Date	Title

After execution by or on behalf of Hospital, please return to:

CalOptima
Attn: Regulatory Affairs
505 City Parkway West
Orange, California 92868

ATTACHMENT E-2

CERTIFICATION REGARDING LOBBYING

Approved by OMB

Complete this form to disclose lobbying activities pursuant to 31 U.S.C. 1352
0348-0046 (See reverse for public burden disclosure)

<table>
<tr><td>1. Type of Federal Action:
contract
grant
cooperative agreement loan
loan guarantee
loan insurance</td><td>2. Status of Federal Action:
bid/offer/application initial
award post-award</td><td>3. Report Type:
initial filing
material change

For Material Change Only:
Year _____ quarter_____
date of last report</td></tr>
<tr><td colspan="2">4. Name and Address of Reporting Entity:
Prime Subawardee Tier, if known:</td><td rowspan="2">5. If Reporting Entity in No. 4 is Subawardee, Enter Name and Address of Prime:

Congressional District, If known:</td></tr>
<tr><td colspan="2">Congressional District, If known:</td></tr>
<tr><td colspan="2">6. Federal Department/Agency:</td><td>Federal Program Name/Description:
CDFA Number, if applicable:</td></tr>
<tr><td colspan="2">8. Federal Action Number, if known:</td><td>9. Award Amount, if known:</td></tr>
<tr><td colspan="2">10. a. Name and Address of Lobbying Entity
(If individual, last name, first name, MI):
(attach Continuation Sheets(s)</td><td>b. Name and Address of Lobbying Entity
(If individual, last name, first name, MI):
SF-LLL-A, If necessary)</td></tr>
<tr><td colspan="2">Amount of Payment (check all that apply):
$ actual planned</td><td rowspan="3">13. Type of Payment (check all that apply):
a. retainer
b. one-time fee
c. commission
d. contingent fee
e. deferred
f. other, specify:</td></tr>
<tr><td colspan="2">Form of Payment (check all that apply):
a. cash
b. in-kind, specify: Nature</td></tr>
<tr><td colspan="2">Value</td></tr>
</table>

14. Brief Description of Services Performed or to be Performed and Dates(s) of Service, including Officer(s), Employee(s), or Member(s) Contracted for Payment indicated in item 11: (Attach Continuation Sheet(s) SF-LLL-A, If necessary)	
15. Continuation Sheet(s) SF-LLL-A Attached: Yes No	
16. Information requested through this form is authorized by Title 31, U.S.C., Section 1352. This disclosure of lobbying activities is a material representation of fact upon which reliance was placed by the tier above when this transaction was made or entered into. This disclosure is required pursuant to Title 31, U.S.C., Section 1352. This information will be reported to the Congress semiannually and will be available for public inspection. Any person who fails to file the required disclosure shall be subject to a civil penalty of not less than $19,000 and not more than $100,000 for each such failure.	Signature: Print Name: Title: Telephone No.: Date:
Federal Use Only	

INSTRUCTIONS FOR COMPLETION OF SF-LLL, DISCLOSURE OF LOBBYING ACTIVITIES

This disclosure form shall be completed by the reporting entity, whether subawardee or prime federal recipients at the initiation or receipt of a covered federal action, or a material change to a previous filing, pursuant to Title 31, U.S.C., Section 1352. The filing of a form is required for each payment or agreement to make payment to any lobbying entity for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with a covered federal action. Use the SF-LLL-A Continuation Sheet for additional information if the space on the form is inadequate. Complete all items that apply for both the initial filing and material change report. Refer to the implementing guidance published by the Office of Management and Budget for additional information.

Identify the type of covered federal action for which lobbying activity is and/or has been secured to influence the outcome of a covered federal action.

Identify the status of the covered federal action.

Identify the appropriate classification of this report. If this is a follow-up report caused by a material change to the information previously reported, enter the year and quarter in which the change occurred. Enter the date of the last previously submitted report by this reporting entity for this covered federal action.

Enter the full name, address, city, state, and ZIP code of the reporting entity. Include Congressional District, if known. Check the appropriate classification of the reporting entity that designates if it is, or expects to be, a prime or subaward recipient. Identify the tier of the subawardee, e.g., the first subawardee of the prime is the 1st tier. Subawards include but are not limited to subcontracts, subgrants, and contract awards under grants.

If the organization filing the report in Item 4 checks "Subawardee," then enter the full name, address, city, state, and ZIP code of the prime federal recipient. Include Congressional District, if known.

Enter the name of the federal agency making the award or loan commitment. Include at least one organizational level below agency name, if known. For example, Department of Transportation United States Coast Guard.

Enter the federal program name or description for the covered federal action (Item 1). If known, enter the full Catalog of Federal Domestic Assistance (CDFA) number for grants, cooperative agreements, loans, and loan commitments.

Enter the most appropriate federal identifying number available for the federal action identified in Item 1 (e.g., Request for Proposal (RFP) number; Invitation for Bid (IFB) number; grant announcement number; the contract grant, or loan award number; the application/proposal control number assigned by the federal agency). Include prefixes, e.g., "RFP-DE-90401."

For a covered federal action where there has been an award or loan commitment by the federal agency, enter the federal amount of the award/loan commitment for the prime entity identified in Item 4 or 5.

10. (a) Enter the full name, address, city, state, and ZIP code of the lobbying entity engaged by the reporting entity identified in Item 4 to influence the covered federal action.

10. (b) Enter the full names of the Individual(s) performing services and include full address if different from 10.(a). Enter last name, first name, and middle initial (MI).

Enter the amount of compensation paid or reasonably expected to be paid by the reporting entity (Item 4) to the lobbying entity (Item 10). Indicate whether the payment has been made (actual) or will be made (planned). Check all boxes that apply. If this is a material change report, enter the cumulative amount of payment made or planned to be made.

Check the appropriate box(es). Check all boxes that apply. If payment is made through an in-kind contribution, specify the nature and value of the in-kind payment.

Check the appropriate box(es). Check all boxes that apply. If other, specify nature.

Provide a specific and detailed description of the services that the lobbyist has performed, or will be expected to perform, and the date(s) of any services rendered. Include all preparatory and related activity, not just time spent in actual contact with federal officials, identify the federal official(s) or employee(s) contacted or the officer(s), employee(s), or Member(s) of Congress that were contacted.

Check whether or not a SF-LLL-A Continuation Sheet(s) is attached.

The certifying official shall sign and date the form, print his/her name, title, and telephone number.

Public reporting burden for this collection of information is estimated to average 30 minutes per response, including time for reviewing instruction, searching existing data sources, gathering and maintaining the data needed, and completing and renewing the collection of information. Send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to the Office of Management and Budget, Paperwork Reduction Project, (0348-0046), Washington, DC 20503.

ATTACHMENT F
SUBCONTRACT REGULATORY TERMS

A. **General Terms**: Language addressing the following matters shall be included in Downstream subcontracts:

1. The right of CalOptima's Regulators to monitor, audit, evaluate, inspect and have access to books, records and other information as provided in this Contract.
2. CalOptima's Regulators' right to inspect, evaluate, and audit any pertinent information related to the Contract for a period of ten (10) years from the final date of the contract period or from the date of completion of any audit as provided in this Contract.
3. Prohibitions against holding Enrollees liable for payment of any fees that are the obligation of CalOptima or the Hospital, as applicable.
4. The services are in accordance with CalOptima's obligations to CMS and applicable CalOptima Policies.
5. The obligations of Downstream Entities to protect Enrollee privacy and confidentiality including health records, as provided in this Contract.
6. The obligation to comply with all federal and state laws, regulations and CMS instructions, including those laws that must be incorporated into such Downstream subcontracts as indicated in this Contract.
7. Language related to the obligations to submit timely and accurate Encounter Data and other data and reports required by CalOptima and CalOptima's Regulators as provided in this Contract and in CalOptima's Policies.
8. All requirements included in Attachment E not expressly addressed herein.

B. **Delegation Terms**. If, and to the extent that sub-delegation is permitted by CalOptima and Hospital obtains CalOptima's approval as provided in this Contract, Downstream Entity subcontracts must include:

1. Language that specifies (i) the delegated activities and reporting requirements; (ii) that provides for revocation of the delegated activities and other remedies in the event CalOptima or CalOptima's Regulators find that the delegated party as not performed satisfactorily; (iii) that the performance of the parties is monitored by CalOptima on an ongoing basis; and (iv) that CalOptima may impose corrective action as necessary.
2. If the subcontract relates to credentialing of medical providers, language that the credentials of medical professionals affiliated with the party or parties will either be reviewed by CalOptima or the credential process will be reviewed and approved by CalOptima and that CalOptima must audit the process on an ongoing basis.
3. If the subcontract delegates selection of providers it must include language that CalOptima retains the right to approve, suspend or terminate any such arrangement and that CalOptima shall provide a written statement to a provider of the reason or reasons for the termination with cause.

C. **Medical Provider Downstream Subcontract Terms**.

All subcontracts or arrangements with medical providers shall include provisions addressing:

1. The term of the contract, including the beginning and ending dates as well as methods of extension, renegotiation and termination and full disclosure of the method and amount of compensation or other consideration.

2. The obligation to pay contracted medical providers under the terms of the contract and prompt payment provision, the terms of which are developed and agreed to by the parties.

3. The obligations to provide services in a culturally competent manner to all Enrollees, including those with limited English proficiency or reading skills, and diverse culturally and ethnic background and provide interpreter services for Enrollees at all provider sites.

4. The obligation to (i) abide by all federal and state laws and regulations regarding confidentiality and disclosure of medical records, or other health and enrollment information; (ii) to ensure that medical information is released in accordance with applicable federal or state law, or pursuant to court orders or subpoenas; (iii) to maintain Enrollee records and information in an accurate and timely manner; and (iv) to ensure timely access by Enrollees to the records and information that pertain to them.

5. The obligation to hold CalOptima, CalOptima's Regulators and Enrollees harmless in the event that Hospital cannot or will not pay for services performed by the Downstream Entity and for Medicare Part A and B cost sharing. Specifically, Medicare Parts A and B services must be provided at zero cost-sharing to Enrollees.

6. Medical providers' EMTALA obligations and that they must not create any conflicts with hospital actions required to comply with EMTALA.

7. Language prohibiting providers, including PCPs, from closing or otherwise limiting their acceptance of Enrollees as patients unless the same limitations apply to all commercially insured Enrollees.

8. Language that prohibits the Downstream Entity from refusing to contract or pay an otherwise eligible health care Provider for the provision of Covered Services solely because such Provider has in good faith: (a) Communicated with or advocated on behalf of one or more of his or her prospective, current or former patients regarding the provisions, terms or requirements of the 'Downstream Entity's health benefit plans as they relate to the needs of such Provider's patients; or (b) communicated with one or more of his or her prospective, current or former patients with respect to the method by which such Provider is compensated by the Downstream Entity for services provided to the patient.

9. Language that states the Provider is not required to indemnify the Hospital for any expenses and liabilities, including judgments, settlements, attorneys' fees, court costs and any associated charges, incurred in connection with any claim or action brought against the Hospital based on its management decisions, utilization review provisions or other policies, guidelines or actions.

10. The obligation of the medical provider to assist CalOptima in the transfer of care, including in the transfer of care in the event of sub-subcontract termination for any reason.

11. Acknowledgement that assignment or delegation of the subcontract will be void unless prior written approval is obtained from CMS and CalOptima.

12. 'The Provider's right to submit a grievance and a description of the formal process to resolve the Provider's grievances.

13. The obligation to participate and cooperate in Hospital's Quality Improvement System.

14. Language addressing requirements related to payment of Non-Participating Provider emergency and post-stabilization services.

ATTACHMENT G
CMS SPECIFIC PROGRAM PERFORMANCE REQUIREMENTS

1. HCC Coding Requirements and Performance Improvement Activities

1.1 CMS pays CalOptima health-based capitation to compensate CalOptima for services rendered to Enrollees. CMS utilizes encounter data to assign Hierarchical Condition Categories ("**HCC**") to Enrollees. The Enrollee's HCC determines the payment amount received by CalOptima accounting for the variation in expenditures for Medicare Enrollees based on an Enrollee's health status.

1.2 Hospital shall submit Enrollee-specific accurate encounter and service data. Encounters are to be submitted no less than monthly using the ANSI 837P and/or 837I format version 5010 as appropriate, or current format as required by CalOptima.

1.3 Hospital shall support and aid CalOptima's review of encounters, including to production and/or access of supporting medical records.

1.4 To enhance encounter submission accuracy and completeness, CalOptima has initiated performance improvement activities ("**PIAs**"). These PIAs include Enrollee medical and behavioral health assessments provided in the home or a residential facility.

1.5 Hospital has the option to perform these PIAs provided Hospital can demonstrate that Hospital's PIAs meet all CalOptima standards and guidelines. Should Hospital not perform the PIAs or Hospital's PIAs not meet CalOptima standards and guidelines as determined by CalOptima, CalOptima shall perform these activities on behalf of Hospital and the cost for these PIAs shall be charged to or shared with Hospital. CalOptima will provide sixty (60) days' notification prior to taking any such action.

2. ESRD Waiver Responsibilities

2.1 Hospital shall demonstrate to CalOptima that Hospital administers a CalOptima-approved complex case management program for all End Stage Renal Disease (ESRD) Enrollees, which is in accordance with CMS requirements and CalOptima Policies and standards.

2.2 CalOptima shall advise Hospital if its ESRD complex case management program does not meet CMS requirements and CalOptima Policies and clinical standards. If Hospital cannot meet requirements as provided by CalOptima, CalOptima shall have the option to de-delegate the Hospital for the management of ESRD Enrollees and retain a portion of the Capitation Payment for ESRD Enrollees commensurate with the costs for providing or outsourcing such services.

2.3 CalOptima shall provide notification to Hospital of the intent to de-delegate. Hospital shall have the opportunity to submit a corrective action plan to CalOptima in accordance with CalOptima policy.

3. Appeals Rights

Hospital may appeal CalOptima's decision to take the actions outlined above, by filing a complaint pursuant to CalOptima Policies. If Hospital is dissatisfied with the result of any appeal; it shall proceed in accordance with CalOptima's legal claims and judicial review policy.

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken February 3, 2022
Regular Meeting of the CalOptima Board of Directors

Report Item

19. Authorize Amendments to the CalOptima Community Network Professional Services Contracts to Add OneCare as a Covered CalOptima Program

Contact

Yunkyung Kim, Chief Operating Officer (714) 246-8408

Recommended Action

Authorize amendment to the CalOptima Community Network (CCN) Professional Services Contracts to add OneCare as a covered CalOptima program, effective January 1, 2023.

Background & Discussion

Staff requests that the CalOptima Board of Directors (Board) authorize amending the CCN Professional Services Contracts to add OneCare as a covered program, effective January 1, 2023.

In 2014, the California Department of Health Care Services (DHCS) launched the Cal MediConnect (CMC) pilot to coordinate delivery of medical, behavioral health, long-term care, and home- and community-based services and integrate Medi-Cal and Medicare benefits for dual eligible beneficiaries into a single delivery system.

CalOptima participates in CMC via OneCare Connect (OCC), which was implemented on July 1, 2015. CMC was extended past its original termination date of December 31, 2017 but is now scheduled to end on December 31, 2022. As the CMC pilot winds down, OCC members will transition into OneCare (CalOptima's Dual Eligible Special Needs Plan) on January 1, 2023.

CCN providers are not currently contracted to provide services to OneCare members. For a seamless member transition and to minimize any potential disruption to members' access to care, staff is recommending amending the CCN provider agreements to include OneCare participation beginning in CY 2023.

To ensure continuity of care for OCC members as Cal MediConnect sunsets, staff requests the Board authorize amending the CCN Professional Services Contract to add OneCare as a covered program, effective January 1, 2023

Fiscal Impact

The recommended action to add OneCare to the scope of the existing professional services contracts is operational in nature, with no additional fiscal impact anticipated during the current fiscal year. Management will include medical and administrative expenses associated with these actions to support member transition to OneCare in the CalOptima Fiscal Year 2022-23 Operating Budget.

Rationale for Recommendation

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Amending the CCN contracts to cover OneCare will ensure that CalOptima OCC members have a comprehensive OneCare provider network to provide a seamless transition of care for CalOptima members currently participating in OneCare Connect.

Concurrence
Gary Crockett, Chief Counsel

Attachments

1. Presentation: 2021-09-02 Board Meeting OneCare Connect Transition.pptx
2. CMC 3-way Contract with CMS and DHCS: 2019.10.9_CA 3-Way Contract-H8016 CalOptima-Final Eff. 9-1-19 to 12-31-2022
3. CalAIM-Proposal-03-23-2021
4. CCN OneCare Amendment

/s/ Michael Hunn *01/27/2022*
Authorized Signature **Date**

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A Public Agency

CalOptima

Better. Together.

OneCare Connect (OCC) Transition

Board of Directors Meeting
September 2, 2021

Ladan Khamseh, Chief Operating Officer
Ravina Hui, Director, Program Implementation (Medicare)

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Background

- On April 1, 2014, the Department of Health Care Services (DHCS) implemented the Coordinated Care Initiative (CCI)
  - Introduced Cal MediConnect (CMC) duals demonstration
    - Coordinated delivery of medical, behavioral health, long-term care, and home- and community-based services
    - Delivered coordinated Medi-Cal and Medicare benefits in a single delivery system

Background (cont.)

- On July 1, 2015, CalOptima implemented OneCare Connect (OCC) Cal MediConnect Plan (Medicare-Medicaid Plan)
  - Based on three-way contract between the Centers for Medicare & Medicaid Services (CMS), DHCS and CalOptima
  - Qualified OneCare members cross-walked into OCC
    - OneCare program retained for duals who didn't qualify for OCC

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Background (cont.)

- CMC demonstration period
  - Initially set to end December 31, 2017
  - CalOptima received state and federal authority for several CMC extensions
    - Three-way contract amended
      - January 1, 2018, demonstration year (DY) extended through December 31, 2019
      - September 1, 2019, DY extended through December 31, 2022
  - CMC will sunset on December 31, 2022

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Member Transition

- CalOptima received state and federal authority to transition current OCC members into the OneCare Program
  - Via CalAIM legislation
  - Proposes enrollment of CMC plan to a Dual Eligible Special Needs Plan (D-SNP) managed by the same parent organization
    - OCC members will be cross-walked into OneCare on January 1, 2023

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2023 Anticipated OneCare Provider Network

- Offer the same provider network options between OCC and OneCare
  - Supports seamless member transition
  - Minimizes disruption to member's access to care
- Expect all existing OCC health networks to participate in OneCare, including CalOptima Community Network (CCN)
  - Consistent with the current OC risk arrangement, OCC full risk health networks will transition to shared risk model
  - Provides better program viability for health networks and CalOptima

Current Health Network Participation

2021 OneCare Connect Health Networks	2021 OneCare Participation	2023 Anticipated OneCare Participation (as Shared Risk)
AltaMed Health Services Corporation	Participating	Participating
AMVI Care Health Network, Inc.*	Participating as AMVI/ Prospect Medical Group, a California general partnership between AMVI/IMC Health Network, Inc., a Medical Corporation and Santa Ana/Tustin Physician's Group, Inc.	Participating as AMVI Care Health Network, Inc.
Prospect Health Plan*		Participating as Prospect Medical Group, Inc.
Arta Western California Inc.	Participating	Participating
CalOptima Community Network	Not participating	Participating
Family Choice Medical Group, Inc.	Participating	Participating
Heritage Provider Network, Inc.*	Not participating	Participating
Monarch Health Plan Inc.*	Participating as Monarch Healthcare, a Medical Group, Inc.	Participating as Monarch Healthcare, a Medical Group, Inc.
Orange County Physicians IPA Medical Group, Inc. dba Noble Community Medical Associates, Inc. of Mid-Orange County	Participating	Participating
Talbert Medical Group, P.C.	Participating	Participating
United Care Medical Group, Inc.	Participating	Participating

*OCC Full Risk Health Networks

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Next Steps

Deliverables	Time Frame
Request Board authority to extend OneCare contracts to OCC health networks and amend the CCN provider contracts to include OneCare	• December 2021 Board (CCN) • May 2022 Board (health networks)
Release contracts to health networks and CCN providers	• January 2022 (CCN) • May 2022 (health networks)
Contract execution by OneCare health networks and CCN providers (effectuated in CY 2023)	• No later than May 31, 2022
Conduct readiness assessment for health networks transitioning to OneCare	• Q4 2022
OneCare Connect sunsets with members transitioning to OneCare	• January 1, 2023

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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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Contract

Between

United States Department of Health and Human Services
Centers for Medicare & Medicaid Services

In Partnership with

California Department of Health Care Services

and

Orange County Health Authority

Effective: September 1, 2019

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This Contract, effective September 1, 2019 is between the Department of Health and Human Services, acting by and through the Centers for Medicare & Medicaid Services (CMS), the state of California, acting by and through the Department of Health Care Services (DHCS) and Orange County Health Authority (the Contractor). The Contractor's principal place of business is 505 City Parkway West, Orange, CA 92868.

WHEREAS, CMS is an agency of the United States, Department of Health and Human Services, responsible for the administration of the Medicare, Medicaid, and State Children's Health Insurance Programs under Title XVIII, Title XIX, Title XI, and Title XXI of the Social Security Act;

WHEREAS, DHCS is an agency responsible for operating a program of medical assistance under 42 U.S.C. § 1396 et seq and California Welfare and Institutions Code § 14000 et seq, designed to work closely with health care professionals, county governments and health plans to provide a health care safety net for California's low-income and persons with disabilities;

WHEREAS, a purpose of this Contract is to test a new model of payment and service delivery pursuant to 1115A of the Social Security Act;

WHEREAS, the Contractor is in the business of ensuring access to care needed to improve health and quality of life, and CMS and DHCS desire to purchase services from the Contractor to offer quality, accessible care; improve care coordination among medical care, behavioral health, and long-term services and supports; and further the goals of the *Olmstead* Decision;

WHEREAS, the Contractor agrees to furnish these services in accordance with the terms and conditions of this Contract and in compliance with all federal and state laws and regulations;

WHEREAS, this Contract replaces in its entirety, the Contracted entered into by CMS , DHCS, and the Contractor executed December 18, 2013 and re-executed on January 1, 2018, provided, however, that any duties, obligations, responsibilities, or requirements that are imposed upon the Contractor in this revised Contract, but that were not imposed upon the Contractor either in the original version of this Contract executed on December 18, 2013, as amended, or under applicable laws or regulations, shall be prospective in nature only (effective September 1, 2019).

NOW, THEREFORE, in consideration of the mutual promises set forth in this Contract, the parties agree as follows:

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1. Definition of Terms

1.1. **Actual Non-Service Expenditures –** The Contractor's actual amount incurred for non-service expenditures, including both administrative and care management costs, for Enrollees during each Demonstration Year. These costs will exclude costs incurred by the Contractor prior to the start of the Demonstration. Any reinsurance costs reflected here will be net reinsurance costs.

1.2. **Actual Service Expenditures –** The Contractor's actual amount paid for Covered Services (as defined in Appendix A) delivered during each Demonstration Year. Actual Service Expenditures shall be priced at the Contractor fee level and should include all payments to providers for Covered Services, including pay-for-performance payments, risk-sharing arrangements, or sub-capitation payments.

1.3. **Adjusted Final Capitation Rate Revenue –** The Adjusted Interim Capitation Rate Revenue with the Minimum Savings Percentages, rather than the County-Specific Interim Savings Percentages, applied. This is determined by multiplying the Adjusted Interim Capitation Rate Revenue by (1- the Minimum Savings Percentage) / (1- the County-Specific Interim Savings Percentage).

1.4. **Adjusted Interim Capitation Rate Revenue –** The Total Capitation Rate Revenue excluding the monthly capitation payments for Medicare Part D services, and any risk adjustment or reconciliation associated with Medicare Part D payments.

1.5. **Adjusted Non-Service Expenditures –** The Contractor's Actual Non-Service Expenditures, adjusted to reflect the following:
-At the discretion of the State and CMS, exclusion of any costs, including care management, associated with Medicare Part D services as identified in CMS bid instructions and other guidance;
- Exclusion of costs greater than one hundred twenty five percent (125%) of the median cost per member per month across all participating Contractors during the Demonstration Year. Consideration will be given to any Contractor with significant non-typical membership mixes that may cause this exclusion to come into effect;
- Exclusion of reinsurance costs (net of reinsurance premiums); and
- Adjustments resulting from CMS and the State's review of the Contractor's

non-service expenditures to address any inappropriate or excessive non-service expenditures (including executive compensation and stop loss expenditures).

1.6. **Adjusted Service Expenditures –** The Contractor's Actual Service Expenditures, adjusted to reflect the following:
- Exclusion of the net cost of all services provided under Medicare Part D;
- Reductions to reflect any recoveries from other payors outside of claims adjudication, including those pursuant to coordination of benefits, third party liability, rebates, supplemental payments, adjustments in claims paid, adjustments from providers including adjustments to claims paid, and Enrollee contributions to care. These adjustments shall exclude any adjustments associated with coverage of Medicare Part D services; and
- Adjustments resulting from CMS and the State review of Contractor reimbursement methodologies and levels to address any excessive pricing.

1.7. **Advance Directive –** An individual's written directive or instruction, such as a power of attorney for health care or a living will, recognized under State law (whether statutory or as recognized by the courts of the State) for the provision of that individual's health care if the individual is unable to make his or her health care wishes known.

1.8. **Adverse Benefit Determination --** (i) The denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for medical necessity, appropriateness, setting or effectiveness of a Covered Service; (ii) the reduction, suspension, or termination of a previously authorized service; (iii) the denial, in whole or in part, of payment for a service; (iv) the failure to provide services in a timely manner; (v) the failure of the Contractor to act within the required timeframes for the standard resolution of Grievances and Appeals; (vi) for a resident of a rural area with only one Contractor, the denial of an Enrollee's request to obtain services outside of the Network; or (vii) the denial of an Enrollee's request to dispute a financial liability.

1.9. **Appeal** - In general, an Enrollee's actions, both internal and external to the Contractor requesting review of the Contractor's denial, reduction or termination of benefits or services, from the Contractor. Appeals relating to Medi-Cal covered benefits and services shall proceed pursuant to the laws and regulations governing Medi-Cal Appeals. Appeals relating to Medicare covered benefits and services shall proceed pursuant to the laws and

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regulations governing Medicare Appeals. A Medi-Cal based Appeal is defined as review by the Contractor of an Adverse Benefit Determination.

1.10. **Behavioral Health —** An all-inclusive term referring to mental health services provided through the mental health plan (MHP) or Contractor and substance use disorder services.

1.11. **Cal MediConnect —** California's State-specific name for the Capitated Financial Alignment Model Demonstration.

1.12. **Cal MediConnect Plan (also, Contractor) —** A health plan or other qualified entity jointly selected by the State and CMS for participation in this Demonstration.

1.13. **Cal MediConnect Ombuds Program-** The independent contractor established to safeguard the rights and dignity of all beneficiaries supported by Cal MediConnect. This office will be responsible for assisting and resolving issues that Enrollees may encounter with Cal MediConnect Plans.

1.14. **California (or State) —** For purposes of this document, California (or State) is generally used to refer to DHCS, though it may encompass collectively CDA, DHCS, DMHC, and DSS.

1.15. **Capitated Financial Alignment Model Demonstration ("the Demonstration") —** A model in which a state, CMS, and a Contractor enter into a three-way Contract, and the Contractor receives a prospective blended capitation payment to provide comprehensive, coordinated care.

1.16. **Capitated Financial Alignment Model Memorandum of Understanding (CFAM-MOU) —** For purposes of this Contract, this is a document between CMS and California regarding a Federal-State Partnership to Test a Capitated Financial Alignment Model (signed March 27, 2013). This MOU document details the principles under which CMS and the State plan to implement and operate the Demonstration. It also outlines the activities CMS and the State plan to conduct in preparation for implementation of the Demonstration, before the parties execute this Contract setting forth the terms and conditions of the Demonstration and initiate the Demonstration.

1.17. **Capitation Rate —** The sum of the monthly capitation payments (reflecting coverage of Medicare Parts A & B services, Medicare Part D services, and Medicaid services, pursuant to Appendix A of this Contract). Total Capitation Rate Revenue will be calculated as if all Contractors had received the full

quality withhold payment.

1.18. **Care Coordination** –Delineated through requirements, processes and the care model throughout this Contract, Care Coordination is also detailed in WIC Sections 14182.17(d)(4) and 14186(b).

1.19. **Care Coordinator** — A clinician or other trained individual employed or contracted by the PCP or the Contractor who is accountable for providing Care Coordination services, which include assuring appropriate referrals and timely two-way transmission of useful Enrollee information; obtaining reliable and timely information about services other than those provided by the Primary Care Provider; participating in the initial assessment; and supporting safe transitions in care for Enrollees moving between settings. The Care Coordinator serves on one (1) or more Interdisciplinary Care Teams (ICT), coordinates and facilitates meetings and other activities of those ICTs. The Care Coordinator also participates in the Initial Assessment of each Enrollee on whose ICT he or she serves.

1.20. **Care Plan Option (CPO) Services** – A CPO Service is optional under the beneficiary's Individualized Care Plan (ICP). A CPO Service is designed to only supplement, not replace, the required Medi-Cal services under the beneficiary's Individualized Care Plan (ICP). CPO Services are offered entirely at the Contractor's discretion.

1.21. **Centers for Medicare & Medicaid Services (CMS)** — The federal agency under the United States Department of Health and Human Services responsible for administering the Medicare and Medicaid programs.

1.22. **Chronic Mental Disorder** — To be considered to have a Chronic Mental Disorder, the Enrollee shall have one or more of the following diagnoses or its successor diagnoses included in the most recent version of the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association: (a) Pervasive Developmental Disorders, (b) Attention Deficit and Disruptive Behavior Disorders, (c) Feeding and Eating Disorder of Infancy, Childhood, or Adolescence, (d) Elimination Disorders, (f) Schizophrenia and Other Psychiatric Disorders, (g) Mood Disorders, (h) Anxiety Disorders, (i) Somatoform Disorders, (j) Factitious Disorders, (k), Dissociative Disorders, (l) Paraphilias, (m) Gender Identity Disorders, (n) Eating Disorders, (o) Impulse Control Disorders Not Elsewhere Classified (p) Adjustment Disorders, (q) Personality Disorders, or (r) Medication-Induced

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Movement Disorders.

1.23. **Community Based Adult Services (CBAS) —** Outpatient, facility-based program that delivers skilled nursing care, social services, therapies, personal care, family/caregiver training and support, nutrition services, and transportation to eligible Medi-Cal beneficiaries, aged 18 years and older, blind, or disabled.

1.24. **Contract —** The participation agreement that CMS and DHCS have with a Contractor, for the terms and conditions pursuant to which a Contractor may participate in this Demonstration.

1.25. **Contract Management Team (CMT) —** A group of CMS and DHCS representatives responsible for overseeing the contract management functions outlined in Section 3.1.1 of the Contract.

1.26. **Contract Operational Start Date —** The first date on which enrollment into the Contractor's Cal MediConnect coverage is effective.

1.27. **Contractor —** An entity approved by CMS and DHCS that enters into a Contract with CMS and DHCS in accordance with, and to meet, the purposes specified in this Contract.

1.28. **County Organized Health System (COHS) —** A type of Medi-Cal managed care delivery model in which DHCS contracts with a single health plan created by the County Board of Supervisors.

1.29. **County Social Services Agency**- Local county agency that administers the IHSS program.

1.30. **Covered Services —** The set of services to be offered by the Contractor as defined in Appendix A.

1.31. **Department of Aging (CDA) –** In California, CDA administers programs that serve older adults, adults with disabilities, family caregivers, and residents in long-term care facilities throughout the State. CDA administers funds allocated under the federal Older Americans Act, the Older Californians Act, and through the Medi-Cal program. CDA certifies CBAS centers for participation in the Medi-Cal Program and provides administrative oversight for the MSSP waiver.

1.32. **Department of Health Care Services (DHCS) –** The State department in California responsible for administration of the federal Medicaid Program (referred to as Medi-Cal in California). DHCS is generally referred to as the

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State in this document**.**

1.33. **Department of Managed Health Care (DMHC**) – The State department charged with overseeing health care service plans licensed under the Knox-Keene Act.

1.34. **Department of Social Services (CDSS)** – The State department responsible for overseeing and providing social services, including the In Home Support Services (IHSS) program.

1.35. **Developmental Disability –** A disability which originates before the individual attains age 18, continues, or can be expected to continue, indefinitely, and constitutes a substantial disability for that individual as defined in the California Code of Regulations.

1.36. **Drug Medi-Cal Benefits –** The substance use disorder Medi-Cal benefits that are listed in Title 22, California Code of Regulations, section 51341.1(d) and Welfare and Institutions Code section 14132.03 .

1.37. **Dual-Plan Letter (DPL) -** DPLs convey information or interpretation of changes in policy or procedure at the federal or State levels, and about changes in federal or State law and regulations. DPLs provide instruction to the Contractor on how to implement these changes on an operational basis, and about how federal or State law affect the way in which they operate, or deliver services to Enrollees. The Department shall notify and consult with stakeholders, including the Contractor, prior to the issuance of a DPL in compliance with the provisions of Welfare and Institutions Code section 14186.4(c).

1.38. **Emergency Medical Condition —** A medical condition that manifests itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in: (1) placing the health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; (2) serious impairment to bodily functions; or (3) serious dysfunction of any bodily organ or part.

1.39. **Emergency Services** – Inpatient and outpatient services covered under this Contract that are furnished by a Provider qualified to furnish such services and that are needed to evaluate or stabilize an Enrollee's Emergency Medical

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Condition.

1.40. **Encounter Data -** The record of an Enrollee receiving any item(s) or service(s) provided through Medicaid or Medicare under a prepaid, capitated, or any other risk basis payment methodology submitted to CMS. This record must incorporate the Health Insurance Portability and Accountability Act of 1996 (HIPAA) security, Privacy, and transaction standards and be submitted in the ASC X12N 837 format or any successor format.

1.41. **Enrollee —** Any Medicare-Medicaid eligible individual who is enrolled with a Contractor.

1.42. **Enrollee Communications —** Materials designed to communicate Covered Services, policies, processes and/or Enrollee rights to Enrollees. This includes pre-enrollment, post-enrollment, and operational materials.

1.43. **Enrollment Broker —** Entity contracted by DHCS through the Health Care Options Program to provide information and enrollment assistance to Medicare-Medi-Cal beneficiaries.

1.44. **Exempt Grievance –** Grievances received by telephone that are not coverage disputes, disputed health care services involving medical necessity, or experimental or investigational treatment and that are resolved by the next business day following receipt.

1.45. **External Quality Review Organization --** An independent entity that contracts with the State and evaluates the access, timeliness, and quality of care delivered by the Contractor to their Enrollees.

1.46. **Federally-Qualified Health Center (FQHC) —** An entity that has been determined by CMS to satisfy the criteria set forth in 42 U.S.C. § 1396d(a)(2)(C).

1.47. **First Tier, Downstream and Related Entity —** An individual or entity that enters into a written arrangement that is acceptable to CMS and DHCS with the Contractor, to provide administrative or health care services to the Contractor under this Contract.

1.48. **Geographic Managed Care (GMC) County —** A county in which DHCS contracts with two or more Knox Keene licensed health plans for Medi-Cal managed care.

1.49. **Grievance:**" Any complaint or dispute, other than one that constitutes an organization determination under 42 C.F.R. § 422.566 or other than an

Adverse Benefit Determination under 42 C.F.R. § 438.400, expressing dissatisfaction with any aspect of the Contractor's or Provider's operations, activities, or behavior, regardless of whether remedial action is requested pursuant to 42 C.F.R. § 422.561. A Grievance is filed and decided at the Contractor level. (Possible subjects for Grievances include, but are not limited to, the quality of care or services provided and aspects of interpersonal relationships such as rudeness of a Provider or employee, or failure to respect the Enrollee's rights as provided for in Appendix B of this Contract). Also called a "Complaint."

1.50. **Health Care Options Program (HCO)** -- A program within the California Department of Health Care Services which operates as an Enrollment Broker providing enrollment assistance to eligible MMP beneficiaries.

1.51. **Health Outcomes Survey (HOS) —** Beneficiary survey used by CMS to gather valid and reliable health status data in Medicare managed care for use in quality improvement activities, plan accountability, public reporting, and improving health.

1.52. **Health Plan Management System (HPMS) —** A system that supports contract management for Medicare health plans and prescription drug plans and supports data and information exchanges between CMS and health plans. Current and prospective Medicare health plans submit applications, information about Provider Networks, plan benefit packages, formularies, and other information via HPMS.

1.53. **Health Risk Assessment —** An assessment tool which identifies primary, acute, long-term services and supports, and Behavioral Health and functional needs.

1.54. **Healthcare Effectiveness Data and Information Set (HEDIS) —** Tool developed and maintained by the National Committee for Quality Assurance that is used by health plans to measure performance on dimensions of care and service in order to maintain and/or improve quality.

1.55. **High Risk Enrollee —** For risk stratification purposes, an Enrollee who is at increased risk of having an adverse health outcome or worsening of his or her health status if he or she does not receive initial contact by the Contractor within forty-five (45) calendar days after coverage date. The higher risk Enrollees who should be identified from the fee for service utilization data,

include but are not limited to Enrollees who:

- Have been on oxygen within the past ninety (90) days,
- Have been hospitalized within the last ninety (90) days, or have had three (3) or more voluntary and/or involuntary hospitalizations within the past year related to Behavioral Health illnesses,
- Have had three (3) or more emergency room visits in the past year in combination with other evidence of high utilization of services (e.g. multiple prescriptions consistent with the diagnoses of chronic diseases),
- Have In Home Supportive Services (IHSS) greater than or equal to one hundred ninety five (195) hours/month,
- Are enrolled in the Multipurpose Senior Service Program (MSSP),
- Are receiving Community Based Adult Services (CBAS),
- Have ESRD, AIDS, and/or a recent organ transplant,
- Have been currently being treated for cancer,
- Have been prescribed anti-psychotic medication within the past ninety (90) days,
- Have been prescribed fifteen (15) or more medications in the past ninety (90) days, or
- Have other conditions as determined by the Contractor, based on local resources.

1.56. **Indian Enrollee —** An Enrollee who is an Indian (as defined at 25 USC 1603(13), 1603(28), or 1679(a), or who has been determined eligible as an Indian, under 42 C.F.R. § 136.12.) This includes an Enrollee is a member of a Federally recognized tribe; resides in an urban center and meets one or more of four criteria including: is member of a tribe, band, or other organized group of Indians, including those tribes, bands, or groups terminated since 1940 and those recognized now or in the future by the State in which they reside, or who is a descendant, in the first or second degree, of any such member; is an Eskimo or Aleut or other Alaska Native; is considered by the Secretary of the Interior to be an Indian for any purpose; or is determined to be an Indian under regulations issued by the Secretary; is considered by the Secretary of the Interior to be an Indian for any purpose; or is considered by the Secretary of Health and Human Services to be an Indian for purposes of eligibility for Indian Health Services, including as a California Indian, Eskimo, Aleut, or other Alaska Native Enrollee.

1.57. **Indian Health Care Provider –** A health care program operated by the Indian Health Services (IHS) or by an Indian Tribe, Tribal Organization, or Urban Indian Organization (I/T/U) as those terms are defined in Section 4 of the

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Indian Health Care Improvement Act (25 U.S.C. § 1603).

1.58. **Individualized Care Plan (ICP or Care Plan)** — The plan of care developed by an Enrollee and/or an Enrollee's Interdisciplinary Care Team or health plan.

1.59. **Interdisciplinary Care Team (ICT)** — A team comprised of the Primary Care Provider and Care Coordinator, and other providers at the discretion of the Enrollee, that works with the Enrollee to develop, implement, and maintain the ICP.

1.60. **In-Home Supportive Services (IHSS)** — Pursuant to Article 7 of California Welfare and Institutions Code (Welf. & Inst. Code) (commencing with section 12300 of Chapter 3, and sections 14132.95, 14132.952, and 14132.956), IHSS is a program that provides in-home care for people who cannot safely remain in their own homes without assistance.

1.61. **Long Term Services and Supports (LTSS)** — A wide variety of services and supports that help eligible beneficiaries meet their daily needs for assistance and improve the quality of their lives. Examples include assistance with bathing, dressing and other basic activities of daily life and self-care, as well as support for everyday tasks such as laundry, shopping, and transportation. LTSS are provided over an extended period, predominantly in homes and communities, but also in facility-based settings such as nursing facilities. As described in California Welfare and Institutions Code section 14186.1, Medi-Cal covered LTSS includes all of the following:

- In-Home Supportive Services (IHSS);
- Community-Based Adult Services (CBAS);
- Multipurpose Senior Services Program (MSSP) services; and
- Skilled Nursing Facility services and subacute care services.

1.62. **Low Risk Enrollee** —Enrollee who does not meet the minimum requirements of a High Risk Enrollee.

1.63. **Marketing, Outreach, and Enrollee Communications** — Any informational materials targeted to Enrollees that are consistent with the definitions of communication materialsand marketing materials at 42 C.F.R. § 422.2260.

1.64. **Medicaid** — The program of medical assistance benefits under Title XIX of the Social Security Act and various Demonstrations and waivers thereof. California's State-specific name for this program is Medi-Cal.

1.65. **Medi-Cal Dental –** Adult dental benefits provided through Medi-Cal

(California's Medicaid program).

1.66. **Medi-Cal Managed Care Behavioral Health Services -** Behavioral Health services specified in the Welfare and Institutions Code section 14132.03 that will be provided by the Contractor.

1.67. **Medi-Cal Managed Care Plan –** A health plan directly contracted with the California Department of Health Care Services to provide Medi-Cal services to eligible beneficiaries.

1.68. **Medi-Cal Appeal** - A request for a fair hearing in accordance with California Code of Regulations Title 22, section 51014.1 and Welfare and Institutions Code section 10950.

1.69. **Medically Necessary Services —** Services must be provided in a way that provides all protections to the Enrollee provided by Medicare and Medi-Cal. Per Medicare, services must be reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member, or otherwise medically necessary under 42 U.S.C. § 1395y. In accordance with Title XIX law and related regulations, and per Medi-Cal, medical necessity means reasonable and necessary services to protect life, to prevent significant illness or significant disability, or to alleviate severe pain through the diagnosis or treatment of disease, illness, or injury under the Welfare and Institutions Code section 14059.5.

1.70. **Medi-Cal Specialty Mental Health Services —** The Medi-Cal services specified in California Code of Regulations, Title 9 section 1810.247. Specialty mental health services do not include the Medi-Cal Managed Care Behavioral Health Services specified in the Welfare and Institutions Code section 14132.03 that will be provided by the Contractor. Specialty mental health services are provided through a MHP, in accordance with California Code of Regulations, Title 9, Chapter 11 of Division 1 and include:

A. Rehabilitative services, which includes mental health services, medication support services, day treatment intensive, day rehabilitation, crisis intervention, crisis stabilization, adult residential treatment services, crisis residential services, and psychiatric health facility services;
B. Psychiatric inpatient hospital services;
C. Targeted Case Management;
D. Psychiatrist services; and
E. Psychologist services.

1.71. **Medicare —** Title XVIII of the Social Security Act, the federal health insurance program for people age 65 or older, people under 65 with certain disabilities, and people with End Stage Renal Disease (ESRD) or Amyotrophic Lateral Sclerosis. Medicare Part A provides coverage of inpatient hospital services and services of other institutional providers, such as skilled nursing facilities and home health agencies. Medicare Part B provides supplementary medical insurance that covers physician services, outpatient services, some home health care, durable medical equipment, and laboratory services and supplies, generally for the diagnosis and treatment of illness or injury. Medicare Part C provides Medicare beneficiaries with the option of receiving Part A and Part B services through a private health plan. Medicare Part D provides outpatient prescription drug benefits.

1.72. **Medicare Advantage —** The Medicare managed care options that are authorized under Title XVIII of the Social Security Act as specified at 42 C.F.R. Part 422.

1.73. **Medicare Appeal —** An Enrollee's request for formal review of an Adverse Benefit Determination of the Contractor in regards to a Medicare service in accordance with Section 2.15.

1.74. **Medicare-Medicaid Coordination Office —** Formally the Federal Coordinated Health Care Office, established by Section 2602 of the Affordable Care Act.

1.75. **Medicare-Medicaid Enrollee (or Enrollee) —** For the purposes of this Demonstration, an individual who is entitled to, or enrolled for, benefits under Part A of title XVIII of the Social Security Act, and enrolled for benefits under Part B of title XVIII of such Act, and is eligible for medical assistance under a State plan under title XIX of such Act or under a waiver of such plan.

1.76. **Medicare-Medicaid Plan (MMP)** -- A health plan contracted with DHCS and CMS to comprehensively manage the full continuum of Medicare and Medi-Cal benefits for Medicare-Medicaid Enrollees including Long Term Supports and Services as needed and desired by the Enrollee.

1.77. **Mental Health Plan (MHP):** Pursuant to California Code of Regulations, Title 9 section 1810.226, a MHP is an entity that enters into a contract with DHCS to provide directly, or arrange and pay, for Medi-Cal Specialty Mental Health Services. A MHP may be a county, counties acting jointly or another

governmental or non-governmental entity.

1.78. **Minimum Data Set (MDS) —** A clinical screening system, mandated by federal law for use in nursing facilities, that assesses the key domains of function, health, and service use. MDS assessment forms include the MDS-HC for home care and the MDS 2.0 for nursing facility residents.

1.79. **Multi-Purpose Senior Services Program (MSSP**) **—** A California-specific program, the 1915(c) Home and Community-Based Services Waiver that provides Home and Community-Based Services (HCBS) to Medi-Cal eligible individuals who are 65 years or older with disabilities as an alternative to nursing facility placement.

1.80. **Network Provider —** An appropriately credentialed and licensed individual, facility, agency, institution, organization, or other entity that has an agreement with the Contractor, or any First Tier, Downstream, or Related Entity, for the delivery of services covered under the Contract. A Network Provider must meet the requirements in Section 2.9.9.1.

1.81. **Notice of Action (NOA) –** A written notice of any action within the timeframes for each type of action as provided by 42 C.F.R. §§ 438.404 and 422.568.

1.82. **Passive Enrollment —** An enrollment process through which an eligible individual is enrolled by DHCS into a Contractor's plan following a minimum sixty (60) day advance notification that includes the opportunity for the Enrollee to choose another plan or opt out prior to the effective date.

1.83. **Post-Stabilization Care Services —** Services related to an emergency medical condition that are provided after an Enrollee is stabilized in order to maintain the stabilized condition, or are provided, to improve or resolve the condition.

1.84. **Primary Care Provider (PCP) --** A person responsible for supervising, coordinating, and providing initial and primary care to patients; for initiating referrals; and for maintaining the continuity of patient care. A PCP may be a physician or non-physician medical practitioner.

1.85. **Privacy —** Requirements established in the Privacy Act of 1974, the Health Insurance Portability and Accountability Act of 1996, and implementing regulations, as well as relevant California privacy laws.

1.86. **Program of All-Inclusive Care for the Elderly (PACE) —** As defined in 42 C.F.R. § 460.6, and authorized under California law at Welfare and

Institutions Code section 14591 et seq., PACE is a capitated program for individuals over the age of 55 certified by DHCS for nursing home level of care. PACE organizations cover all Medicare and Medicaid benefits, including medical services and long-term services and support, organizes a comprehensive service delivery system governed by federal regulations, and integrate Medicare and Medicaid financing. PACE is a three-way partnership between the federal Government, California, and the PACE Organizations.

1.87. **Provider Network —** A network of health care and social support providers, including but not limited to primary care physicians, nurses, nurse practitioners, physician assistants, Care Coordinators, specialty providers, Behavioral Health providers, community and institutional long-term care providers, pharmacy providers, and acute providers employed by or under subcontract with the Contractor. (See Appendix C of the Contract).

1.88. **Readiness Review —**Prior to being eligible to accept Demonstration enrollments, each prospective Contractor selected to participate in the Demonstration must undergo a Readiness Review. The Readiness Review evaluates each prospective Contractor's ability to comply with the Demonstration requirements, including but not limited to, the ability to quickly and accurately process claims and enrollment information, accept and transition new Enrollees, and provide adequate access to all Medicare and Medicaid-covered Covered Services that are Medically Necessary with Enrollee protections. Only Contractors passing the Readiness Review will participate in the Demonstration. At a minimum, each Readiness Review includes a desk review and a site visit to the prospective Contractor's headquarters.

1.89. **Recovery Model —** Framework for Behavioral Health that uses "recovery-oriented" services in recognition that systems of care should ensure culturally competent care for persons with severe mental illness and substance use disorders in the most appropriate, least restrictive level of care necessary to achieve meaningful outcomes such as health, home, purpose and community, consistent with the system of care as set forth in California Welfare and Institutions Code sections 5802 and 5806. Core practices within recovery-oriented systems include peer support, individual choice and person-driven approaches. The Recovery Model recognizes that Behavioral Health issues involve an individualized complex interaction between social, environmental and physiological components, and the need to incorporate all of these factors

within the care system in order to achieve health and wellness.

1.90. **Request for Solutions —** Document released in December 2011 by DHCS to assess if contractors have the requisite qualifications and resources suited to provide seamless access to the full continuum of medical care and social supports and services that Enrollees need to maintain good health and a high quality of life in the setting of their choice.

1.91. **Rural Health Clinic (RHC) –** An entity that meets all of the requirements for designation as a RHC under § 1861(aa)(1) of the Social Security Act and is approved for participation in the Medi-Cal program.

1.92. **Service Area —** The county or counties that the Contractor is approved to operate in under the terms of this Contract. A Service Area may have designated ZIP Codes (under the U.S. Postal Service) within a county that are approved by CMS and DHCS to operate under the terms of this Contract. See Appendix I for the Service Area for this contract.

1.93. **Skilled Nursing Facility (SNF) —** As defined in California Code of Regulations, Title 22 section 51121(a), any institution, place, building, or agency which is licensed as a SNF by the California Department of Public Health (CDPH) or is a distinct part or unit of a hospital, meets the standard specified in section 51215 of these regulations (except that the distinct part of a hospital does not need to be licensed as a SNF) and has been certified by DHCS for participation as a SNF in the Medi-Cal program. Section 51121(b) further defines the term "Skilled Nursing Facility" as including terms "skilled nursing home", "convalescent hospital", "nursing home", or "nursing facility".

1.94. **State Fair Hearing —** A "State Fair Hearing" is a quasi-judicial proceeding conducted by a judge, during which each hearing party may present arguments and evidence, including witness(es), and cross examine witness(es) against them, with respect to a decision regarding the availability or delivery of services or benefits, made by an agency. An "agency" is a government unit or managed care health plan involved in a hearing as a hearing party. Such agencies include all 58 California counties, the Los Angeles Department of Children and Family Services, the California Department of Aging, the CDSS Office of Services to the Blind, all 27 Medi-Cal Field Offices, and several CDHS units, including: Beneficiary Utilization Review Unit, Benefits Branch-Vision, In-Home Operations, Managed Care

Operations Branch, Recovery Section, and Office of Medi-Cal Dental Services.

1.95. **Streamlined Enrollment:** A process to permit Contractors operating in non-COHS counties to submit opt-in enrollments to DHCS on behalf of their members enrolled in the matching plan's Medi-Cal line of business.

1.96. **Threshold Languages —** As specified in annual guidance to Contractors on specific translation requirements for their service areas.

1.97. **Total Adjusted Expenditures –** The sum of the Adjusted Service Expenditures and the Adjusted Non-Service Expenditures.

1.98. **Total Capitation Rate Revenue –** The sum of the monthly capitation payments for the Demonstration Year (reflecting coverage of Medicare Parts A/B services, Medicare Part D services and Medi-Cal services, pursuant to Appendix A of this contract) including: 1) the application of risk adjustment methodologies, as described in Section 4.2; and 2) any payment adjustments as a result of the reconciliation described in Sections 4.13 and 4.14. Total Capitation Rate Revenue will be calculated as if all Contractors had received the full quality withhold payment.

1.99. **Two- Plan County —** A type of Medi-Cal managed care delivery model in which DHCS contracts two plans, offering beneficiaries a choice of health plan a with a "Local Initiative" (LI) and a "commercial plan" (CP). An LI is a non-profit, locally government health plan serving Medi-Cal beneficiaries.

1.100. **Urgent Care — S**ervices required to prevent serious deterioration of health following the onset of an unforeseen condition or injury (i.e., sore throats, fever, minor lacerations, and some broken bones). Medical services required promptly to prevent impairment of health due to symptoms that do not constitute an Emergency Medical Condition, but that are the result of an unforeseen illness, injury, or condition for which medical services are immediately required. Urgent Care is appropriately provided in a clinic, physician's office, or in a hospital emergency department if a clinic or physician's office is inaccessible. Urgent Care does not include primary care services or services provided to treat an Emergency Condition.

2. Contractor Responsibilities

Through the Capitated Financial Alignment Model Demonstration (the "Demonstration"), CMS and DHCS will work in partnership to offer Medicare-Medicaid Enrollees the option of enrolling in a Contractor's plan, which consists of a comprehensive network of health and social service providers. The Contractor will deliver and coordinate all components of Medicare and Medi-Cal Covered Services for Enrollees.

2.1. Compliance: The Contractor must, to the satisfaction of CMS and DHCS:

2.1.1. Comply with all provisions set forth in this Contract.

2.1.2. Comply with all applicable provisions of federal and State laws, the CFAM-MOU, regulations, guidance, waivers, Demonstration terms and conditions, including the implementation of a compliance plan. The Contractor must comply with the Medicare Advantage requirements in Part C of Title XVIII, and 42 C.F.R. Part 422, Part 423, and Part 438 except to the extent that variances from these requirements are provided in the CFAM-MOU.

2.1.3. Maintain appropriate licensure as a health care service plan in accordance with the Knox-Keene Health Care Service Plan Act of 1975 as amended and have no adverse actions with regard to enforcement or quality management. County-Organized Health System (COHS) plans are exempt from Knox-Keene licensure for their Medi-Cal business pursuant to WIC section 14087.95. Despite this exemption from licensure, this Contract obligates all Contractors, including COHS plans, to comply with all provisions of this Contract, including the contractual provisions relating to the Knox-Keene Act, unless otherwise expressly excluded.

2.1.4. The Contractor agrees that it will develop and implement an effective compliance program that applies to its operations, consistent with 42 C.F.R. § 420, et seq, 42 C.F.R. § 422.503, and 42 C.F.R. §§ 438.600-610, 42 C.F.R. § 455.

2.1.4.1. The Contractor must report all employees, providers, and Enrollees suspected of Fraud, waste, and/or Abuse that warrant investigation to DHCS – Office of Inspector General, the Medicaid Fraud Control Unit and CMS.

2.1.5. Comply with all current and applicable DPLs issued by DHCS. All current DPLs can be viewed at: http://www.dhcs.ca.gov/formsandpubs/Pages/MgdCareDualsPlanL

etters.aspx

2.1.5.1. All DPLs will be reviewed by CMS prior to issuance.

2.1.6. In the event an APL applies to an MMP, DHCS and CMS will jointly issue a memo to the plans via HPMS for the interim period between an APL issuance and a DPL issuance.

2.1.7. Maintain its contract with DHCS for the provision of Covered Services under the Medi-Cal program.

2.1.8. For Contractors that make or receive payments under the contract of at least $5,000,000, the Contractor must adopt and implement written policies for all employees of the Contractor, and of any contractor or agent of the Contractor, that provide detailed information about the False Claims Act and other Federal and State laws described in section 1902(a)(68) of the Social Security Act, including information about rights of employees to be protected as whistleblowers.

2.2. Contract Management and Readiness Review Requirements

2.2.1. Contract Readiness Review Requirements

2.2.1.1. CMS, or its designee, with participation by DHCS, will conduct a Readiness Review of each Contractor, which must be completed successfully prior to the Contract Operational Start Date.

2.2.1.2. CMS and DHCS Readiness Review Responsibilities

2.2.1.2.1. CMS and DHCS, or its designees, will conduct a Readiness Review of each Contactor that will include, at a minimum, one on-site review. This review shall be conducted prior to enrollment of beneficiaries into the Contractor's Plan. CMS and DHCS, or its designees, will conduct the Readiness Review to verify the Contractor's assurances that the Contractor is ready and able to meet its obligations under the Contract.

2.2.1.2.2. The scope of the Readiness Review will include, but is not limited to, a review of the following elements:

2.2.1.2.2.1. Network Provider composition and access, in accordance with Section 2.10;

2.2.1.2.2.2. Staffing, including Key Personnel and functions directly impacting on Enrollees (e.g., adequacy of Enrollee Services staffing), in accordance with Section 2.11;

2.2.1.2.2.3. Capabilities of First Tier, Downstream and Related Entities, in accordance with Appendix C;

2.2.1.2.2.4. Care Coordination capabilities, in accordance with Section 2.5.2;

2.2.1.2.2.5. Provider contracts templates, including any Provider Performance Incentives, in accordance with Sections 2.9 and 5.1.7;

2.2.1.2.2.6. Enrollee services capability (materials, processes and infrastructure, e.g., call center capabilities), in accordance with Section 2.12;

2.2.1.2.2.7. Comprehensiveness of quality management/quality improvement and utilization management strategies, in accordance with Section 2.11.6 and 2.16;

2.2.1.2.2.8. Internal Grievance and Appeal policies and procedures, in accordance with Section 2.14 and 2.15;

2.2.1.2.2.9. Fraud and abuse and program integrity, in accordance with Section 2.1.2;

2.2.1.2.2.10. Financial solvency, in accordance with Section 2.18;

2.2.1.2.2.11. Information systems, including claims payment system performance, interfacing and reporting capabilities and validity testing of Encounter Data, in accordance with Section 2.19, including IT testing and security assurances.

2.2.1.2.3. For Contractors that are COHS plans, the scope of the Readiness Review will extend to the enrollment functions that the Contractor will be conducting as described in Section 2.3.1.

2.2.1.2.4. No individual shall be enrolled into the Contractor's Cal MediConnect Plan unless and until CMS and the DHCS determine that the Contractor is ready and able to perform its obligations under the Contract as demonstrated during the Readiness Review.

2.2.1.2.5. CMS and DHCS or its designee will identify to the Contractor all areas where the Contractor is not ready and able to meet its obligations under the Contract and provide an opportunity for the Contractor to correct such areas to remedy all deficiencies prior to the start of marketing.

2.2.1.2.6. CMS or DHCS may, in its discretion, postpone the date the Contractor may start marketing or the Contract Operational Start Date for any Contractor that fails to satisfy all Readiness Review requirements. If, for any reason, the Contractor does not fully satisfy CMS or DHCS that it is ready and able to perform its obligations under the Contract prior to the start of marketing or the Contract Operational Start Date, and CMS or DHCS does not agree to postpone the Contract Operational Start Date, or extend the date for full compliance with the applicable Contract requirement, then CMS or DHCS may terminate the Contract pursuant to Section 5.5 of this Contract.

2.2.1.3. Contractor Readiness Review Responsibilities

2.2.1.3.1. The Contractor shall demonstrate to CMS and DHCS satisfaction that the Contractor is ready and able to meet all Contract requirements identified in the Readiness Review prior to the Contract Operational Start Date, and prior to the Contractor engaging in marketing of its Demonstration product;

2.2.1.3.2. Provide CMS and DHCS or its designee with the corrected materials requested by the Readiness Review.

2.2.2. Contract Management

2.2.2.1. The Contractor must employ a qualified individual to serve as the compliance officer of its Capitated Financial Alignment Model. The compliance officer must be primarily dedicated to the Contractor's program, hold a senior management position in the Contractor's organization, and be authorized and empowered to represent the Contractor in all matters pertaining to the Contractor's program. The compliance officer must act as liaison between the Contractor, CMS, and DHCS, and has responsibilities pursuant to this Contract, DPLs and other relevant guidance and authorities that include but, are not limited to, the following:

2.2.2.1.1. Ensure the Contractor's compliance with the terms of the Contract, including securing and coordinating resources necessary for such compliance;

2.2.2.1.2. Implement all action plans, strategies, and timelines, including but not limited to those described in the Contractor's response to the approved Request for Solutions (RFS);

2.2.2.1.3. Oversee all activities by the Contractor and its First Tier, Downstream and Related Entities.

2.2.2.1.4. Receive and respond to all inquiries and requests made by CMS and DHCS in timeframes and formats specified by CMS and DHCS;

2.2.2.1.5. Meet with representatives of CMS or DHCS, or both, on a periodic or as-needed basis and resolve issues that arise within specified timeframes;

2.2.2.1.6. Ensure the availability to CMS and DHCS upon their request, of those members of the Contractor's staff who have appropriate expertise in administration, operations, finance, management information systems, claims processing and payment, clinical service provision, quality management, Enrollee

services, utilization management, Provider Network management, and benefit coordination;

2.2.2.1.7. Coordinate requests and activities among the Contractor, all First Tier, Downstream and Related Entities CMS, and DHCS;

2.2.2.1.8. Make best efforts to promptly resolve any issues related to the Contract identified either by the Contractor, CMS, or DHCS; and

2.2.2.1.9. Meet with CMS and DHCS at the time and place requested by CMS and the State, determine that the Contractor is not in compliance with the requirements of the Contract.

2.2.3. Organizational Structure

2.2.3.1. Contractor shall maintain an organizational structure sufficient to conduct the proposed operations and ensure that its financial resources are sufficient for sound business operations in accordance with:

2.2.3.1.1. County Organized Health System, Geographic Managed Care, and Two- Plan County: Title 28 CCR Sections 1300.67.3, 1300.75.1, 1300. 76.3, 1300.77.1, 1300.77.2, 1300.77.3, 1300.77.4, and Health and Safety Code, Section 1375.1.

2.2.4. Delegation Oversight

2.2.4.1. Contractor shall provide ongoing delegation oversight of the structures, processes, and outcomes of First Tier, Downstream, and Related Entities operations.

2.2.4.2. Contractor shall continually assess its First Tier, Downstream, and Related Entities' ability to perform delegated activities through initial reviews, on-going monitoring, performance reviews, analysis of data, and utilization of available benchmarks, if available.

2.2.4.3. Contractor's Quality Improvement (QI) department shall maintain documentation of oversight activities.

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2.2.4.4. Contractor's delegation oversight and monitoring activities shall emphasize results. To that end, Contractor shall identify areas requiring improvement and shall monitor the performance of the First Tier, Downstream, and Related Entities to ensure that such improvement occurs.

2.2.4.5. Contractor delegates activities to its First Tier, Downstream, and Related Entities in accordance with terms and conditions, contracts, applicable regulations, and this contract.

2.2.4.6. Contractor shall provide delegation oversight of its First Tier, Downstream, and Related Entities that includes the following:

2.2.4.6.1. Desktop and annual on-site revises;

2.2.4.6.2. Monitoring; and

2.2.4.6.3. Continuous improvement activities.

2.3. Enrollment Activities

2.3.1. General Enrollment

2.3.1.1. Contractor shall accept all eligible beneficiaries as defined in Appendix J – Eligible Populations.

2.3.1.2. Eligible beneficiaries residing within the Contractor Service Area may be enrolled at any time up to six (6) months prior to the end of the Demonstration. Eligible beneficiaries shall be accepted by Contractor in the order in which they apply without regard to race, color, national origin, creed, ancestry, religion, language, age, gender, marital status, sexual orientation, health status, need for health care services or disability.

2.3.1.3. Enrollee coverage shall begin at 12:01 a.m. on the first day of the calendar month for which the eligible beneficiary's name is added to the approved list of Enrollees furnished by CMS and the DHCS Enrollment Broker. The term of enrollment shall continue unless this Contract expires, is terminated, or the Enrollee is disenrolled under the conditions described in Section 2.3.2, Disenrollment.

2.3.1.4. Enrollment will proceed unless restricted by CMS or the Sstate. Such restrictions will be defined in writing by CMS or the Sstate and the Contractor notified at least ten (10) calendar days prior to the start of the period of restriction. Release of restrictions will be in writing and transmitted to the Contractor at least ten (10) days calendar prior to the date of the release.

2.3.1.5. Intelligent Assignment. Enrollment activities specific to Two-Plan Counties and GMC Counties (Los Angeles, San Diego, San Bernardino, Santa Clara, Riverside):

2.3.1.5.1. On a quarterly basis, Contractor shall provide DHCS with a complete list of Network Providers and National Provider Identifier (NPI) numbers to assist in the assignment of eligible beneficiaries as part of the Passive Enrollment process. The Network Provider list will include all Network Providers for the Provider Network, where applicable.

2.3.1.5.2. Updates to the Network Provider list shall be sent to DHCS on a quarterly basis for the purposes of intelligent assignment, or as changes to the Provider Network are applied.

2.3.1.5.3. As part of the Enrollment process, DHCS will exclude individuals identified as at-risk or potentially at-risk for abuse or overuse of specified prescription drugs per 42 C.F.R. §§ 423.100 and 423.153(f).

2.3.1.5.4. As part of the Passive Enrollment process, DHCS will initially assign an Enrollee to a Cal MediConnect Plan based on a hierarchical logic in accordance with Section 2.3.1.5.1. Subject to 42 C.F.R. §§ 423.100 and 423.153(f), Enrollees shall have the ability to change Cal MediConnect Plans at any time.

2.3.1.5.4.1. DHCS shall utilize the following hierarchical logic to determine Primary Contractor Plan assignment:

2.3.1.5.4.1.1. If a beneficiary is in a Medi-Cal Managed Care Plan that is participating in the Cal MediConnect

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Program and is not enrolled in a Medicare Advantage product, DHCS will assign the beneficiary to the matching Cal MediConnect plan.

2.3.1.5.4.1.2. If the beneficiary is in a Medicare Advantage Dual Special Needs Plan owned by the parent organization of an MMP, DHCS will assign the beneficiary to the matching MMP.

2.3.1.5.4.1.3. If a beneficiary is in fee-for-service Medi-Cal and Medicare, DHCS will match the beneficiary's highest utilized and paid prescribing and/or rendering provider data [based on the most recent and available twelve (12) months of Medicare and Medi-Cal claim data] to the list of Network Providers supplied by the Contractor, in accordance with Section 2.3.1.5.1.

2.3.1.5.4.1.4. If only one (1) Cal MediConnect Plan is identified with the beneficiary's provider(s) in its network, DHCS will assign the beneficiary to that Cal MediConnect Plan.

2.3.1.5.4.1.5. If two (2) or more Cal MediConnect Plans are identified or if there is insufficient claim data to match to a Cal MediConnect Plan, the system will select a Cal MediConnect Plan based on an equal distribution ratio. For example, if there are two (2) Cal MediConnect Plans in the county, DHCS will assign based on a 50/50 split. In San Diego, the system will divide beneficiary assignments equally across the four (4) Cal MediConnect Plans.

2.3.1.5.4.1.6. This distribution is dependent on Contractor capacity and subject to be altered per the direction of the Contract Management Team (CMT).

2.3.1.5.5. DHCS will notify CMS and the Contractor of the beneficiary assignments via the enrollment transactions sent to CMS and the 834 Enrollment file.

2.3.1.5.6. DHCS will inform the Contractor of the provider NPIs used in the plan selection process.

2.3.1.5.7. CMS will notify the Contractor of the beneficiary assignments via the Daily Transaction Response Reply (DTRR) file distributed through the CMS Enrollment Broker.

2.3.1.5.8. Contractor is responsible for outreach to the Network Provider for enrollment related activities and for providing data to DHCS.

2.3.1.5.9. Contractor shall maintain systems to accept enrollment transactions from CMS' and the State's systems. Contractor shall process enrollment and disenrollment transactions according to the Medicare-Medicaid Plan Enrollment and Disenrollment Guidance, posted at http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/MMPFinalEnrollGuidance.pdf

2.3.1.6. Enrollment activities specific to County Organized Health Systems.

2.3.1.6.1. Contractor shall maintain systems to identify eligible beneficiaries as defined in Appendix J, and transmit enrollment transactions to CMS and the State's systems. Contractor shall process enrollment and disenrollment transactions according to the Medicare-Medicaid Plan Enrollment and Disenrollment Guidance Document.

2.3.1.7. Subject to CMT approval and Section 2.17.1.1.2, the Contractor may participate in Streamlined Enrollment.

2.3.1.7.1. Eligible Enrollees must be enrolled in the Contractor's Medi-Cal plan product.

2.3.1.8. CMS and DHCS may adjust the volume and spacing of Passive Enrollment periods, and will consider input from the Contractor in making any such adjustments.

2.3.1.9. The Contractor may, via the CMT, request a capacity limit pursuant to 42 C.F.R. § 422.60. For purposes of this Demonstration, CMS and DHCS will consider financial stability and network adequacy in the determination of a capacity limit.

2.3.2. Disenrollments

2.3.2.1. The Contractor shall have a mechanism for receiving timely information about all disenrollments from the Contractor's plan, including the effective date of disenrollment, from CMS and DHCS systems.

2.3.2.2. Contractor in Two-Plan and GMC Counties shall have processes and procedures in place to refer Enrollees that request disenrollment from the Plan to the DHCS Enrollment Broker.

2.3.2.3. Enrollees with a share of cost that do not meet the share of cost on the first of the month will be deemed eligible and remain enrolled for up to two (2) months at the Contractor's responsibility before being disenrolled per California's State-specific guidance to the Medicare-Medicaid Plan Enrollment and Disenrollment Guidance (Section 2.3.1.5.9.). Please see Appendix J for eligibility requirements for beneficiaries with a share of cost.

2.3.2.4. Subject to 42 C.F.R. §§ 423.38 and 423.100, Enrollees can elect to disenroll from the Cal MediConnect Plan or the Demonstration at any time and enroll in another Cal MediConnect Plan in a Two-Plan County or GMC county, a Medicare Advantage plan, PACE (as otherwise permissible); or elect to receive services through Medicare fee-for-service and a prescription drug plan and to receive Medicaid services in accordance with DHCS's Medi-Cal program and any waiver programs. (see Appendix L) Disenrollments received by DHCS or its contractor, or by CMS or its

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contractor, either orally or in writing, by the last calendar day of the month will be effective on the first calendar day of the following month.

2.3.2.4.1. The Contractor shall be responsible for ceasing the provision of Covered Services to an Enrollee upon the effective date of disenrollment.

2.3.2.4.2. DHCS and CMS shall terminate an Enrollee's coverage upon any of the occurrences specified in the Medicare-Medicaid Plan Enrollment and Disenrollment Guidance, including but not limited to the following:

2.3.2.4.2.1. The Enrollee's death. This disenrollment is effective the first day of the calendar month following the month of death. Termination may be retroactive to the month in which the Enrollee dies.

2.3.2.4.2.2. When an Enrollee elects to change Demonstration Plans. The effective date of disenrollment is the first day of the month after the month in which the disenrollment request was received.

2.3.2.4.2.3. When an Enrollee requests and is enrolled in a new Medicare Advantage plan through 1-800-Medicare. The effective date of disenrollment is the first day of the month after the month in which the disenrollment request was received.

2.3.2.4.2.4. When an Enrollee elects to receive his or her Medicare services through Medicare fee-for-service and a separate Medicare prescription drug plan.

2.3.2.4.2.5. The termination or expiration of this Contract terminates coverage for all Enrollees with the Contractor. Termination will take effect at 11:59 p.m. on the last day of the month in which this Contract terminates or expires, unless otherwise agreed to, in writing, by the parties.

2.3.2.4.3. The Contractor may not request the disenrollment of any Enrollee due to an adverse change in the Enrollee's health status or because of the Enrollee's utilization of medical services, diminished mental capacity, or uncooperative or disruptive behavior resulting from his or her special needs. The Contractor, however, may submit a written request, accompanied by supporting documentation to the CMT to disenroll an Enrollee, for cause, for the following reasons:

2.3.2.4.3.1. Enrollee remains out of the Service Area or cannot be located for more than six (6) consecutive months; or

2.3.2.4.4. The Contractor may not threaten, intimidate, pressure, or otherwise interfere with the Enrollee's right to disenroll.

2.3.2.5. Discretionary Involuntary Disenrollment: 42 C.F.R. § 422.74 and Sections 40.3 and 40.4 of the Medicare-Medicaid Plan Enrollment and Disenrollment Guidance provide instructions to Cal MediConnect Plans on discretionary involuntary disenrollment. This Contract and other guidance provide procedural and substantive requirements the Contractor, DHCS, and CMS must follow prior to involuntarily disenrolling an Enrollee. If all of the procedural requirements are met, DHCS and CMS will decide whether to approve or deny each request for involuntary disenrollment based on an assessment of whether the particular facts associated with each request satisfy the substantive evidentiary requirements.

2.3.2.5.1. Bases for Discretionary Involuntary Disenrollment:

2.3.2.5.1.1. Disruptive conduct: When the Enrollee engages in conduct or behavior that substantially impairs the Contractor's ability to furnish Covered Items and Services to either this Enrollee or other Enrollees and provided the Contractor made and documented reasonable efforts to resolve the problems presented by the Enrollee.

2.3.2.5.2. Procedural requirements:

2.3.2.5.2.1. The Contractor's request must be in writing and include all of the supporting documentation outlined under the evidentiary standards in Section 2.3.2.5.3.

2.3.2.5.2.2. The process requires three (3) written notices. The Contractor must include in the request, submitted to DHCS and CMS, evidence that the advance notice and notice of intent have already been sent to the Enrollee. The notices are:

2.3.2.5.2.2.1. Advance notice to inform the Enrollee that the consequences of continued disruptive behavior will be disenrollment. The advance notice must include a clear and thorough explanation of the disruptive conduct and its impact on the Contractor's ability to provide services, examples of the types of reasonable accommodations the Contractor has already offered, the Grievance procedures, and an explanation of the availability of other accommodations. If the disruptive behavior ceases after the Enrollee receives notice and then later resumes, the Contractor must begin the process again. This includes sending another advance notice.

2.3.2.5.2.2.2. Notice of intent to request the State and CMS' permission to disenroll the Enrollee; and

2.3.2.5.2.2.3. Planned action notice advising that CMS and the State have approved the Contractor's request. This planned action notice is not a procedural prerequisite for

approval and should not be sent under any circumstances prior to the receipt of express written approval and a disenrollment transaction from CMS and DHCS.

2.3.2.5.2.3. The Contractor must provide information about the Enrollee, including age, diagnosis, mental status, functional status, a description of his or her social support systems, and any other relevant information;

2.3.2.5.2.4. The submission must include statements from providers describing their experiences with the Enrollee (or refusal in writing, to provide such statements); and

2.3.2.5.2.5. Any information provided by the Enrollee. The Enrollee can provide any information he/she wishes.

2.3.2.5.2.6. If the Contractor is requesting the ability to decline future Enrollments for this individual, the Contractor must include this request explicitly in the submission.

2.3.2.5.2.7. Prior to approval, the complete request must be reviewed by DHCS and CMS including representatives from the Center for Medicare and must include staff with appropriate clinical or medical expertise.

2.3.2.5.3. Evidentiary standards: At a minimum, the supporting documentation must demonstrate the following to the satisfaction of both DHCS and CMS staff with appropriate clinical or medical expertise:

2.3.2.5.3.1. The Enrollee is presently engaging in a pattern of disruptive conduct that is seriously impairing the Contractor's ability to furnish Covered Items and Services to the Enrollee and/or other Enrollees.

2.3.2.5.3.2. The Contractor took reasonable efforts to address the disruptive conduct including at a minimum:

2.3.2.5.3.2.1. A documented effort to understand and address the Enrollee's underlying interests and needs reflected in his/her disruptive conduct and provide reasonable accommodations as defined by the Americans with Disabilities Act including those for individuals with mental and/or cognitive conditions. An accommodation is reasonable if it is efficacious in providing equal access to services and proportional to costs. DHCS and CMS will determine whether the reasonable accommodations offered are sufficient.

2.3.2.5.3.2.2. A documented provision of information to the individual of his or her right to use the Grievance procedures.

2.3.2.5.3.2.3. The Contractor provided the Enrollee with a reasonable opportunity to cure his/her disruptive conduct.

2.3.2.5.3.3. The Contractor must provide evidence that the Enrollee's behavior is not related to the use, or lack of use, of medical services.

2.3.2.5.3.4. The Contractor may also provide evidence of other extenuating circumstances that demonstrate the Enrollee's disruptive conduct;

2.3.2.5.4. Limitations: The Contractor shall not seek to terminate enrollment because of any of the following:

2.3.2.5.4.1. The Enrollee's uncooperative or disruptive behavior resulting from such Enrollee's special needs unless treating providers explicitly document their belief that there are no reasonable accommodations the Contractor could provide that would address the disruptive conduct.

2.3.2.5.4.2. The Enrollee exercises the option to make treatment decisions with which the Contractor or any health care professionals associated with the Contractor disagree, including the option of declining treatment and/or diagnostic testing.

2.3.2.5.4.3. An adverse change in an Enrollee's health status or because of the Enrollee's utilization of Covered Items and Services.

2.3.2.5.4.4. The Enrollee's mental capacity is, has, or may become diminished.

2.3.2.5.5. Fraud or abuse: When the Enrollee provides fraudulent information on an Enrollment form or the Enrollee willfully misuses or permits another person to misuse the Enrollee's ID card.

2.3.2.5.5.1. The Contractor may submit a request that an Enrollee be involuntarily disenrolled if an Enrollee knowingly provides, on the election form, fraudulent information that materially affects the individual's eligibility to enroll in the Contractor's plan; or if the Enrollee intentionally permits others to use his or her enrollment card to obtain services from the Contractor.

2.3.2.5.5.2. Prior to submission, the Contractor must have and provide to CMS/DHCS credible evidence substantiating the allegation that the Enrollee knowingly provided fraudulent information or intentionally permitted others to use his or her card.

2.3.2.5.5.3. The Contractor must immediately notify the CMT so that the Enrollment Broker and the HHS Office of the Inspector General may initiate an investigation of the alleged fraud and/or abuse.

2.3.2.5.6. The Contractor must provide notice to the Enrollee prior to submission of the request outlining the intent to request disenrollment with an explanation of the basis of the plan's decision and information on the Enrollee's access to Grievance procedures and a fair hearing.

2.4. Covered Services

2.4.1. The Contractor must authorize, arrange, integrate, and coordinate the provision of all Covered Services for its Enrollees. (See Covered Services in Appendix A.) Covered Services must be available to all Enrollees, as authorized by the Contractor. Covered Services include the Behavioral Health services that become Medi-Cal managed care benefits, pursuant to Welfare and Institutions Code section 14132.03.

2.4.2. The Contractor must provide the full range of Covered Services. If either Medicare or Medi-Cal provides more expansive services than the other program does for a particular condition, type of illness, or diagnosis, the Contractor must provide the most expansive set of services required by either program.

2.4.3. Care Plan Option (CPO) Services may be provided at the sole discretion of the Contractor and in accordance with the ICP.

2.4.3.1. The Grievance and Appeals process for CPO Services shall be the same process as used for others benefits authorized by the Contractor, as described in Sections 2.14 and 2.15, and shall comply with Welfare & Institutions Code section 14450 and Health & Safety Code sections 1368 and 1368.1.

2.4.3.2. CPO Services may include, but are not limited to:

2.4.3.2.1. Respite care: in home or out-of-home, which shall not supplant authorized IHSS hours;

2.4.3.2.2. Additional Personal Care and Chore Type Services beyond those authorized by IHSS; Contractor will

notify counties if additional personal care services are provided.

2.4.3.2.3. Nutritional assessment, supplements, and home delivered meals;

2.4.3.2.4. Home maintenance and minor home or environmental adaptation; and

2.4.3.2.5. Supplemental protective supervision.

2.4.3.3. Other services and requirements in accordance with the guidance provided in current and applicable DPL(s) as described in Section 2.1.5.

2.4.4. The Contractor may not contract with, or otherwise pay for any items or services (other than an emergency item or service, not including items or services furnished in an emergency room of a hospital):

2.4.4.1. Furnished by the Contractor by any individual or entity during any period when the individual or entity is excluded from participation under Titles V, XVIII, or XX, or under Title XIX pursuant to sections 1128, 1128A, 1156, or 1842(j)(2);

2.4.4.2. Furnished at the medical direction or on the prescription of a physician, during the period when such physician is excluded from participation under Titles V, XVIII, or XX, or under Title XIX pursuant to sections 1128, 1128A, 1156, or 1842(j)(2) and when the person furnishing such item or service knew, or had some reason to know, of the exclusion (after a reasonable time period and after reasonable notice has been furnished to the person;

2.4.4.3. Furnished by an individual or entity to whom the State has failed to suspend payments during any period when there is a pending investigation of a credible allegation of fraud against the individual or entity, unless the State determines there is good cause not to suspend such payments;

2.4.4.4. Furnished by an individual or entity that is included on the preclusion list, as defined in 42 C.F.R. § 422.222.

2.4.5. The Contractor may not pay for an item or service with respect to any amount expended for which funds may not be used under the Assisted Suicide Funding Restriction Act of 1997.

2.5. Care Delivery Model

2.5.1. Contractor shall abide by the care delivery model described within this Contract and is not required to submit a model of care to CMS or DHCS unless otherwise requested.

2.5.2. Care Coordination. The Contractor shall offer Care Coordination and case management services to all Enrollees, as described in Welfare and Institutions Code sections 14182.17(d)(4) and 14186(b).

2.5.2.1. Contractor will coordinate Enrollee care across the full continuum of service providers, including medical, Behavioral Health, and LTSS.

2.5.2.2. Contractor will focus on providing services in the least restrictive setting.

2.5.2.3. Care Coordination will be led by the Care Coordinator with participation by members of the ICT.

2.5.2.4. Contractor shall ensure effective linkages of clinical and management systems among Network Providers. Such linkages shall be established in plan policies and procedures.

2.5.2.4.1. Such linkages shall include communication protocols among First Tier, Downstream, and Related Entities.

2.5.2.5. Contractor's policies and procedures shall clarify all communications and reporting protocols related to coordination of services including but not limited to how Contractor shall oversee all such coordination activities.

2.5.2.6. Contractor will ensure that Care Coordination services:

2.5.2.6.1. Reflect a person-centered, outcome-based approach, consistent with the, CFAM-MOU, and DHCS' RFS;

2.5.2.6.2. Follow Enrollee's direction about the level of involvement of his or her caregivers or medical providers;

2.5.2.6.3. Span medical and LTSS systems, including coordination with IHSS, with a focus on transitions;

2.5.2.6.4. Reflect coordination with county agencies and direct contractors, if applicable, for Behavioral Health services;

2.5.2.6.5. Reflect coordination with county agencies, if applicable, for IHSS services;

2.5.2.6.6. Reflect coordination with Medi-Cal Dental and any MMP supplemental dental benefits, as applicable, for dental services;

2.5.2.6.7. Include development of Individual Care Plans (ICP) with Enrollees, as described in Section 2.8.3;

2.5.2.6.8. Are performed by nurses, social workers, Primary Care Providers, if appropriate, other medical, Behavioral Health, or LTSS professionals, and health plan Care Coordinators, as applicable; and

2.5.2.6.9. Reflect access to appropriate community resources, as defined in Welfare and Institution Code sections 14132.275(f)(7) and 14182.17(d) (4)(G) and (6)(B) and monitoring of skilled nursing utilization, with a focus on providing services in the least restrictive setting and transitions between the facilities and community.

2.5.2.7. Contractor will have a process for assigning a Care Coordinator to each Enrollee. Assignment will be made to a Care Coordinator with the appropriate experience and qualifications based on an Enrollee's assigned risk level and individual needs.

2.5.2.7.1. Contractor shall ensure an adequate ratio of Care Coordinators to Enrollees to provide Care Coordination as required through this Contract. The CMT shall monitor the ratio of Care Coordinators to Enrollees on a regular basis.

2.5.2.8. Interdisciplinary Care Team (ICT). The Contractor shall offer an ICT for each Enrollee, which will be developed around the Enrollee and ensure the integration of the Enrollee's medical and LTSS and the coordination of Behavioral Health

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Services delivered by a county Behavioral Health agency and IHSS services, when applicable. ICTs must be comprised of professionals appropriate for the needs, preferences, and abilities of the Enrollee.

2.5.2.8.1. Every Enrollee will have access to an ICT.

2.5.2.8.2. Enrollees may request the exclusion of any ICT member.

2.5.2.8.3. Contractor must include information about the ICT and ICP in their new member welcome packets.

2.5.2.8.4. ICT Functions. ICT will facilitate care management, including assessment, care planning, and authorization of services, transitional care issues and work closely with providers listed in Section 2.5.2.8.6.1to stabilize medical conditions, increase compliance with Care Plans, maintain functional status, and meet individual Enrollees Care Plan goals. ICT functions will include, at a minimum:

2.5.2.8.4.1. Develop and implement an ICP with Enrollee and/or caregiver participation as further described in Sections 2.5.2.11.7 and 2.8.3;

2.5.2.8.4.2. Conduct ICT meetings periodically, including at the Enrollee's discretion;

2.5.2.8.4.3. Manage communication and information flow regarding referrals, transitions, and care delivered outside the primary care site;

2.5.2.8.4.4. Maintain a call line or other mechanism for Enrollee inquiries and input , and a process for referring to other agencies, such as LTSS, IHSS, or Behavioral Health agencies, as appropriate;

2.5.2.8.4.5. Conduct conference calls among the Contractor, providers, and Enrollees;

2.5.2.8.4.6. Maintain a mechanism for monitoring Enrollee complaints and Grievances ; and

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2.5.2.8.4.7. Use secure email, fax, web portals or written correspondence to communicate. The ICT must take the Enrollee's individual needs (e.g., communication, cognitive, or other barriers) into account in communicating with the Enrollee.

2.5.2.8.5. Composition of ICT. ICT must be person-centered: built on the Enrollee's specific preferences and needs, delivering services with transparency, individualization, respect, linguistic and cultural competence, and dignity.

2.5.2.8.5.1. The ICT will be led by professionally knowledgeable personnel to address the Enrollee's medical, behavioral and LTSS care. If the ICT is led by a PCP, the PCP must be credentialed.ICT will include the Enrollee and/or authorized representative, family and/or caregiver if approved by the Enrollee, PCP (this may be a specialist, if a specialist is serving as the PCP), Care Coordinator, and may include the following persons, as needed and if applicable:

2.5.2.8.5.1.1. Hospital discharge planner;

2.5.2.8.5.1.2. Nursing facility representative;

2.5.2.8.5.1.3. Social Worker, including the IHSS social worker if IHSS services are provided;

2.5.2.8.5.1.4. Specialized providers, such as pharmacists and physical therapists;

2.5.2.8.5.1.5. If receiving IHSS, the IHSS provider, if authorized by Enrollee;

2.5.2.8.5.1.6. If enrolled in CBAS, the CBAS provider, if authorized by Enrollee;

2.5.2.8.5.1.7. MSSP care manager;

2.5.2.8.5.1.8. Behavioral Health specialist, which may include, but is not limited to, a specialty mental health provider or a substance use disorder counselor; and

2.5.2.8.5.1.9. Other professionals, as appropriate, and as delineated in applicable and current DPLs

2.5.2.8.6. Communication with ICT. Contractor will support multiple levels of interdisciplinary communication and coordination, such as individual consultations among providers, county agencies, and Enrollees. Contractor will have a documented process for coordinating the exchange of information amongst all ICT members, including when a change in ICT membership occurs.

2.5.2.8.7. Contractor will have procedures for notifying the ICT of emergency department use, hospital admission (psychiatric or acute) or SNF and coordinating a discharge plan.

2.5.2.8.8. Competencies of ICT. Contractor will provide training for ICT members, and potential ICT members, initially and on an annual basis. Required training topics include:

2.5.2.8.8.1. Person-centered planning processes;

2.5.2.8.8.2. Cultural competence;

2.5.2.8.8.3. Accessibility and accommodations;

2.5.2.8.8.4. Independent living and recovery and wellness principles; and

2.5.2.8.8.5. Information about LTSS programs, eligibility for these services, and program limitations.

2.5.2.8.8.6. Coordination with counties on IHSS.

2.5.2.8.9. Nothing in this contract shall be construed as requiring the Enrollee to participate on the ICT. The

Contractor shall allow the Enrollee to opt-out of the ICT at any time and the ICT shall be able to continue its operations. Enrollees may not be disenrolled for lack of participation on the ICT. Criteria for disenrollment are discussed in Section 2.3.2.

2.5.2.8.10. If an Enrollee refuses an ICT, at a minimum the Care Coordinator must provide his or her contact information to the Enrollee and re-visit the refusal at the time of reassessment, or if the Enrollee's PCP changes.

2.5.2.8.11. The administration of the ICT will also follow all applicable current DPLs.

2.5.2.9. Individual Care Plan (ICP). Contractor will develop an ICP for each Enrollee. Contractor will regularly engage Enrollees and/or their representatives in the design, reassessment and updates of the ICPs.

2.5.2.9.1. Enrollees or their authorized representative must have the opportunity to review and sign the ICP and any of its amendments. Contractor must provide Enrollees with copies of the ICP and any of its amendments. The ICP must be made available in alternative formats and in an Enrollee's preferred written or spoken language.

2.5.2.10. If an Enrollee refuses to be involved in ICP development, the Contractor must seek to re-visit the refusal at least at the time of reassessment, or if the Enrollee's PCP changes.

2.5.2.11. ICPs will include:

2.5.2.11.1. The name and contact information for the Enrollees current, assigned Care Coordinator. Enrollee service numbers may be used only if the number will transfer the Enrollee to her/his assigned Care Coordinator;

2.5.2.11.2. The name and contact information for the Enrollee's PCP and any specialists;

2.5.2.11.3. A complete, current list of the Enrollee's medications;

2.5.2.11.4. Enrollee goals, preferences, choices and abilities;

2.5.2.11.5. Measurable objectives and timetables to meet medical, Behavioral Health services, and LTSS needs as determined through the HRA, Multipurpose Senior Services Program (MSSP), and Community-Based Adult Services (CBAS) records, behavioral health utilization, other data, self and provider referrals, and input from members of the ICT, as appropriate;

2.5.2.11.6. Coordination of carved-out and linked services, and referral to appropriate community resources and other agencies, when appropriate;

2.5.2.11.7. Timeframes for reassessment and updating of Care Plan, to be done at least annually or if a significant change in condition occurs;

2.5.2.11.8. If the Enrollee is receiving Behavioral Health services, the ICP will also include:

2.5.2.11.8.1. The name and contact information of the primary county or county-contracted Behavioral Health provider;

2.5.2.11.8.2. Attestation that the county Behavioral Health provider and PCP have reviewed and approved the ICP; and

2.5.2.11.8.3. Record of at least one (1) case review meeting that included the county Behavioral Health provider and includes date of meeting, names of participants, and evidence of creation or adjustment of care goals.

2.5.2.11.9. If the Enrollee is receiving IHSS, the ICP should also include:

2.5.2.11.9.1. The name and contact information for the county social worker with the responsibility for authorizing and overseeing IHSS hours; and

2.5.2.11.9.2. The name and contact information for the IHSS worker.

2.5.2.11.10. Additional components discussed in current and applicable DPLs consistent with Section 2.1.5.

2.5.2.12. The Contractor will transfer, to another MMP, or its designated Contractor for Enrollees, information necessary to support continuity of care when an Enrollee transfers to another MMP. This information includes, but is not limited to, assessment, ICP, and other pertinent information.

2.5.2.12.1. The information shall be provided no later than thirty (30) calendar days from receipt of the notice of disenrollment to the Contractor and in theformat specified by DHCS and CMS.

2.5.2.12.2. This data sharing package and process will be subject to CMT approval following a joint planning process in the first half of 2018 with CMS, DHCS, and the Contractor.

2.5.2.12.2.1. Detail regarding data transfer methods, the content of the transfer package, look back periods, eligible beneficiaries, and other transfer specifics will be determined via this planning process

2.5.2.13. Basic Case Management. The PCP and/or Care Coordinator, in collaboration with the Contractor, will provide basic case management services.

2.5.2.13.1. Enrollees may choose to refuse any treatment, including case management.

2.5.2.13.2. Basic case management services include:

2.5.2.13.2.1. A review of clinical information from the provider;

2.5.2.13.2.2. Completion of the HRA. (see Section 2.8);

2.5.2.13.2.3. Creation of the ICP, in collaboration with the ICT (see Section 2.8.3);

2.5.2.13.2.4. Identification and referral to appropriate providers and facilities, such as medical, rehabilitation, support services, LTSS,

Behavioral Health, Care Plan Option Services, and for covered and non-covered services;

2.5.2.13.2.5. Direct communication with Enrollee, Enrollee providers, and family;

2.5.2.13.2.6. Enrollee and family education, including health lifestyle changes when warranted (see Section 2.9.11.8); and

2.5.2.13.2.7. Coordination of services outside of the Cal MediConnect Plan, such as referral to appropriate community social services, specialty mental health, Drug Medi-Cal services, IHSS service agencies or Medi-Cal Dental.

2.5.2.14. Complex Case Management. Contractor will develop methods to identify Enrollees who may benefit from complex case management services, using the risk stratification and HRA results (see sections 2.8.1 and 2.8.2) as well as utilization and clinical data and any other available information across medical, LTSS, and Behavioral Health domains, as well as self and provider referrals.

2.5.2.14.1. Complex case management services will include:

2.5.2.14.1.1. Basic case management services (see Section 2.5.2.13 et. seq.)

2.5.2.14.1.2. Management of acute or chronic illness

2.5.2.14.1.3. Intense coordination of resources to ensure Enrollee maintains optimal health or improved functionality, maintains current functioning, prevents or delays functional decline, and avoids institutionalization when appropriate and possible.

2.5.2.15. Coordination of Care Management. Contractor shall coordinate with external organization(s) for provision of Covered Services (described in Appendix A) as appropriate for the Enrollee (see Sections 2.6 and 2.7).

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2.5.2.15.1. Contractor shall develop and implement processes for coordination models that support appropriate referral of Enrollee to MSSP organization for services, assessment, eligibility determination, delineation of roles and responsibilities for care management.

2.5.2.15.2. Contractor shall develop and implement processes for coordination of care for nursing facility residents, including care transition plans and programs to move Enrollees back into the community to the extent possible, in accordance with WIC section 14182.17(d)(4)(H) and in accordance with the guidance provided in current and applicable DPL(s) as described in Section 2.1.5.

2.5.2.16. Coordination of Care Management with external organization for provision of IHSS as appropriate for the Enrollee.

2.5.2.16.1. Contractor shall develop and implement processes for coordination models that support appropriate referral of Enrollees to county IHSS agency for services, assessment, eligibility determination, delineation of roles and responsibilities for care management.

2.5.2.17. Care Plan Option Services. A CPO Service is optional under the Enrollee's ICP. See Section 2.4.3.

2.5.2.18. Annual Evaluation of Care Management Program. Contractor will conduct annual review, analysis, and evaluation of the effectiveness of the care management program processes and identify actions to be implemented to improve the quality of care and delivery of services.

2.5.2.18.1. Contractor will have a process for developing a corrective action plan, with specified timelines, for any out of compliance findings.

2.5.2.19. Discharge Planning and Care Coordination. Contractor shall ensure provision of discharge planning when Enrollee is admitted to a hospital or institution and continuation into the post discharge period. Discharge planning shall include ensuring that the necessary care, services, and supports are

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in place in the community for the Enrollee once he or she is discharged from a hospital or institution, including scheduling an outpatient appointment and/or conducting follow-up with the Enrollee and/or caregiver. Minimum criteria for discharge planning checklist must include:

2.5.2.19.1. Documentation of pre-admission status, including living arrangements, physical and mental function, social support, durable medical equipment (DME), and other services received. Documentation of pre-discharge factors, including an understanding of the medical condition or functional status by Enrollee or a representative of the Enrollee as applicable, physical and mental health status, financial resources, and social supports.

2.5.2.19.2. Per current and applicable DPLs regarding discharge planning, services needed after discharge, type of placement preferred by the Enrollee/representative of the Enrollee and hospital/institution, type of placement agreed to by the Enrollee/representative of Enrollee, specific agency/home recommended by the hospital, specific agency/home agreed to by the Enrollee/representative of the Enrollee, and pre-discharge counseling recommended.

2.5.2.19.3. Post-transition discharge policies and procedures will cover criteria to include, but not limited to, access to necessary medical care and follow up, medications, durable medical equipment and supplies, transportation, and integration of community based LTSS programs, as well as coordination with IHSS services authorized by the counties.

2.5.2.19.4. Coordination, as appropriate, with: 1) county agencies for IHSS and Behavioral Health services (through social worker and providers, as needed); 2) MSSP providers; 3) CBAS centers; 4) community organizations such as Area Agencies on Aging and DHCS Care Transition projects; 5) LTSS providers, including nursing facilities; 6) specialized providers (including, but not limited to specialists, pharmacists, physical/occupational therapists; 7) Medi-Cal Dental and, 8) others as deemed appropriate. For IHSS, the

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Contractor's coordination process must be developed jointly with county social service agencies and consider State requirements for counties regarding discharge planning.

2.5.2.19.5. Policies and procedures governing expedited MSSP assessment and eligibility determination as part of the Contractor's Care Coordination process for Enrollees who are being discharged from the hospital or at risk of immediate placement in a SNF.

2.5.2.19.6. Summary of the nature and outcome of Enrollee involvement in the discharge planning process, anticipated problems in implementing post-discharge plans, and further action contemplated by the hospital/institution.

2.5.2.19.7. For Enrollees receiving Behavior Health services, Contractor will have procedures developed jointly with the MHP for:

2.5.2.19.7.1. Notification of the ICT of hospital admission (psychiatric or acute) and coordinating a discharge plan, if applicable.

2.5.2.19.7.2. Direct transfers between psychiatric inpatient hospital services and inpatient hospital services required to address an Enrollee's medical problems based on changes in the Enrollee's mental health or medical condition.

2.5.2.20. In addition to the oversight of plan complaints, Grievances, and Cal MediConnect Ombuds Program activity via the CMT, the Contractor shall include ombudsman reports in quarterly updates to local advisory convenings and shall participate in all statewide stakeholder and oversight convenings as delineated in DPLs.

2.6. Long-Term Services and Supports (LTSS).

2.6.1. Contractor will ensure access to, provision of, and payment for: 1) CBAS for Enrollees who meet eligibility criteria for CBAS as defined in Section 2.6.1.1.1, and 2), MSSP for Enrollees who meet the eligibility

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criteria for MSSP pursuant to Welfare and Institutions Code section 9560.

2.6.1.1. Community Based Adult Services (CBAS): The Contractor shall contract for CBAS, which is an outpatient, facility-based program that delivers skilled nursing care, social services, therapies, personal care, family/caregiver training and support, nutrition services, and transportation to eligible Enrollees.

2.6.1.1.1. The Contractor shall make available the CBAS benefit to Enrollees who are age twenty-one (21) or older and derive their Medi-Cal eligibility from the State Plan, are Medicare beneficiaries, are either aged, blind, or disabled and who qualify based on the following criteria.

2.6.1.1.1.1. Meet medical necessity criteria as established by the State and meet "Nursing Facility Level of Care A" (NF-A) criteria, as set forth in the DHCS Code of Regulations, or above NF-A Level of Care; or

2.6.1.1.1.2. Have a moderate to severe cognitive disorder such as dementia, including dementia characterized by the descriptors of, or equivalent to, stages 5, 6, or 7 of the Alzheimer's Type; or

2.6.1.1.1.3. Have a mild cognitive disorder such as Dementia, including Dementia of the Alzheimer's Type, and needs assistance or supervision with two of the following: bathing, dressing, self-feeding, toileting, ambulation, transferring, medication management, or hygiene, or;

2.6.1.1.1.4. Have a Chronic Mental Disorder or acquired, organic, or traumatic brain injury. In addition to the presence of a Chronic Mental Disorder or acquired, organic, or traumatic brain injury, the Enrollee shall need assistance or supervision with either:

2.6.1.1.1.4.1. Two (2) of the following: bathing, dressing, self-feeding, toileting, ambulation, transferring, medication management, or hygiene; or

2.6.1.1.1.4.2. One (1) need from the above list and one (1) of the following: money management, accessing community and health resources, meal preparation, or transportation.

2.6.1.2. Multi-purpose Senior Services Program (MSSP): A program approved under the federal Medicaid Home and Community-Based, 1915(c) Waiver that provides HCBS to Medi-Cal eligible individuals who are 65 years or older with disabilities as an alternative to nursing facility placement.

2.6.1.2.1. Contractor shall inform its Enrollees about the MSSP and establish a mechanism to refer Enrollees who are enrolled in Cal MediConnect and are potentially eligible for the MSSP to MSSP providers for eligibility determination.

2.6.1.2.2. Care Coordination – Contractor shall coordinate and work collaboratively with MSSP providers on Care Coordination activities surrounding the MSSP Waiver Participant including, but not limited to: coordination of benefits between Contractor and MSSP provider to avoid duplication of services and coordinate Care Management activities particularly at the point of discharge from the MSSP.

2.6.1.2.3. For Enrollees that may qualify for MSSP, but are on the waiting list, the Contractor may provide alternate services as identified through the development of the ICP as described in Sections 2.5.2.11.7 and 2.8.3.

2.6.2. The Contractor will ensure referral to IHSS for Enrollees who meet the eligibility criteria for IHSS pursuant to Welfare and Institutions Code section 12305.6.

2.6.2.1. In-Home Supportive Services (IHSS): A program that serves aged, blind, or disabled persons who are unable to perform activities of daily living and cannot remain safely in their

own homes without help pursuant to the California Welfare and Institutions Code (commencing with section 12300) of Chapter 3, and sections 14132.95, 14132.952, and 14132.956.).

2.6.2.1.1. Contractor will coordinate with county agencies to facilitate IHSS participation on the ICT. Contractor will ensure Network Providers coordination with IHSS.

2.6.2.1.2. Contractor will coordinate with county agencies to develop and implement detailed processes for coordination and integration of IHSS which shall include, but not be limited to:

2.6.2.1.2.1. Provision of intake activities and redeterminations by IHSS social workers and allocation of IHSS hours according to WIC section 12301.1 and how that information is coordinated and shared with the ICT.

2.6.2.1.2.2. Framework for referrals to IHSS county agencies, coordination for change of condition, discharge planning, reassessments, and the ICT.

2.6.2.1.3. DHCS and CDSS will continue to provide the Contractor with IHSS assessment data.

2.6.3. Nursing Facilities

2.6.3.1. Contractor shall contract with SNFs, as defined in California Code of Regulations Title 22 section 51121(a), in its Service Area that are licensed by California Department of Public Health (CDPH) and certified by DHCS for participation as a SNF in the Medi-Cal Program and additional Contractor credentialing standards, if any. See Section 2.10.2.3.

2.6.3.2. If SNFs beds are not available in the Contractor's Service Area, Contractor shall contract with qualified SNFs in areas outside of the Contractor's Service Area, in correspondence to the Contractor's projected need for SNF beds of its Enrollees.

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2.7. Coordinated Primary Care and Behavioral Health.

2.7.1. Contractor shall provide Enrollee access to Behavioral Health services covered by Medicare and Medi-Cal with a focus on the Recovery Model (See Covered Services in Appendix A). Coordination of Behavioral Health services financed and administered by county agencies shall include at a minimum the following:

2.7.1.1. Contractor will develop and implement a plan to ensure seamless access, coordination and delivery of Covered Services that are Medically Necessary to Enrollees who meet the medical necessity criteria.

2.7.1.1.1. To determine responsibility for covering Medi-Cal Specialty Mental Health Services, the Contractor and county will follow the medical necessity criteria for specialty mental health 1915(b) waiver services described in the California Code of Regulations Title 9 sections 1820.205, 1830.205, and 1830.210. The outpatient criteria can be summarized as the following three criteria: 1) diagnosis – one or more of the specified diagnoses; 2) impairment – significant impairment or probability of deterioration of an important area of life functioning; or; 3) intervention: services must address the impairment, be expected to significantly improve the condition, and the condition is not responsive to a physical health care based treatment.

2.7.1.1.2. To determine medical necessity for Drug Medi-Cal Benefits, Contractor and counties will follow California Code of Regulations Title 22 sections 51303 and 54301. Services shall be prescribed by a physician, and are subject to utilization controls, as set forth in California Code of Regulations Title 22 section 51159.

2.7.1.1.3. To determine medical necessity for the authorization of Covered Services that become Medi-Cal managed care Behavioral Health Services on January 1, 2014, pursuant to Welfare and Institutions Code section 14132.03, the Contractor shall use medical necessity criteria set forth current and applicable DPL(s) as described in Section 2.1.5.

2.7.1.2. Contractor will have a Memorandum of Understanding (MOU) with county agencies that finance and administer Behavioral Health services. The MOU must be approved by CMS and DHCS. It will include:

2.7.1.2.1. Service Coordination: Contractor will include comprehensive screening for Behavioral Health as part of the HRA (see Section 2.8.2.2) and ICP (see Section 2.8.3). The local MOU will describe:

2.7.1.2.1.1. Delineation of clinical responsibilities and provider contracting responsibilities;

2.7.1.2.1.2. Point of contact within the Cal MediConnect Plan and county entity(ies) and the various communications processes to address issues related to clinical coordination, including pharmaceutical coordination;

2.7.1.2.1.3. A process for resolving disagreements related to clinical decision making, administrative, and policy issues;

2.7.1.2.1.4. Standardized approaches to screening, referral, and linkages and coordination for mental health and substance use services with timelines specified; and

2.7.1.2.1.5. Processes for clinical consultation and coordination of ICPs.

2.7.1.2.2. Administrative coordination: Contractor will clearly delineate administrative responsibilities and provider contracting responsibilities, including:

2.7.1.2.2.1. Point of contacts and communication processes to address administrative coordination;

2.7.1.2.2.2. Process for annual review and evaluation of administrative management programs; and

2.7.1.2.2.3. Process for demonstrating how administrative problem identification and resolution occurs.

2.7.1.2.3. Information exchange: Contractor will develop data sharing mechanisms with the county Behavioral Health agencies, to the greatest extent practicable under State and federal Privacy laws, to share accurate and timely information to inform care delivery. It will describe:

2.7.1.2.3.1. Information flow between Contractor and county agencies; and

2.7.1.2.3.2. Processes for exchange of health information.

2.7.1.2.4. Performance measures: Contractor is required to report on measures related to Behavioral Health services for which they have direct contracts with providers including Medicare Behavioral Health benefits.

2.7.1.2.4.1. Contractor is required to show evidence of data sharing agreement with county agencies that provide Medi-Cal Behavioral Health services. The data sharing agreements shall provide for the exchange of data in compliance with all applicable State and federal laws.

2.7.1.2.4.2. Shared financial accountability is discussed in Section 4.7.4.

2.8. Health Risk Assessments, ICP, and Care Coordination

2.8.1. Risk Stratification. Contractor will use an approved health risk stratification mechanism or algorithm to identify new Enrollees with high risk and more complex health care needs. The health risk stratification shall be conducted in accordance applicable DPL(s) as indicated in Section 2.1.5

2.8.1.1. Contractor shall use the following data sources to identify an Enrollees' risk level.

2.8.1.1.1. Medicare utilization data, including Medicare Parts A, B, and D.

2.8.1.1.2. Medi-Cal utilization data, including IHSS, MSSP, SNF, and Behavioral Health pharmacy data.

2.8.1.1.3. Results of previously administered assessments.

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2.8.1.1.4. Other population- and individual-based tools.

2.8.2. Health Risk Assessment (HRA). In accordance with all applicable federal and State laws WIC section 14182.17(d)(2), and in accordance with applicable DPL(s) as indicated in Section 2.1.5. Contractor will complete HRAs for all Enrollees.

2.8.2.1. The HRA will serve as the starting point for the development of the ICP.

2.8.2.2. For all Enrollees, the assessment process will, at a minimum, identify:

2.8.2.2.1. Referrals to appropriate LTSS and home- and community-based services;

2.8.2.2.2. Caregivers, Enrollees, and authorized representatives participation;

2.8.2.2.3. Facilitation of timely access to primary care, specialty care, DME, medications, and other health services needed by the Enrollee, including referrals to resolve physical or cognitive barriers to access;

2.8.2.2.4. Facilitation of communication among the Enrollee's providers, including Behavioral Health providers as appropriate;

2.8.2.2.5. Identification of the need for providing other activities or services needed to assist Enrollees in optimizing health or functional status, including assisting with self-management skills or techniques, health education, and other modalities improve health or functional status; and

2.8.2.2.5.1. Support for Enrollees who need more complex case management, as described in Sections 2.5.2.14 and 2.5.2.15.

2.8.2.2.5.2. Other elements in accordance with applicable DPL(s) as indicated in Section 2.1.5.

2.8.2.3. For Enrollees identified by the risk stratification mechanism described in Section 2.8.1 as higher-risk, the Contractor will complete the HRA within forty-five (45) calendar days of

enrollment in accordance with applicable DPL(s) as indicated in Section 2.1.5.

2.8.2.4. For Enrollees identified by the risk stratification mechanism described in Section 2.8.1 as lower-risk, the Contractor will complete the HRA within ninety (90) calendar days of enrollment in accordance with applicable DPL(s) as indicated in Section 2.1.5

2.8.2.5. Contractor shall notify PCPs of enrollment of any new Enrollee who has not completed a HRA within the time period set forth above and whom Contractor has been unable to contact. Contractor shall encourage PCPs to conduct outreach to their Enrollees and to schedule visits.

2.8.2.6. Reassessments will be conducted at least annually, within twelve (12) months of last assessment, or as often as the health and/or functional status of the Enrollee requires.

2.8.2.6.1. When determining the mode for completing reassessment, the Contractor will consider the reason the assessment needs to be updated, the Enrollee's needs and health or functional status, and the preference of the Enrollee.

2.8.2.7. Contractor will regularly use electronic health records and claims data to inform reassessments and to identify Enrollees at high risk, with newly diagnosed acute and chronic conditions, or high frequency emergency department or hospital use, or IHSS or Behavioral Health referral.

2.8.3. Individualized Care Plan (ICP). A comprehensive, person-centered ICP will be developed for each Enrollee that includes Enrollee goals and preferences, measurable objectives and timetables to meet medical needs, Behavioral Health and LTSS needs. It must include timeframes for reassessment. See Section 2.5.2.11.7.

2.8.3.1. The Contractor must complete the ICP within ninety (90) calendar days of enrollment.

2.8.3.2. The Contractor will provide the ICP to the Enrollee no less than annually.

2.8.4. Continuity of Care. Contractor shall ensure Enrollees continue to have access to medically necessary items, services, and medical and LTSS providers as described below and in accordance with applicable DPL(s) as indicated in Section 2.1.5.

2.8.4.1. Contractor must allow Enrollees to maintain their current providers and service authorizations at the time of enrollment for:

2.8.4.1.1. A period up to twelve (12) months for Medicare services if all of the following criteria are met under WIC section 14132.275(l)(2)(A):

2.8.4.1.1.1. Contractor will verify the Enrollee has an existing relationship with the provider prior to enrollment by identifying whether the Enrollee has seen the requested out-of-network PCP or specialist at least once within the previous twelve (12) months from the date of enrollment The link between the new Enrollee and the out-of-network provider may be established by the Contractor using Medicare data provided by DHCS or by documentation by the provider or Enrollee;

2.8.4.1.1.2. Provider is willing to accept payment from the Contractor based on the current Medicare fee schedule; and

2.8.4.1.1.3. Contractor would not otherwise exclude the provider from its Provider Network due to documented quality of care concerns or State or federal exclusion requirements.

2.8.4.1.2. A period of up to twelve (12) months for Medi-Cal services if all of the following criteria are met under Welfare and Institutions Code section 14182.17(d)(5)(G).

2.8.4.1.2.1. Contractor will verify the Enrollee has an existing relationship with the provider prior to enrollment by identifying whether the Enrollee has seen the requested out-of-network provider at least once within the previous

twelve (12) months from the date of enrollment. The link between the new Enrollee and the out-of-network provider may be established by the Contractor using Medi-Cal FFS claims, treatment authorization request data or Medi-Cal managed care Encounter Data provided by the State or by documentation from the provider or Enrollee.

2.8.4.1.2.2. Provider is willing to accept payment from the Contractor based on the Contractor's rate for the service offered or applicable Medi-Cal rate, whichever is higher; and

2.8.4.1.2.3. Contractor would not otherwise exclude the provider from their Provider Network due to documented quality of care concerns or State or federal exclusion requirements.

2.8.4.1.3. Enrollees will not be required to change nursing facilities during the duration of the Demonstration if they resided in the nursing facility prior to enrollment in MediConnect, the facility is licensed by CDPH, meets acceptable quality standards, and the facility and Contractor agree to rates in accordance with Section 2.8.4.1.2.2.

2.8.4.1.4. Sections 2.8.4.1.1 and 2.8.4.1.2 do not apply to providers of the following: durable medical equipment, medical supplies, transportation, other ancillary services, or carved-out services.

2.8.4.1.5. Contractor must inform Enrollees of its new Network Providers.

2.8.4.1.6. If an Enrollee receives care from an out-of-network provider, Contractor must advise the Enrollee and provider that they have received care from an out-of-network provider that would not otherwise be covered at an in-network level.

2.8.4.1.7. Part D transition rules and rights will continue as provided for in current law and regulation for the

entire integrated formulary associated with the Cal MediConnect Plan.

2.8.4.1.8. The DHCS will distribute an enrollment choice packet that will provide descriptions of continuity of care rights, developed in all Threshold Languages, and distributed to Enrollees in their enrollment choice packet, distributed sixty (60) days before they are enrolled in a Cal MediConnect Plan.

2.8.4.1.8.1. Contractors in COHS will distribute an enrollment package that will provide descriptions of continuity of care rights, developed in all Threshold Languages, and distributed to Enrollees in their enrollment packet, distributed sixty (60) days before they are enrolled in a Cal MediConnect Plan.

2.8.4.1.9. Out of Network Reimbursement Rules – For reimbursement of out-of-network Emergency Services or Urgent Care services, as defined by 42 C.F.R. § 424.101 and 42 C.F.R. § 405.400 respectively, the Health Care Professional is required to accept as payment in full by the Contractor the amounts that the Health Care Professional could collect for that service if the beneficiary were enrolled in original Medicare or Medi-Cal FFS. However, the Contractor is not required to reimburse the Health Care Professional more than the Health Care Professional's charge for that service. The original Medicare reimbursement amounts for providers of services (as defined by section 1861(u) of the Act) do not include payments under 42 C.F.R. §§ 412.105(g) and 413.76. A section 1861(u) provider of services may be paid an amount that is less than the amount it could receive if the beneficiary were enrolled in original Medicare or Medicaid FFS if the provider expressly notifies the Contractor in writing that it is billing an amount less than such amount. For Emergency Services and postabilization care services, as defined by 42 C.F.R. § 438.114(a), for which Medi Cal is the primary payor, the Contractor must comply with 42 C.F.R. § 438.114 and an out-of-network provider is required to accept the applicable Medi-Cal fee-for-service payment

amount as payment in full by the Contractor consistent with 42 U.S.C. § 1396u-2(b)(2)(D). Enrollees maintain balance billing protections as provided in Section 5.1.12.

2.8.4.1.9.1. Contractors may authorize other out-of-network services to promote access to and continuity of care. For services that are part of the traditional Medicare benefit package, prevailing Medicare Advantage policy will apply, under which the Contractor shall pay non-contracted Health Care Professionals and section 1861(u) providers of services the amount the provider could collect for that service if the beneficiary were enrolled in original Medicare (less any payments under 42 C.F.R. §§ 412.105(g) and 413.76 for section 1861(u) providers) regardless of setting and type of care for authorized out-of-network services.

2.8.4.1.10. If an Enrollee is receiving any service that would not otherwise be authorized by the Contractor after the continuity of care period, the Contractor must notify the Enrollee prior to the end of the continuity of care period that the service will no longer be authorized, according to the requirements at 42 C.F.R. § 438.404 and 42 C.F.R. § 422.568 and in accordance with applicable DPL(s) as indicated in Section 2.1.5.

2.8.4.1.11. The Contractor must provide an appropriate transition process for Enrollees who are prescribed Part D drugs that are not on its formulary (including drugs that are on the Contractor's formulary but require prior authorization or step therapy under the Contractor's utilization management rules). This transition process must be consistent with the requirements at 42 C.F.R. § 423.120(b)(3).

2.8.4.1.12. If Contractor's Provider Network is unable to provide necessary services covered under the Contract to a particular Enrollee, Contractor must adequately and timely cover these services out of network for the

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Enrollee, for as long as the Contractor is otherwise unable to provide them, as required by 42 C.F.R § 438.206(b)(4).

2.9. Provider Network

2.9.1. The Contractor must demonstrate annually that it has an adequate network as approved by CMS and the State to ensure adequate access to medical, Behavioral Health, pharmacy, and LTSS, excluding IHSS, providers that are appropriate for and proficient in addressing the needs of the enrolled population, including physical, communication, and geographic access.

2.9.2. The Contractor must maintain a Provider Network sufficient to provide all Enrollees with access to the full range of Covered Services, including Behavioral Health services, other specialty services, and all other services required in 42 C.F.R. §§ 422.112, 423.120, and 438.206 and under this Contract (see Covered Services in Appendix A).

2.9.2.1. Contractor will be required to comply with 42 C.F.R. § 438.56(d)(2).

2.9.3. The Contractor must notify the CMT of any significant Provider Network changes immediately, but no later than five (5) days, following a change in Contractor's Provider Network that renders Contractor unable to provide one (1) or more Covered Services within the access to care standards set forth in Section 2.10.2, with the goal of providing notice to the CMT at least sixty (60) days prior to the effective date of any such change.

2.9.4. The Contractor must comply with the requirements specified in 42 C.F.R. §§ 422.504, 423.505, 438.214, which includes selection and retention of providers, credentialing and recredentialing requirements, and nondiscrimination.

2.9.5. The Contractor shall assure that all network providers that provide Medicare Covered Services do not appear on the CMS preclusion list in order to receive reimbursement for claims or otherwise participate in the Medicare program. Pursuant to 42 C.F.R. § 438.602(b), the Contractor shall ensure that all such providers are enrolled with DHCS as Medicaid providers consistent with the provider screening, disclosure, and enrollment requirements of 42 C.F.R. 455, subparts B and E. Payment of a portion of a Medicare Covered Service is not considered a Medicaid Covered Service for the purpose of this section.

2.9.6. The Contractor may not employ or contract with providers excluded from participation in federal health care programs under either Section 1128 or Section 1128A of the Social Security Act; this does not include IHSS providers.

2.9.7. The Contractor may also offer single-case out-of-network agreements to providers who are: 1) not willing to enroll in the Contractor's Provider Network, 2) currently serving Enrollees, 3) willing to continue serving them at the Contractor in-network rate of payment, under the following circumstances:

2.9.7.1. The Contractor's Provider Network does not have an otherwise qualified Network Provider to provide the services within its Provider Network, or transitioning the care in-house would require the Enrollee to receive services from multiple providers/facilities in an uncoordinated manner which would significantly impact the Enrollee's condition;

2.9.7.2. Transitioning the Enrollee to another provider could endanger life, cause suffering or pain, cause physical deformity or malfunction, or significantly disrupt the current course of treatment; or

2.9.7.3. Transitioning the Enrollee to another provider would require the Enrollee to undertake a substantial change in recommended treatment for Medically Necessary Covered Services.

2.9.8. The Provider Network shall be responsive to the linguistic, cultural, and other unique needs of any minority, person who is homeless, Enrollees with disabilities, or other special population served by the Contractor, including the capacity to communicate with Enrollees in languages other than English, when necessary, as well as those who are deaf, hard-of-hearing or deaf and blind.

2.9.8.1. Contractor shall have a cultural and linguistic services program that incorporates the requirements of California Code of Regulations Title 22 section 53876 regardless of whether it operates in a Two-Plan County. Contractor shall monitor, evaluate, and take effective action to address any needed improvement in the delivery of culturally and linguistically appropriate services. Contractor shall review and update its cultural and linguistic services consistent

with the group needs assessment requirements as specified by DHCS.

2.9.8.2. Contractor shall implement and maintain a written description of its cultural and linguistic services program, which shall include at minimum the following:

2.9.8.2.1. An organizational commitment to deliver culturally and linguistically appropriate health care services;

2.9.8.2.2. Goals and objectives;

2.9.8.2.3. A timetable for implementation and accomplishment of the goals and objectives;

2.9.8.2.4. An organizational chart showing the key staff persons with overall responsibility for cultural and linguistic services and activities. A narrative shall explain the chart and describe the oversight and direction to the community advisory committee, provisions for support staff, and reporting relationships. Qualifications of staff, including appropriate education, experience and training shall also be described; and

2.9.8.2.5. Standards and performance requirements for the delivery of culturally and linguistically appropriate health care services.

2.9.8.3. Linguistic Capability of Employees: Contractor shall assess, identify and track the linguistic capability of interpreters or bilingual employees and contracted staff (clinical and non-clinical).

2.9.8.4. The Contractor shall educate Network Providers through a variety of means including, but not limited to, provider alerts or similar written issuances, about their legal obligations under State and federal law to communicate with Enrollees with limited English proficiency, including the provision of interpreter services, and the resources available to help providers comply with those obligations.

2.9.8.5. The Contractor shall ensure that multilingual Network Providers and, to the extent that such capacity exists within the Contractor's Service Area, all Network Providers,

understand and comply with their obligations under Sate or federal law to assist Enrollees with skilled medical interpreters and the resources that are available to assist Network Providers to meet these obligations.

2.9.8.6. The Contractor shall ensure that Network Providers have interpreters/translators that are available for those who are deaf or hearing-impaired within the Contractor's Service Area.

2.9.8.7. The Contractor shall ensure that its Network Providers are responsive to the unique linguistic, cultural, ethnic, racial, religious, age, gender or other unique needs of Enrollees, including Enrollees who are homeless, disabled (both congenital and acquired disabilities) and other special populations served under the Contract.

2.9.8.8. The Contractor shall ensure that its Network Providers have an understanding of disability-competent care.

2.9.8.9. Contractor shall comply with all applicable federal requirements in Section 504 of the Rehabilitation Act of 1973 and the Americans with Disabilities Act (ADA) of 1990 (42 U.S.C. Section 12101 et seq.), 45 C.F.R. Part 84 and 28 C.F.R. Part 36. Title IX of the Education Amendments of 1972 (regarding education programs and activities), and the Age Discrimination Act of 1975.

2.9.9. Provider Qualifications and Performance

2.9.9.1. All Network Providers of Covered Services must be qualified in accordance with current applicable legal, professional, and technical standards and appropriately licensed, certified or registered. All providers must have good standing in the Medicare and Medi-Cal programs and a valid NPI number, as applicable. Providers that have been terminated from or suspended either Medicare or Medi-Cal cannot participate in Contractor's Provider Network.

2.9.9.1.1. Contractor is responsible for the oversight of all Network Providers delivering non-Covered Services (e.g., CPO Services).

2.9.10. Subcontracting Requirements

2.9.10.1. The Contractor remains fully responsible for meeting all of the terms and requirements of the Contract regardless of whether the Contractor subcontracts for performance of any Contract responsibility. No subcontract will operate to relieve the Contractor of its legal responsibilities under the Contract.

2.9.10.2. Contractor may enter into subcontracts with other entities in order to fulfill the obligations of the Contract. Contractor shall evaluate the prospective First Tier, Downstream or Related Entity's ability to perform the subcontracted services, shall oversee and remain accountable for any functions and responsibilities delegated and shall meet the subcontracting requirements per this Contract and 42 C.F.R. §§ 422.504(i), 423.505(i), 438.230(b)(3), (4) and California Code of Regulations Title 22 section 53867.

2.9.10.3. All contracts entered into with First Tier, Downstream and Related Entities shall be in writing and in accordance with the requirements of the 42 C.F.R. § 438.230(b)(2), Knox-Keene Health Care Services Plan Act of 1975, Health and Safety Code section 1340 et seq.; Title 28, CCR Section 1300 et seq.; WIC Section 14200 et seq.; Title 22, CCR Section 53800 et seq.; and other applicable federal and State laws and regulations, including the required contract provisions between the Contractor and First Tier, Downstream and Related Entities in Appendix C.

2.9.10.4. The Contractor remains fully responsible for functions delegated and for ensuring adherence to the legal responsibilities under the Contract, as described in Appendix C, except that the Contractor's legal responsibilities under this Contract for the provision of LTSS shall be limited as set forth in WIC sections 14186 through 14186.4.

2.9.10.5. The Contractor is responsible for the satisfactory performance and adequate oversight of its First Tier, Downstream and Related Entities. First Tier, Downstream and Related Entities are required to meet the same federal and State financial and program reporting requirements as the Contractor. Additional required contract provisions between the Contractor and First Tier, Downstream and Related Entities is contained in Appendix C.

2.9.10.6. The Contractor must:

2.9.10.6.1. Establish contracts and other written agreements between the Contractor and First Tier, Downstream and Related Entities for Covered Services not delivered directly by the Contractor or its employees;

2.9.10.6.2. Contract only with qualified or licensed providers who continually meet federal and State requirements, as applicable, and the qualifications contained in Appendix C.

2.9.10.6.3. This section does not apply to the California Department of Social Services or any other State department contracting with the Contractor for the provision of services under the Demonstration.

2.9.11. Provider Education and Training

2.9.11.1. Provider Education. Prior to any enrollment of Enrollees under this Contract and thereafter, Contractor shall conduct Network Provider education regarding Contractor policies and procedures as well as the Cal MediConnect program and the Contractor model of care.

2.9.11.2. Provider Training. Contractor shall ensure that all Network Providers receive training regarding the Cal MediConnect Program in order to operate in full compliance with the Contract and all applicable federal and State statutes and regulations, including rights and responsibilities pertaining to Grievance and Appeals procedures and timelines under this contract. Contractor shall ensure that Network Provider training relates to Cal MediConnect services-including but not limited to the care coordination benefit, policies, procedures and any modifications to existing services, policies or procedures. Training shall include methods for sharing information among Contractor, Network Provider, Enrollee and/or other healthcare professionals. Contractor shall conduct training for all Network Providers within thirty (30) working days after the Contractor places a newly contracted provider on active status. Contractor shall ensure that Network Provider training includes information on all Enrollee rights including the right to full disclosure of health care information and the right to actively participate in

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health care decisions. The Contractor will maintain policies and procedures on Advance Directives pursuant to 42 C.F.R. §§ 422.128, 438.3(j), and 489.102, and will educate its Network Providers concerning its policies and procedures on Advance Directives. Contractor shall ensure that ongoing training is conducted when deemed necessary by either the Contractor, CMS, or DHCS.

2.9.11.2.1. Contractor shall develop and implement a process to provide information to Network Providers and to train Network Providers on a continuing basis regarding clinical protocols, evidenced-based practice guidelines and DHCS-developed cultural awareness and sensitivity instruction. This process shall include an educational program for Network Providers regarding health needs specific to this population that utilizes a variety of educational strategies, including but not limited to, posting information on websites as well as other methods of educational outreach to Network Providers.

2.9.11.3. Provider Orientation. Contractor shall conduct orientation sessions for Network Providers and their office staff.

2.9.11.4. Cultural Competency Training. Contractor shall provide cultural competency, sensitivity, or diversity training for staff, Network Providers and First Tier, Downstream and Related Entities with direct Enrollee interaction. The training shall cover information about the identified cultural groups in the Contractor's Service Areas, such as the groups' beliefs about illness and health; methods of interacting with providers and the health care structure; and, language and literacy needs including limited English proficiency; and diverse cultural and ethnic backgrounds.

2.9.11.5. Provider Manual. The Provider Manual shall be a comprehensive online reference tool for the Provider and staff regarding, but not limited to, administrative, prior authorization, and referral processes, claims and encounter submission processes, continuity of care requirements, and plan benefits. The Provider Manual shall also address topics such as clinical practice guidelines, availability and access standards, care management programs and Enrollee rights.

2.9.11.5.1. Except as otherwise required or authorized by CMS, DHCS or by operation of law, ensure that Network Providers receive thirty (30) days advance notice in writing of policy and procedure changes, and maintain a process to provide education and training for Network Providers regarding any changes that may be implemented, prior to the policy and procedure changes taking effect.

2.9.11.6. Provider Directory. Contractor shall make its Provider Directory available to Providers via Contractor's web-portal and as described in Section 2.17.5.10.

2.9.11.7. Provider-based Health Education for Enrollees. Contractor shall encourage Network Providers to provide health education to Enrollees as described in Section 2.9.11.8. Contractor shall ensure that Network Providers have the preventive care, disease-specific and plan services information necessary to support Enrollee education in an effort to promote compliance with treatment directives and to encourage self-directed care.

2.9.11.8. Health Education. Contractor shall implement and maintain a health education program that includes programs, services, functions, and resources necessary to provide health education, health promotion and patient education for all Enrollees. This includes helping the Enrollee understand their health plan and the benefits the plan provides.

2.9.11.8.1. Contractor shall ensure administrative oversight of the health education program by a qualified full-time health educator.

2.9.11.8.2. Contractor shall provide health education programs and services at no charge to Enrollees directly and/or through subcontracts or other formal agreements with providers that have expertise in delivering health education services to the Enrollee population.

2.9.11.8.3. Contractor shall ensure the organized delivery of health education programs using educational strategies and methods that are appropriate for

Enrollees and effective in achieving behavioral change for improved health.

2.9.11.8.4. Contractor shall ensure that health education materials are written at the sixth grade reading level and are culturally and linguistically appropriate for the intended audience.

2.9.11.8.5. Contractor shall maintain a health education program that provides educational interventions addressing the following health categories and topics:

2.9.11.8.5.1. Appropriate use of health care services – e.g., managed health care; preventive and primary health care; obstetrical care; health education services; and, complementary and alternative care.

2.9.11.8.5.2. Risk-reduction and healthy lifestyles – e.g., tobacco use and cessation; alcohol and drug use; injury prevention; prevention of sexually transmitted diseases; HIV and unintended pregnancy; nutrition, weight control, and physical activity.

2.9.11.8.5.3. Self-care and management of health conditions – e. g., pregnancy; asthma; diabetes; and, hypertension.

2.9.11.8.6. Contractor shall ensure that Enrollees receive point of service education as part of preventive and primary health care visits. Contractor shall provide education, training, and program resources to assist Network Providers in the delivery of health education services for Enrollees.

2.9.11.8.7. Contractor shall maintain health education policies and procedures, and standards and guidelines; conduct appropriate levels of program evaluation; and, monitor performance of providers that are contracted to deliver health education services to ensure effectiveness, as approved by the Contractor's quality improvement committee.

2.9.11.8.8. Contractor shall periodically review the health education program to ensure appropriate allocation of health education resources, and maintain documentation that demonstrates effective implementation of the health education requirements.

2.9.11.9. Health, Safety and Welfare Education. As part of its Provider education, Contractor shall include information related to identifying, preventing and reporting abuse, neglect, exploitation, and critical incidents.

2.9.11.10. Disability Sensitivity Training. As part of its Provider education, Contractor shall provide disability sensitivity training for its medical, Behavioral Health, MSSP and CBAS providers. (see Section 2.9.8.8).

2.10. Network Management

2.10.1. General requirements. The Contractor shall establish, maintain, and monitor a network that is sufficient to provide adequate access to all Covered Services in the Contract. Section 2.9.1 discusses the annual network review and approval requirement.

2.10.1.1. Taking into consideration:

2.10.1.1.1. The anticipated number of Enrollees;

2.10.1.1.2. The expected utilization of services, in light of the characteristics and health care needs of Contractor's Enrollees;

2.10.1.1.3. The number and types of providers required to furnish the Covered Services;

2.10.1.1.4. The number of Network Providers who are not accepting new patients; and

2.10.1.1.5. The geographic location of Network Providers and Enrollees, taking into account distance, travel time, the means of transportation and whether the location provides physical access for Enrollees with disabilities.

2.10.1.2. The Contractor will work in collaboration with Network Providers to actively improve the quality of care provided to

Enrollees, consistent with the quality improvement goals and all other requirements of this Contract.

2.10.1.3. The Contractor shall operate a toll-free pharmacy technical help call center or make available call support to respond to inquiries from pharmacies and providers regarding the Enrollee's prescription drug benefit; inquiries may pertain to operational areas such as claims processing, benefit coverage, claims submission, and claims payment. This requirement can be accommodated through the use of on-call staff pharmacists or by contracting with the Contractor's pharmacy benefit manager during non-business hours as long as the individual answering the call is able to address the call at that time. The call center must operate or be available during the entire period in which the Contractor's network pharmacies in its Service Area are open, (e.g., Contractors whose pharmacy networks include twenty-four (24) hour pharmacies must operate their pharmacy technical help call centers twenty-four (24) hours a day as well). The pharmacy technical help call center must meet the following operating standards:

2.10.1.3.1. Average hold time must not exceed two (2) minutes, with the average hold time defined as the time spent on hold by the caller following the interactive voice response (IVR) system, touch tone response system, or recorded greeting and before reaching a live person.

2.10.1.3.2. Eighty (80) percent of incoming calls answered within thirty (30) seconds.

2.10.1.3.3. Disconnect rate of all incoming calls not to exceed five (5) percent.

2.10.2. Access to Care Standards. The Contractor must demonstrate annually that its Provider Network meets the stricter of the following standards:

2.10.2.1. For Medicare medical providers and facilities, time, distance and minimum number standards updated annually on the CMS website (https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-

Office/FinancialAlignmentInitiative/MMPInformationandGuidance/MMPApplicationandAnnualRequirements.html);

2.10.2.2. For Medicare pharmacy providers, time, distance and minimum number as required in Appendix E, Article II, Section I and 42 C.F.R. § 423.120; or

2.10.2.3. For Medi-Cal providers and facilities, the Contractor contract with a sufficient number of LTSS providers, including but not limited to SNFs (distinct part and free-standing), MSSP, CBAS and County Social Services Agencies located in the Contractor's Service Area.

2.10.2.3.1. If the LTSS provider within the Service Area cannot meet the Enrollee's medical needs, the Contractor must contract with the nearest LTSS provider outside of the covered Service Area. Contractor is responsible for all Covered Services, pursuant to WIC section 14186.3(c).

2.10.2.3.2. Contractor shall ensure the provision of acceptable accessibility standards in accordance with 42 C.F.R. §§ 438.206(c) and 438.68 and Title 28 CCR Section 1300.67.2.2 and as specified below.

2.10.2.4. Ensure that Network Providers offer hours of operation that are no less than the hours of operation offered to commercial Enrollees or comparable to Medi-Cal fee-for-service, if the provider serves only Medi-Cal Enrollees.

2.10.3. Appropriate Clinical Timeframes. Except for LTSS, Contractor shall communicate, enforce, and monitor providers' compliance with these standards:

2.10.3.1. Contractor shall ensure that Enrollees are offered appointments for covered health care services within a time period appropriate for their condition.

2.10.3.2. Enrollees must be offered appointments within the following timeframes:

2.10.3.2.1. Urgent Care appointment for services that do not require prior authorization – within forty-eight (48) hours after request;

2.10.3.2.2. Urgent appointment for services that do require prior authorization within ninety-six (96) hours after request;

2.10.3.2.3. Non-urgent primary care appointments – within ten (10) business days after request;

2.10.3.2.4. Appointment with a specialist – within fifteen (15) business days after request;

2.10.3.2.5. Non-urgent appointment for ancillary services for the diagnosis or treatment of injury, illness, or other health condition – within fifteen (15) business days after request.

2.10.3.3. Shortening or Expanding Timeframes: Timeframes may be shortened or extended as clinically appropriate by a qualified health care professional acting within the scope of his or her practice consistent with professionally recognized standards of practice. If the timeframe is extended, it must be documented within the Enrollee's medical record that a longer timeframe will not have a detrimental impact on the Enrollee's health.

2.10.3.4. Contractor will monitor providers regularly to determine compliance with the timely access requirements

2.10.3.5. Contractor will take corrective action if it, or its providers, fail to comply with timely access requirements.

2.10.4. PCP Assignment

2.10.4.1. The Contractor will allow each Enrollee to choose his or her PCP to the extent possible and appropriate. If the Enrollee does not select a PCP within thirty (30) calendar days of the effective coverage date, Contractor shall assign that Enrollee to a PCP and notify the Enrollee and the assigned PCP in writing no later than forty (40) calendar days after the Enrollee's coverage date.

2.10.4.2. If an Enrollee does not select a PCP within thirty (30) calendar days of the effective date of coverage date, Contractor shall use FFS utilization data or other data sources, including electronic data, to:

2.10.4.2.1. Establish existing provider relationships for the purpose of PCP assignment, including a specialist or clinic, if an Enrollee indicates a preference for either. Contractor shall comply with all federal and State Privacy laws in the provision and use of this data.

2.10.4.3. Contractor shall notify the PCP that an Enrollee has selected or been assigned to the PCP within ten (10) calendar days from when selection or assignment is completed by the Enrollee or the Contractor, respectively.

2.10.4.4. Contractor shall maintain procedures that proportionately include contracting traditional and safety-net providers in the assignment process for Enrollees who do not choose a PCP.

2.10.4.5. If, at any time, an Enrollee notifies the Contractor of a PCP choice, such choice shall override Enrollee assignment to a PCP in accordance with applicable DPL(s) as indicated in Section 2.1.5.

2.10.5. Provider Credentialing, Recredentialing, and Board Certification

2.10.5.1. Credentialing and Recredentialing: Contractor shall develop and maintain written policies and procedures that include initial credentialing, recredentialing, recertification, and reappointment of physicians including PCPs and specialists in accordance with the DHCS Policy Letter 02-03, check to see if a provider is suspended or excluded suspended, excluded, or otherwise ineligible because of a sanction to receive, directly or indirectly, reimbursement from the Medi-Cal program pursuant to WIC section 14043.61 and 42 C.F.R. § 455.436;, and adhere to managed care standards at 42 C.F.R. § 422.204. 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.

2.10.5.1.1. Contractor shall ensure those policies and procedures are reviewed and approved by the plan governing body, or designee.

2.10.5.1.2. Contractor shall ensure that the responsibility for recommendations regarding credentialing decisions will rest with a credentialing committee or other peer review body.

2.10.5.2. 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 provider credentialing or recredentialing and in accordance with applicable DPL(s) as indicated in Section 2.1.5.

2.10.5.3. Credentialing and Practitioner Licensure Authorities and Application within Approved Contracts: Contractor will use procedures consistent with DHCS policy for all of Medi-Cal. DHCS can modify these rules at any time and is required to notify CMS ninety (90) days prior of any such changes.

2.10.6. Federally Qualified Health Centers (FQHC) and Rural Health Clinics (RHC): Contractor shall meet federal requirements for access to FQHC services, including those in 42 U.S.C. § 1396 b(m). Contractor shall reimburse FQHCs and RHCs in accordance with current federal and State laws and regulations. If FQHC and RHCs services are not available in the Provider Network, Contractor shall authorize out-of-network services subject to the prevailing Medicare Advantage payment requirements for out-of-network services.

2.10.6.1. FQHC and RHCs Reimbursements: The Contractor shall ensure that its payments to FQHCs and RHCs for services to Enrollees are no less than the sum of:

2.10.6.1.1. The level and amount of payment that the plan would make for such services if the services had been furnished by an entity providing similar services that was not a FQHC and RHCs, and

2.10.6.1.2. The amount of cost-sharing that would have been paid to the FQHC for serving the Enrollee if the Enrollee were in Medicare fee-for-service, consistent with how such amounts are included in the Medi-Cal component of the Capitation Rates.

2.10.6.1.3. The intent of these provisions is to ensure that Contractors pay FQHCs and RHCs amounts consistent with Medicare and Medi-Cal managed care policies while preserving the opportunity for FQHCs to separately claim supplemental payments under such policies.

2.10.7. IHSS Network. Contractor shall develop and execute an MOU with County Social Services Agency responsible for IHSS that reflects an agreement between the Contractor and County Social Services Agency regarding roles and responsibilities for Cal MediConnect and IHSS. This MOU will specify the role of the county in:

2.10.7.1. Assessing, approving, and authorizing each current and new Enrollee's initial and continuing need for services, in addition to sharing those assessments with the Enrollee's ICT.

2.10.7.2. Sharing confidential data regarding IHSS authorized hours and services as necessary and as permissible under applicable State and federal law.

2.10.7.3. Determining whether the Enrollees' desires to have his or her IHSS providers involved in care planning or coordination, and if so, obtain express consent from the Enrollee or his or her authorized representative.

2.10.7.4. Support an Enrollee who is at risk for out-of-home placement in obtaining IHSS services.

2.10.7.5. Report documentation that Contractor has developed and will conduct a benefit orientation and training program specific to IHSS for First Tier, Downstream and Related Entities. The Contractor also provides documentation that it has trained personnel of IHSS organizations regarding the Contractor's Covered Services and policies and procedures to access services and coordinate care.

2.10.8. Emergency Services Programs (ESPs)

2.10.8.1. Contractor shall have, as a minimum, a designated emergency service facility, providing care on a twenty-four (24) hour-a-day, seven (7) day-a-week basis. This designated emergency service facility will have one or more physicians and one nurse on duty in the facility at all times.

2.10.9. Emergency Care

2.10.9.1. Contractor shall cover Emergency Services without prior authorization pursuant to Title 28 CCR Section 1300.67(g), Title 22 CCR Section 53216, and Section 1932(b)(2) of the Social Security Act. Contractor shall coordinate access to emergency care services in accordance with 42 C.F.R. § 438.114 and the Contractor's DHCS-approved emergency department protocol.

2.10.9.2. Contractor shall ensure adequate follow-up care for those Enrollees who have been screened in the emergency room and require non-emergency care.

2.10.9.3. Contractor shall ensure that a contracting physician is available twenty-four (24) hours a day to authorize Medically Necessary post-stabilization care and coordinate the transfer of stabilized Enrollees in an emergency department, if necessary.

2.10.9.4. Contractor may not specify what constitutes an Emergency Medical Condition on the basis of lists of diagnoses or symptoms.

2.10.9.5. Contractor may not refuse to cover Emergency Services based on the emergency room provider, hospital, or fiscal agent not notifying the Enrollee's PCP, MCO, PIHP, PAHP or applicable State entity of the Enrollee's screening and treatment within ten (10) calendar days of presentation for Emergency Services.

2.10.9.6. An Enrollee who has an Emergency Medical Condition may not be held liable for payment of subsequent screening and treatment needed to diagnose the specific condition or stabilize the Enrollee.

2.10.9.7. May not deny payment for treatment obtained under either of the following circumstances:

2.10.9.7.1. An Enrollee had an Emergency Medical Condition, including cases in which the absence of immediate medical attention would not have had the outcomes specified in the definition of an Emergency Medical Condition.

2.10.9.7.2. The Contractor's representative instructs the Enrollee to seek Emergency Services.

2.10.9.8. The attending emergency physician, or the provider actually treating the Enrollee, is responsible for determining when the Enrollee is sufficiently stabilized for transfer or discharge, and that determination is binding on the entities as responsible for coverage and payment.

2.10.10. Post-Stabilization Care Services

2.10.10.1. The Contractor must cover and pay for Post-Stabilization Care Services.

2.10.10.2. The Contractor is financially responsible for Post-Stabilization Care Services obtained within or outside the organization that are pre-approved by a Contractor's provider or other Contractor representative.

2.10.10.3. The Contractor is financially responsible for Post-Stabilization Care Services obtained within or outside the Contractor's organization that are not pre-approved by a Network Provider or other Contractor representative, but are administered to maintain the Enrollee's stabilized condition within one (1) hour of a request to the Contractor for pre-approval of further Post-Stabilization Care Services.

2.10.10.4. The Contractor is financially responsible for Post-Stabilization Care Services obtained from within or outside the Contractor that are not pre-approved by a Network Provider or other Contractor representative, but administered to maintain, improve, or resolve the Enrollee's stabilized condition if the Contractor:

2.10.10.4.1. Does not respond to a request for pre-approval within one (1) hour;

2.10.10.4.2. Cannot be contacted; or

2.10.10.4.3. Or the Contractor's representative and the treating physician cannot reach an agreement concerning the Enrollee's care and a Network Provider is not available for consultation.

2.10.10.4.4. In this situation, the Contractor must give the treating physician the opportunity to consult with a Network Provider and the treating physician may continue with care of the Enrollee until a Network Provider is reached or one of the criteria in 42 C.F.R. § 113(c)(3) is met.

2.10.10.5. The Contractor must limit charges to Enrollees for Post-Stabilization Care Services to an amount no greater than what the Contractor would charge the Enrollee if he or she had obtained the services through the Contractor.

2.10.10.6. End of Contractor's financial responsibility. The Contractor's financial responsibility for Post-Stabilization Care Services it has not pre-approved ends when:

2.10.10.6.1. A Network Provider with privileges at the treating hospital assumes responsibility for the Enrollee's care;

2.10.10.6.2. A Network Provider assumes responsibility for the Enrollee's care through transfer;

2.10.10.6.3. Contractor's representative and the treating physician reach an agreement concerning the Enrollee's care; or

2.10.10.6.4. The Enrollee is discharged

2.10.11. Long Term Services and Supports Providers Network

2.10.11.1. Contractor shall develop policies and procedures to train:

2.10.11.1.1. All Contractor staff involved in Care Coordination:

2.10.11.1.1.1. Person-centered planning processes;

2.10.11.1.1.2. Linguistic, cultural, and cognitive competence;

2.10.11.1.1.3. Core concepts of the Olmstead Decision, i.e. serving Enrollees in the least restrictive settings as appropriate;

2.10.11.1.1.4. Accessibility and accommodations; independent living;

2.10.11.1.1.5. Wellness principles;

2.10.11.1.1.6. Criteria for safe transitions, transition planning, Care Plans after transitioning; and,

2.10.11.1.1.7. Along with other required training as specified by DHCS—both initially and on an annual basis.

2.10.11.1.2. Specially designated Care Coordination staff in dementia care management including but not limited to:

2.10.11.1.2.1. Understanding dementia;

2.10.11.1.2.2. Symptoms and progression;

2.10.11.1.2.3. Understanding and managing behaviors and communication problems caused by dementia; caregiver stress and its management; and,

2.10.11.1.2.4. Community resources for Enrollees and caregivers.

2.10.11.1.3. Specially designated Care Coordination staff in MSSP including but not limited to:

2.10.11.1.3.1. An overview of the characteristics and needs of MSSP's target population;

2.10.11.1.3.2. MSSP's eligibility criteria;

2.10.11.1.3.3. Assessment and reassessment processes, services, and service authorization process; and,

2.10.11.1.3.4. How to refer Enrollees to MSSP for assessment and eligibility determination.

2.10.11.1.4. All Contractor staff generally on the addition of LTSS and social services to Contractor

operations. For all trainings, Contractor shall meet specifications set by DHCS, document completion of training, and have specific policies to address non completion.

2.10.12. Women's Health Services: Contractor shall ensure female Enrollees have direct access to a women's health specialist within the network to provide women's routine and preventive health care services. Such access may be in addition to the Enrollee's PCP.

2.10.13. Family Planning Provider Network

2.10.13.1. Contractor shall cover family planning services for all Enrollees whether the family planning services are provided by contracted provider or an out-of-network provider.

2.10.13.2. Contractor agrees to abide by 42 C.F.R. § 438.206.

2.10.14. Indian Health Network: The Contractor shall permit Indian Enrollees eligible to receive services from an Indian Health Care Provider to choose an Indian Health Care Provider as a PCP if the Indian Health Care Provider has capacity to provide such services regardless of whether the Indian Health Care Provider is in or out of network;

2.10.14.1. The Contractor shall demonstrate that there are sufficient Indian Health Care Providers in the Provider Network to ensure timely access to Covered Services for Indian Enrollees who are eligible to receive services;

2.10.14.2. For services provided prior to January 1, 2018, the Contractor shall pay both network and non-network Indian Health Care Providers who provide Covered Services to Indian Enrollees a negotiated rate which shall be no lower than the DHCS fee for service rate for the same service or, in the absence of a negotiated rate, an amount not less than the amount that the Contractor would pay for the Covered Service provided by a non-Indian health care provider;

2.10.14.3. For services provided on or after January 1, 2018, the Contractor shall reimburse Indian Health Care Providers who provide Covered Services to Indian Enrollees, who are eligible to receive services, at the most current and applicable outpatient per-visit rate published in the Federal Register by the Indian Health Service, and Contractor shall ensure any retroactive outpatient per visit rates are

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appropriately reimbursed to the Indian Health Care Provider;

2.10.14.4. The Contractor shall pay non-network Indian Health Care Providers that are FQHCs for the provision of services to an Indian Enrollee at a rate equal to the rate that the Contractor would pay to a network FQHC that is not an Indian health care provider, including any supplemental payment from the State to make up the difference between the contract amount and what the Indian Health Care Provider would have received FFS.

2.10.14.5. When the amount the in-network Indian Health Care Provider receives from the contractor is less than the amount the IHCP would receive FFS, the State must make a supplemental payment to the Indian Health Care Provider that the Indian Health Care Provider would receive FFS or the applicable encounter rate.

2.10.14.6. The Contractor shall not impose enrollment fees, premiums, or similar charges on Indians regardless of payer. The Contractor must exempt from all cost sharing any Indian who is currently receiving or has ever received an item or service furnished by an Indian Health Care Provider or through referral under contract health services.

2.10.14.7. The Contractor must permit an out of network Indian Health Care Provider to refer an Indian Enrollee to a Network Provider.

2.11. Enrollee Access to Services

2.11.1. General. The Contractor must provide services to Enrollees as follows:

2.11.1.1. Authorize, arrange, coordinate and provide to Enrollees all Covered Services that are Medically Necessary;

2.11.1.2. Reasonably accommodate Enrollees and ensure that the programs and services are as accessible (including physical and geographic access) to an Enrollee with disabilities as they are to an Enrollee without disabilities, and shall have written policies and procedures to assure compliance, including ensuring that physical, communication, and programmatic barriers do not inhibit Enrollees with

disabilities from obtaining all Covered Services from the Contractor by:

2.11.1.2.1. Providing flexibility in scheduling to accommodate the needs of the Enrollees;

2.11.1.2.2. Providing interpreters or translators for Enrollees who are deaf and hard of hearing and those with limited English proficiency;

2.11.1.2.3. Ensuring that Enrollees with disabilities are provided with reasonable accommodations to ensure effective communication, including auxiliary aids and services. Reasonable accommodations will depend on the particular needs of the Enrollee and include but are not limited to:

2.11.1.2.3.1. Providing large print (at least 16-point font) versions of all written materials to Enrollees with visual impairments;

2.11.1.2.3.2. Ensuring that all written materials are available in formats compatible with optical recognition software;

2.11.1.2.3.3. Reading notices and other written materials to Enrollees upon request;

2.11.1.2.3.4. Assisting Enrollees in filling out forms over the telephone;

2.11.1.2.3.5. Ensuring effective communication to and from Enrollees with disabilities through email, telephone, and other electronic means;

2.11.1.2.3.6. TTY, computer-aided transcription services, telephone handset amplifiers, assistive listening systems, closed caption decoders, videotext displays and qualified interpreters for the deaf; and

2.11.1.2.3.7. Individualized assistance.

2.11.1.3. The Contractor must identify to DHCS the individual in its organization who is responsible for ADA compliance related to this Demonstration and his/her job title. The Contractor must also establish and execute a work plan to achieve and maintain ADA compliance; and

2.11.1.4. If the Contractor's Provider Network is unable to provide necessary medical services covered under the Contract to a particular Enrollee, the Contractor must adequately and timely cover these services out of network for the Enrollee, for as long as the Contractor is unable to provide them.

2.11.1.5. When a PCP or medical, Behavioral Health or LTSS provider is terminated from the Contractor's plan or leaves the Provider Network for any reason, the Contractor must make a good faith effort to give written notification of termination of such provider, within fifteen (15) days after receipt or issuance of the termination notice, or no later than thirty (30) calendar days before the termination date, to each Enrollee who received his or her care from, or was seen on a regular basis by, the terminated PCP or any other medical, behavioral or LTSS provider. For terminations of PCPs, the Contractor must also report the termination to DHCS and provide assistance to the Enrollee in selecting a new PCP within fifteen (15) calendar days. For Enrollees who are receiving treatment for a chronic or ongoing medical condition or LTSS, the Contractor shall ensure that there is no disruption in services provided to the Enrollee.

2.11.1.6. Contractor shall ensure that each Enrollee has a PCP who is available and physically present at the service site for sufficient time to ensure access for the assigned Enrollee when medically required. This requirement does not preclude an appropriately licensed professional from being a substitute for the PCP in the event of vacation, illness, or other unforeseen circumstances.

2.11.2. Contractor shall ensure Enrollee access to specialists for Covered Services that are Medically Necessary. Contractor shall ensure adequate staff within the Service Area, including physicians, administrative and other support staff directly and/or through subcontracts, sufficient to assure that health services will be provided in accordance with Section 2.10.2 and consistent with all specified requirements.

2.11.2.1. Contractor shall establish acceptable accessibility requirements in accordance with Title 28 CCR Section 1300.67.2.1 and as specified below. DHCS will review and approve requirements for reasonableness. Contractor shall communicate, enforce, and monitor Network Providers' compliance with these requirements.

2.11.2.1.1. Appointments: Contractor shall implement and maintain procedures for Enrollees to obtain appointments for routine care, Urgent Care, routine specialty referral appointments, prenatal care, and adult initial health assessments. Contractor shall also include procedures for follow-up on missed appointments.

2.11.2.1.2. First Prenatal Visit: Contractor shall ensure that the first prenatal visit for a pregnant Enrollee will be available within two (2) weeks upon request.

2.11.2.1.3. Waiting Times: Contractor shall develop, implement, and maintain a procedure to monitor waiting times in the Network Providers' offices, telephone calls (to answer and return), and time to obtain various types of appointments indicated in 2.11.2.1.1 appointments, above.

2.11.2.1.4. Telephone Procedures: Contractor shall require Network Providers to maintain a procedure for triaging Enrollees' telephone calls, providing telephone medical advice (if it is made available) and accessing telephone interpreters.

2.11.2.1.5. After Hours Calls: At a minimum, Contractor shall ensure that all Enrollees have access to appropriate licensed professional for after-hours calls.

2.11.2.1.6. Unusual Specialty Services: Contractor shall arrange for the provision of seldom used or unusual specialty services from specialists outside the network if unavailable within Contractor's network, when determined medically necessary.

2.11.3. Services Not Subject to Prior Approval

2.11.3.1. The Contractor will assure coverage of Emergency Medical Conditions and Urgent Care services. The Contractor must not require prior approval for the following services:

2.11.3.1.1. Any services for Emergency Medical Conditions (which includes emergency Behavioral Health care);

2.11.3.1.2. Urgent Care sought outside of the Service Area;

2.11.3.1.3. Urgent Care under unusual or extraordinary circumstances provided in the Service Area when the contracted medical provider is unavailable or inaccessible;

2.11.3.1.4. Preventative services;

2.11.3.1.5. Family planning services;

2.11.3.1.6. Out-of-area renal dialysis services;

2.11.3.1.7. Basic prenatal care;

2.11.3.1.8. Sexually transmitted disease services; and

2.11.3.1.9. HIV testing.

2.11.4. The Contractor must have a mechanism in place to allow Enrollees with special health care needs to have direct access to a specialist as appropriate for the Enrollee's condition and identified needs, such as a standing referral to a specialty Provider.

2.11.5. Authorization of Services. In accordance with 42 C.F.R. § 438.210, the Contractor shall authorize services as follows:

2.11.5.1. For the processing of requests for initial and continuing authorizations of Covered Services, the Contractor shall:

2.11.5.1.1. Have in place and follow written policies and procedures;

2.11.5.1.2. Have in effect mechanisms to ensure the consistent application of review criteria for authorization decisions;

2.11.5.1.3. Have in place procedures to allow Enrollees to initiate requests for provision of services; and

2.11.5.1.4. Consult with the requesting Network Provider when appropriate.

2.11.5.2. The Contractor shall ensure that an authorized Care Coordinator is available twenty-four (24) hours a day for timely authorization of Covered Services that are Medically Necessary and to coordinate transfer of stabilized Enrollees in the emergency department, if necessary. The Contractor's guidelines for medical necessity must, at a minimum, be consistent with Medicare standards for acute services and prescription drugs and Medi-Cal standards for LTSS.

2.11.5.3. Any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested must be made by a health care professional who has appropriate clinical expertise in treating the Enrollee's medical condition, performing the procedure, or providing the treatment. Behavioral Health services denials must be rendered by board-certified or board-eligible psychiatrists or by a licensed clinician, acting within their scope of practice, with the same or similar specialty as the Behavioral Health services being denied, except in cases of denials of service for psychological testing, which shall be rendered by a qualified psychologist.

2.11.5.4. The Contractor shall assure that all Behavioral Health authorization and utilization management activities are in compliance with 42 U.S.C. § 1396u-2(b)(8). Contractor must comply with the requirements for demonstrating parity for quantitative treatment limitations between Behavioral Health and medical/surgical inpatient, outpatient and pharmacy benefits.

2.11.5.5. The Contractor must notify the requesting Network Provider, either orally or in writing, and give the Enrollee written notice of any decision by the Contractor to deny a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested. The notice must meet the requirements of 42 C.F.R. § 438.404 and Title 22 CCR § 53261, and must:

2.11.5.5.1. Be produced in a manner, format, and language that can be easily understood;

2.11.5.5.2. Be made available in Threshold Languages, upon request;

2.11.5.5.3. Include information, in Threshold Languages about how to request translation services and alternative formats. Alternative formats shall include materials which can be understood by persons with limited English proficiency: and

2.11.5.5.4. In any written communication to a physician or other health care provider of a denial, delay or modification of a request, include the name and telephone number of the health care professional responsible for the denial, delay or modification.

2.11.5.6. The Contractor must make authorization decisions in the following timeframes:

2.11.5.6.1. For standard authorization decisions, provide notice as expeditiously as the Enrollee's health condition requires, within five (5) working days from receipt of the information reasonably necessary to render a decision, and in all circumstances no later than fourteen (14) calendar days after receipt of the request for service, with a possible extension not to exceed fourteen (14) additional calendar days. Such extension shall only be allowed if:

2.11.5.6.1.1. The Enrollee or the Provider requests an extension, or

2.11.5.6.1.2. The Contractor can justify (to the satisfaction of DHCS and/or CMS upon request) that:

2.11.5.6.1.2.1. The extension is in the Enrollee's interest; and

2.11.5.6.1.2.2. There is a need for additional information where:

2.11.5.6.1.2.2.1. There is a reasonable likelihood that receipt of such information would

lead to approval of the request, if received; and

2.11.5.6.1.2.2.2. Such outstanding information is reasonably expected to be received within fourteen (14) calendar days.

2.11.5.6.2. For expedited service authorization decisions, where the provider indicates or the Contractor determines that following the standard timeframe in Section 2.11.5.6.1 could seriously jeopardize the Enrollee's life or health or ability to attain, maintain, or regain maximum function, the Contractor must make a decision and provide notice as expeditiously as the Enrollee's health condition requires and no later than seventy-two (72) hours after receipt of the request for service, with a possible extension not to exceed fourteen (14) additional calendar days. Such extension shall only be allowed if:

2.11.5.6.2.1. The Enrollee or the provider requests an extension; or

2.11.5.6.2.2. The Contractor can justify (to DHCS and/or CMS upon request) that:

2.11.5.6.2.2.1. The extension is in the Enrollee's interest; and

2.11.5.6.2.2.2. There is a need for additional information where:

2.11.5.6.2.2.2.1. There is a reasonable likelihood that receipt of such information would lead to approval of the request, if received; and

2.11.5.6.2.2.2.2. Such outstanding information is reasonably expected to be received within fourteen (14) calendar days.

2.11.5.6.3. In accordance with 42 C.F.R. §§ 438.3(i), 438.210(e), and 422.208, compensation to individuals or entities that conduct utilization management activities for the Contractor must not be structured so as to provide incentives for the individual or entity to deny, limit, or discontinue Medically Necessary Covered Services to any Enrollee.

2.11.6. Utilization Management

2.11.6.1. Utilization management program: Contractor shall develop, implement, and continuously update and improve, a utilization management program that ensures appropriate processes are used to review and approve the provision of medically necessary Covered Services, excluding Part D benefits. Contractor is responsible to ensure that the utilization management program includes:

2.11.6.1.1. Qualified staff responsible for the utilization management program.

2.11.6.1.2. The separation of medical decisions from fiscal and administrative management to assure medical decisions will not be unduly influenced by fiscal and administrative management.

2.11.6.1.3. Allowances for a second opinion from a qualified health professional at no cost to the Enrollee.

2.11.6.1.4. 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 providers are involved in the development and or adoption of specific criteria used by the Contractor.

2.11.6.1.5. Communications to Network Providers of the procedures and services that require prior authorization and ensure that all contracting Network Providers are aware of the procedures and timeframes necessary to obtain prior authorization for these services.

2.11.6.1.6. An established specialty referral system to track and monitor referrals requiring prior authorization through the Contractor. The system shall include authorized, denied, deferred, or modified referrals, and the timeliness of the referrals. Contractor shall ensure that all contracted Network Providers and non-contracting specialty providers are informed of the prior authorization and referral process at the time of referral.

2.11.6.1.7. The quarterly reporting of utilization management activities into the DHCS, including a process to electronically report on the number and types of Appeals, denials, deferrals, and modifications to the appropriate DHCS and CMT staff.

2.11.6.1.8. Procedures for continuously reviewing the performance of health care personnel, the utilization of services and facilities, and cost.

2.11.6.1.9. Procedures to identify, communicate, and implement actions to correct potential over and under-utilization issues that are identified.

2.11.6.2. These activities shall be done in accordance with Health and Safety Code Section 1363.5 and 28 CCR 1300.70(b)(2)(H) and (G) and 42 C.F.R. §§ 422.112, 422.152, 422.202, and 422.4.

2.11.6.3. Pre-Authorizations and Review Procedures Contractor shall ensure that its pre-authorization, concurrent review and retrospective review procedures meet the following minimum requirements:

2.11.6.3.1. Decisions to deny or to authorize an amount, duration, or scope that is less than requested shall be made by a qualified health care professional with appropriate clinical expertise in treating the condition and disease.

2.11.6.3.2. Qualified health care professionals supervise review decisions, including service reductions, and a qualified physician will review all denials that are made, whole or in part, on the basis of

medical necessity. For purposes of this provision, a qualified physician or Contractor's pharmacist may approve, defer, modify, or deny prior authorizations for pharmaceutical services, provided that such determinations are made under the auspices of and pursuant to criteria established by the Contractor's medical director, in collaboration with the Contractor's pharmacy and therapeutics committee or its equivalent.

2.11.6.3.3. There is a set of written criteria or guidelines for utilization review that is based on sound medical evidence, is consistently applied, regularly reviewed, and updated.

2.11.6.3.4. Reasons for decisions are clearly documented.

2.11.6.3.5. Notification to Enrollees regarding denied, deferred or modified referrals is made.

2.11.6.3.6. Decisions and Appeals are made in a timely manner and are not unduly delayed for medical conditions requiring time sensitive services.

2.11.6.3.7. Prior Authorization requirements shall not be applied to Emergency Services, urgently needed services, family planning services, preventive services, basic prenatal care, sexually transmitted disease services, and HIV testing.

2.11.6.3.8. Records, including any NOA, shall meet the retention requirements described in Section 5.4 Records Retention, Inspection, and Audit.

2.11.6.3.9. Contractor must notify the requesting provider or Enrollee of any decision to deny, approve, modify, or delay a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested. The notice to the provider may be orally or in writing.

2.11.7. Timeframes for Authorization

2.11.7.1. Emergency and Urgently Needed Care: No prior authorization required, following the reasonable person

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standard to determine that the presenting complaint might be an emergency.

2.11.7.2. Concurrent review of authorization for treatment regimen already in place: Within five (5) business days or less, consistent with urgency of the Enrollee's medical condition and in accordance with Health and Safety Code Section 1367.01, or any future amendments thereto.

2.11.7.3. Retrospective review: Within thirty (30) calendar days in accordance with Health and Safety Code Section 1367.01, or any future amendments thereto. Retrospective review applies only to Medi-Cal services, but Contractor may at its discretion apply retrospective review to Medicare services.

2.11.7.4. Non Part D covered pharmaceuticals: Twenty-four (24) hours on all drugs that require prior authorization in accordance with WIC section 14185 or any future amendments thereto.

2.11.7.5. Routine authorizations: Five (5) working days from receipt of the information reasonably necessary to render a decision (these are requests for specialty service, cost control purposes, out-of-network not otherwise exempt from prior authorization) in accordance with Health and Safety Code Section 1367.01, or any future amendments thereto, but, no longer than fourteen (14) calendar days from the receipt of the request. The decision may be deferred and the time limit extended an additional fourteen (14) calendar days only where the Enrollee or the Enrollee's provider requests an extension, or the Contractor can provide justification upon request by the State for the need for additional information and how it is in the Enrollee's interest. Any decision delayed beyond the time limits is considered a denial and must be immediately processed as such.

2.11.7.6. Expedited Authorizations: For requests in which a provider indicates, or the Contractor determines that, following the standard timeframe could seriously jeopardize the Enrollee'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 Enrollee's health condition requires and not later than seventy-two (72) hours after receipt of the request for

services. The Contractor may extend this period by up to fourteen (14) calendar days if the Enrollee requests an extension, or if the Contractor justifies, to the DHCS upon request, a need for additional information and how the extension is in the Enrollee's interest. Any decision delayed beyond the time limits is considered a denial and must be immediately processed as such.

2.11.7.7. LTSS Authorization as follows:

2.11.7.7.1. Must include the PCP or case manager signature on any nursing facility authorization or reauthorization request.

2.11.7.7.2. Must include the PCP or case manager signature on any CBAS authorization or reauthorization request.

2.11.7.7.3. Through the HRA and ICT discussions, the Contractor shall refer Enrollees who are potentially eligible for MSSP to MSSP providers for authorization into the MSSP. MSSP providers and the Contractor shall collaborate and coordinate MSSP care management services (see Section 2.6.1.2).

2.11.7.7.4. Through the HRA and ICT discussions, the Contractor shall refer Enrollees who are potentially eligible for IHSS to County Social Services Agency responsible for IHSS service authorization. County IHSS eligibility worker may participate on the ICT whenever IHSS services are involved in the care of the Enrollees.

2.11.8. Review of Utilization Data

2.11.8.1. Contractor shall include within the utilization management program mechanisms to detect both under- and over-utilization of health care services. Contractor's internal reporting mechanisms used to detect Enrollee utilization patterns shall be reported to DHCS upon request.

2.11.9. Delegating Utilization Management Activities

2.11.9.1. Contractor may delegate utilization management activities. If Contractor delegates these activities, Contractor shall comply with Section 2.11.5.

2.11.10. Availability of Services

2.11.10.1. Access to Services for Emergency Conditions and Urgent Care. The Contractor must ensure access to twenty-four (24) hour Emergency Services for all Enrollees, whether they reside in institutions or in the community.

2.11.10.1.1. The Contractor must cover and pay for any services obtained for Emergency Conditions in accordance with 42 C.F.R. § 438.114(c).

2.11.10.1.2. Emergency Medical Treatment and Labor Act (EMTALA): The Contractor and Network Providers must comply with EMTALA, including the requirements for qualified hospital medical personnel to provide appropriate medical screening examinations to any Enrollee who "comes to the emergency department," as defined in 42 C.F.R. § 489.24(b); and, as applicable, to provide Enrollees stabilizing treatment or, if the hospital lacks the capability or capacity to provide stabilizing treatment, appropriate transfers.

2.11.10.1.3. An Enrollee who has an Emergency Condition may not be held liable for payment of subsequent screening and treatment needed to diagnose the specific condition or stabilize the Enrollee.

2.11.10.1.4. The attending emergency physician, or the provider actually treating the Enrollee, is responsible for determining when the Enrollee is sufficiently stabilized for transfer or discharge, and that determination is binding on the Contractor as responsible for coverage and payment.

2.11.10.1.5. The Contractor may not refuse to cover Emergency Services based on the emergency room provider, hospital, or fiscal agent not notifying the Enrollee's Primary Care Provider, the Contractor

or applicable State entity of the Enrollee's screening and treatment within ten (10) calendar days of presentation for Emergency Services.

2.12. Enrollee Services

2.12.1. Enrollee service representatives (ESRs). The Contractor must employ ESRs trained to answer Enrollee inquiries and concerns from Enrollees and potential Enrollees, consistent with the requirements of 42 C.F.R. §§ 422.111(h) and 423.128(d) as well as the following requirements:

2.12.1.1. Be trained to answer Enrollee inquiries and concerns from Enrollees and potential Enrollees regarding medical, behavioral, and LTSS services provided;

2.12.1.2. Be trained in the use of TTY, video relay services, remote interpreting services, how to provide accessible PDF materials, and other alternative formats;

2.12.1.3. Be capable of speaking directly with, or arranging for an interpreter to speak with, Enrollees in their primary language, including American Sign Language (ASL), or through an alternative language device or telephone translation service;

2.12.1.4. Inform callers that interpreter services are free;

2.12.1.5. Be knowledgeable about Medi-Cal, Medicare, the CFAM-MOU, and the terms of the Contract;

2.12.1.6. Be available to Enrollees to discuss and provide assistance with Enrollee Grievances and complaints;

2.12.1.7. Make oral interpretation services available free-of-charge to Enrollees in all non-English languages spoken by Enrollees, including ASL and how to access those services;

2.12.1.8. Maintain the availability of services, such as TTY services, computer-aided transcription services, telephone handset amplifiers, assistive listening systems, closed caption decoders, videotext displays and qualified interpreters and other services for Deaf and hard of hearing Enrollees;

2.12.1.9. Demonstrate sensitivity to culture, including disability competent care and the independent living philosophy;

2.12.1.10. Provide assistance to Enrollees with cognitive impairments; for example, provide written materials in simple, clear language at a reading level of sixth grade and below, and individualized guidance from ESRs to ensure materials are understood;

2.12.1.11. Provide reasonable accommodations needed to assure effective communication and provide Enrollees with a means to identify their disability to the Contractor;

2.12.1.12. Maintain employment standards and requirements (e.g., education, training, and experience) for Enrollee services department staff and provide a sufficient number of staff to meet defined performance objectives; and

2.12.1.13. Ensure that ESRs make available to Enrollees and potential Enrollees, upon request, information concerning the following:

2.12.1.13.1. Enrollees' rights and responsibilities;

2.12.1.13.2. The procedures for an Enrollee to change plans or to opt out of Cal MediConnect;

2.12.1.13.3. How to access oral interpretation services and written materials in Threshold Languages and alternative formats;

2.12.1.13.4. The identity, locations, qualifications, and availability of Network Providers;

2.12.1.13.5. Information on all Covered Services and other available services or resources (e.g., State agency services) either directly or through referral or authorization;

2.12.1.13.6. Be able to direct Enrollees to the Medi-Cal Dental program for any fee-for-service dental benefits available from Medi-Cal;

2.12.1.13.7. The procedures available to an Enrollee and Network Provider(s) to challenge or Appeal the failure of the Contractor to provide a Covered Service and to Appeal any Adverse Benefit Determinations (denials); and

2.12.1.13.8. Additional information that may be required by Enrollees and potential Enrollees to understand the requirements and benefits of the Cal MediConnect.

2.12.2. Enrollee Service Telephone Responsiveness

2.12.2.1. The Contractor must operate a call center during normal business hours seven (7) days a week, consistent with the required Medicare Communications and Marketing Guidelines and the Marketing Guidance for California Medicare-Medicaid Plans. The Enrollee must be able to speak with a live ESR, Monday through Friday, during normal business hours, consistent with the required Medicare Communications and Marketing Guidelines and the Marketing Guidance for California Medicare-Medicaid Plans. The Contractor may use alternative technologies on Saturdays, Sundays, and State and federal holidays (except New Year's Day). The Contractor's ESR's must answer eighty percent (80%) of all Enrollee telephone calls within thirty (30) seconds or less. The Contractor must limit average hold time to two (2) minutes, with the average hold time defined as the time spent on hold by the caller following the interactive voice response (IVR) system, touch tone response system, or recorded greeting and before reaching a live person. The Contractor must limit the disconnect rate of all incoming calls to five percent (5%). The Contractor must have a process to measure the time from which the telephone is answered to the point at which an Enrollee reaches an ESR capable of responding to the Enrollee's question in a manner that is sensitive to the Enrollee's language and cultural needs.

2.12.3. Coverage Determinations and Appeals Call Center Requirements

2.12.3.1. The Contractor must operate a toll-free call center with live ESRs available to respond to Network Providers or Enrollees for information related to requests for coverage under Medicare or Medi-Cal, and Medicare and Medi-Cal Appeals (including requests for Medicare exceptions and prior authorizations). The Contractor is required to provide immediate access to requests for Medicare and Medi-Cal covered benefits and services, including Medicare coverage determinations and redeterminations, via its toll-free call

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centers. The call centers must operate during normal business hours, as specified in the Medicare Communications and Marketing Guidelines and the Marketing Guidance for California Medicare-Medicaid Plans. The Contractor must accept requests for Medicare or Medi-Cal coverage, including Medicare coverage determinations /redeterminations, outside of normal business hours, but is not required to have live Enrollee service representatives available to accept such requests outside normal business hours. Voicemail may be used outside of normal business hours provided the message:

2.12.3.1.1. Indicates that the mailbox is secure;

2.12.3.1.2. Lists the information that must be provided so the case can be worked (e.g., provider identification, beneficiary identification, type of request (coverage determination or Appeal), physician support for an exception request, and whether the Enrollee is making an expedited or standard request);

2.12.3.1.3. For coverage determination calls (including exceptions requests), articulates and follows a process for resolution within twenty-four (24) hours of call for expedited requests and seventy-two (72) hours for standard requests; and

2.12.3.1.4. For Appeals calls, articulates the process, information needed and provide for a resolution within seventy-two (72) hours for expedited Appeal requests and seven (7) calendar days for standard Part D Appeal requests and thirty (30) days for other standard Appeal requests.

2.12.4. Enrollee Advisory Committee

2.12.4.1. The Contractor shall establish an Enrollee advisory committee that will provide regular feedback to the Contractor's governing board on issues of Demonstration management and Enrollee care. The Contractor shall ensure that the Enrollee advisory committee:

2.12.4.1.1. Meets at least quarterly throughout the Demonstration.

2.12.4.1.2. Is comprised of Enrollees, family members and other caregivers that reflect the diversity of the Demonstration population, including individuals with disabilities. CMS and DHCS reserve the right to review and approve Enrollee membership.

2.12.4.2. The Contractor shall also include Ombudsman reports in quarterly updates to the Enrollee advisory committee and shall participate in all statewide stakeholder and oversight convenings as requested by DHCS and/or CMS.

2.13. IHSS Related Complaints, Grievances and Appeals

2.13.1. For Enrollee complaints, Grievances, or Appeals related to IHSS, Contractor must comply with the established Grievance and Appeal process established by CDSS and by the county agencies responsible for IHSS, in compliance with WIC section 10950.

2.14. Enrollee Grievances

2.14.1. Grievance Filing -- The Contractor shall inform Enrollees that they may file a Grievance through either the Contractor or Cal Medi-Connect Ombuds Program for complaints relating to Medicare and Medi-Cal covered benefits and services. Medicare beneficiaries may also file a Grievance through 1-800 Medicare. The Contractor must display a link to the electronic Grievance form on the Medicare.gov Internet Web site on the Contractor's main web page pursuant to 42 C.F.R. § 422.504 (a)(15)(ii). The Contractor must inform Enrollees of the email address, postal address or toll-free telephone number where an Enrollee Grievance regarding Medicare and Medi-Cal covered benefits and services may be filed. Authorized representatives may file Grievances on behalf of Enrollees to the extent allowed under applicable federal or State law.

2.14.2. Internal (plan level) Grievance: An Enrollee may file an Internal Enrollee Grievance regarding Medicare and Medi-Cal covered benefits and services at any time with the Contractor or its providers by calling or writing to the Contractor or provider. The Contractor must have a system in place for addressing Enrollee Grievances, including Grievances regarding reasonable accommodations and access to services under the ADA.

2.14.2.1. Reporting of plan level Grievances: Contractor shall track and report to DHCS the number and types of inquiries, complaints, Grievances, Appeals, and resolutions related to Cal MediConnect, in compliance with 42 C.F.R. § 438.416 and as described in WIC section 14182.17(e)(4)(E), in the format specified by DHCS in accordance applicable DPL(s) as indicated in Section 2.1.5. DHCS will then make the required information publicly available on DHCS' internet web site.

2.14.2.1.1. Internal Grievance: Contractor shall establish and maintain a Grievance process consistent with 42 C.F.R. Part 438 Subpart F, under which Enrollees may submit their Grievance regarding all Covered Services and benefits to the Contractor. Contractor shall establish and maintain a Grievance process approved by DHCS under which Enrollees may submit their Grievances regarding all benefits and services, consistent with the Knox-Keene Act, and the regulations promulgated thereunder, Welfare and Institutions Code section 14450 and CCR, Title 22, Section 53260.

2.14.2.1.2. The Contractor must maintain written records of all Grievance activities, and notify CMS and DHCS of all internal Grievances. The Grievance record must include the name of the covered person for whom the Grievance was filed; the name of the Contractor's representative recording the grievance; a general description of the reason for the Grievance; the date received; the date of each review or, if applicable, review meeting; and resolution information including date of resolution. The Grievance record must be accessible to CMS and DHCS upon request.

2.14.2.1.3. The system must meet the following standards:

2.14.2.1.3.1. Timely acknowledgement of receipt of each Enrollee Grievance;

2.14.2.1.3.2. Timely review of each Enrollee Grievance;

2.14.2.1.3.3. Response, electronically, orally or in writing, to each Enrollee Grievance within a reasonable time, but no later than thirty (30) days after the Contractor receives the Grievance;

2.14.2.1.3.4. Expedited response, orally or in writing, within twenty-four (24) hours after the Contractor receives the Grievance to each Enrollee Grievance whenever Contractor extends the Appeals timeframe or Contractor refuses to grant a request for an expedited Appeal; and

2.14.2.1.3.5. Notice to the Enrollee of the disposition of the grievance. The Notice must meet the requirements of 42 C.F.R. § 438.408(d)(1), and must:

2.14.2.1.3.5.1. Be produced in a manner, format, and language that can be easily understood;

2.14.2.1.3.5.2. Be made available in Threshold Languages, upon request;

2.14.2.1.3.5.3. Include information, in the most commonly used languages about how to request translation services and alternative formats; and

2.14.2.1.3.5.4. Include information about availability to Enrollees of information about Enrollee Appeals, as described in Section 2.15, including reasonable assistance with Enrollee Grievances and Appeals in completing any forms or other procedural steps, which shall include interpreter services and toll-

free numbers with TTY/TDD and interpreter capability.

2.14.2.1.3.6. In compliance with 42 C.F.R. § 438.406(b), procedures to ensure that decision makers on Grievances were not involved in previous levels of review or decision-making nor were a subordinate of any such individual, and who are health care professionals with clinical expertise in treating the Enrollee's condition or disease if any of the following apply:

2.14.2.1.3.6.1. A Grievance regarding denial of expedited resolutions of an Appeal.

2.14.2.1.3.6.2. Any Grievance or Appeal involving clinical issues.

2.14.2.1.3.7. In addition to Grievance logs required by Medicare and Medi-Cal rules and 42 C.F.R. § 438.416, per CA Health and Safety Code section 1368(a)(4)(B) and Title 28 CCR 1300.68(d)(8), the Contractor shall maintain a log of all Exempt Grievances. The log shall be periodically reviewed by the plan and shall include the following information for each Exempt Grievance:

2.14.2.1.3.7.1. The date of the call

2.14.2.1.3.7.2. The name of the complainant

2.14.2.1.3.7.3. The complainant's member identification number

2.14.2.1.3.7.4. The nature of the Grievance

2.14.2.1.3.7.5. The nature of the resolution

2.14.2.1.3.7.6. The name of the plan representative who took the call and resolved the Grievance

2.14.2.1.3.8. Notice to the Enrollee of the disposition of the Grievance.

2.14.3. External Grievance: The Contractor shall inform Enrollees that they may file an external Grievance for Medicare only covered benefits and services through 1-800-Medicare or for Medicare and Medi-Cal covered benefits and services through the Cal MediConnect Ombudsman program. The Contractor must display a link to the electronic Grievance form on the Medicare.gov Internet Web site on the Contractor's main web page per 42 C.F.R. § 422.504(a)(15)(ii).

2.14.3.1. The Contractor must inform Enrollees of the email address, postal address or toll-free telephone number where an Enrollee Grievance may be filed.

2.14.3.2. Consistent with Health & Safety Code Section 1368(b), Contractor, except for non-Knox Keene Act Licensed COHS plans, shall inform Enrollees that they may file an External Grievance for Medi-Cal only covered benefits and services through DMHC's consumer complaint process. Contractor shall inform Enrollees of the DMHC's toll-free telephone number, DMHC's TDD line for the hearing and speech impaired, and DMHC's website address pursuant to Health & Safety Code Section 1368.02

2.15. Enrollee Appeals

2.15.1. Integrated Notice of Action— In accordance with 42 C.F.R. §§ 431.206, 438.404 and 42 C.F.R. §§ 422.568-572, the Contractor must give the Enrollee written notice of any Adverse Benefit Determination. Enrollees will be notified of all applicable Cal MediConnect, Medicare and Medi-Cal Appeal rights through a single notice. The form and content of the notice must be approved by CMS and DHCS. The Contractor shall notify the Enrollee of its decision at least ten (10) days in advance of the date of its action.

2.15.1.1. The notice must explain:

2.15.1.1.1. The action the Contractor has taken or intends to take;

2.15.1.1.2. The reasons for the action, including the right of the Enrollee to be provided upon request and free of charge, reasonable access to and copies of all documents, records, and other information

relevant to the Enrollee's Adverse Benefit Determination. Such information includes medical necessity criteria, and any processes, strategies, or evidentiary standards used in setting coverage limits;

2.15.1.1.3. The citation to the regulations supporting such action

2.15.1.1.4. The Enrollee's, provider's, or authorized representative's right to file an Appeal with the Contractor and whether exhaustion of the Contractor's internal Appeal process is a prerequisite to additional external review from by Medicare, Independent Medical Review by DMHC (if applicable), or a State Fair Hearing;

2.15.1.1.5. Procedures for exercising Enrollee's rights to Appeal;

2.15.1.1.6. Circumstances under which expedited resolution is available and how to request it; and

2.15.1.1.7. If applicable, the Enrollee's rights to have benefits continue pending the resolution of the plan level Appeal.

2.15.1.2. Contractor must provide a member notice of resolution, as expeditiously as the Enrollee's health condition requires, not exceeding thirty (30) calendar days from the day Contractor receives the Appeal, or in the case of an expedited Appeal within seventy-two (72) hours as described in section 2.15.3.5. An Enrollee notice, at a minimum, must include the result and date of the Appeal resolution. For decisions not wholly in the Enrollee's favor, Contractor, at a minimum must include:

2.15.1.2.1. Enrollee's right to request a State Fair Hearing;

2.15.1.2.2. How to request a State Fair Hearing;

2.15.1.2.3. Right to continue to receive benefits pending a State Fair Hearing;

2.15.1.2.4. How to request the continuation of benefits;

2.15.1.2.5. That Enrollee may be liable for cost of any continued benefits if the Contractor's action is upheld on Appeal;

2.15.1.2.6. Enrollee's right to file an external Grievance through DMHC's consumer complaint process or request an Independent Medical Review from DMHC with respect to any and all disputes concerning Medi-Cal based services that are medical in nature and that relate to health care service plan obligations set forth under the Knox-Keene Act and the regulations promulgated thereunder.; and

2.15.1.2.7. How to file an external Grievance through DMHC's consumer complaint process or request an Independent Medical Review from DMHC.

2.15.1.2.8. COHS plans that have not obtained a Knox-Keene license are not required to comply with 2.15.1.2.6 and 2.15.1.2.7 of this Contract.

2.15.1.3. Contractors without a Knox-Keene license may extend the timeframe to resolve an Appeal by up to fourteen (14) days if the Enrollee requests the extension, or Contractor shows that there is a need for additional information and how the delay is in the Enrollee's interest. Contractor must provide the Enrollee with written notice within two (2) calendar days of the reason for the extension and inform the Enrollee of the right to file a Grievance if they disagree with the delay; and the Contractor must make reasonable efforts to provide prompt oral notice of the delay. Effective January 1, 2020, Contractors with a Knox-Keene license may not allow extensions to resolve Appeals.

2.15.1.4. Written material must use easily understood language and format, be available in alternative formats, and in an appropriate manner that takes into consideration those with special needs. The Contractor must inform Enrollees that information is available in alternative formats and how to access those formats.

2.15.2. Appeals relating to Medi-Cal covered benefits and services shall proceed pursuant to the laws and regulations governing Medi-Cal Appeals. Appeals relating to Medicare covered benefits and services

shall proceed pursuant to the laws and regulations governing Medicare Appeals.

2.15.2.1. Written notice must be translated for Enrollees who speak Threshold Languages.

2.15.2.2. Written notices must include language clarifying that oral interpretation is available for all languages and how to access it.

2.15.2.3. The Contractor must maintain written records of all Appeals activities. The Appeal record must include the name of the covered person for whom the Appeal was filed; the name of the Contractor's representative recording the Appeal; a general description of the reason for the Appeal; the date received; the date of each review or, if applicable, review meeting; and resolution information for each level of Appeal including date of resolution. The Appeal record must be accessible to CMS and DHCS upon request.

2.15.3. Medi-Cal Appeals and beneficiary protections will be maintained for Appeals regarding Medi-Cal services.

2.15.3.1. Enrollee or provider may file an Appeal with the Contractor either orally or in writing. The Contractor shall assist the Enrollee in confirming an oral Appeal in writing.

2.15.3.2. Enrollee, the Enrollee's authorized representative, or a Provider with the Enrollee's written consent, may file the oral or written Enrollee Appeal with the Contractor within sixty (60) calendar days after date of the Integrated Notice of Action.

2.15.3.3. Contractor must:

2.15.3.3.1. Timely acknowledge receipt of each Enrollee Appeal, including provide a written acknowledgemnent to the Enrollee within 5 calendar days of receipt.

2.15.3.3.2. Ensure that oral inquiries seeking to Appeal an action are treated as Appeals and confirm those

inquiries in writing unless the Enrollee or provider requests expedited resolution.

2.15.3.3.3. Provide a reasonable opportunity to present evidence and allegation of fact or law, in person, as well as in writing.

2.15.3.3.4. Provide the Enrollee and representative the Enrollee's case file, including medical records, and any other documents and records free of charge. The Enrollee's case file must be provided sufficiently in advance of the resolution timeframes.

2.15.3.3.5. Consider the Enrollee, representative, or estate representative of a deceased Enrollee as parties to the Appeal.

2.15.3.3.6. In compliance with 42 C.F.R. § 438.406(b), ensure that decision makers on Appeals were not involved in previous levels of review or decision-making nor a subordinate of any such individual and are health care professionals with clinical expertise in treating the Enrollee's condition or disease if any of the following apply:

2.15.3.3.6.1. A denial of an Appeal based on lack of medical necessity;

2.15.3.3.6.2. A Grievance regarding denial of expedited resolution of an Appeal; or

2.15.3.3.6.3. Any Appeal involving clinical issues.

2.15.3.4. Contractor shall implement and maintain an Enrollee internal Appeals system, which includes oversight of any First Tier, Downstream or Related Entity, in accordance with all applicable federal and State laws and regulations, including but not limited to the following:

2.15.3.4.1. Federal Medicaid regulations governing Medi-Cal Managed Care Appeals and Medi-Cal Appeals in general, at 42 C.F.R. 431 Subpart E and 42 C.F.R. 438 Subpart F.

2.15.3.4.2. Standards for expedited review of Grievances involving an imminent and serious threat to the health of the Enrollee: Title 28, CCR, Sections 1300.68 and 1300.68.01;

2.15.3.4.3. Internal Contractor Appeal processes, in accordance with the Knox-Keene Act and the regulations promulgated thereunder, and external Appeal processes in accordance with DMHC's Independent Medical Review System set forth in Article 5.55 of the Knox-Keene Act (commencing with Health & Safety Code Section 1374.30) and the regulations promulgated thereunder; and the fair hearing standards for Medi-Cal managed care, Title 22, CCR, Sections 51014.1, 51014.2, 53894, and 53858, as well as 42 C.F.R. § 431.244 related to standard and expedited fair hearings decisions;

2.15.3.4.4. Twelve (12) month continuity of care under certain circumstances. WIC section14182.17 (d)(7)(A)(ii).

2.15.3.5. Expedited internal Medi-Cal Appeals**.** Contractor shall comply with all State law and regulations pertaining to expedited Appeals, as well as the following requirements:

2.15.3.5.1. Contractor shall implement and maintain procedures as described below to resolve expedited internal Appeals for Medi-Cal services. These procedures shall be followed whenever Contractor determines or the provider indicates that taking the time for a standard resolution could seriously jeopardize the Enrollee's life, health, or ability to attain, maintain, or regain maximum function.

2.15.3.5.2. Enrollee or provider may file an expedited Appeal either orally or in writing, and no additional Enrollee follow-up is required.

2.15.3.5.3. Contractor must inform the Enrollee of the limited time available for the Enrollee to present evidence and allegations of fact or law, in person and in writing.

2.15.3.5.4. Contractor must provide an Enrollee notice as quickly as the Enrollee's health condition requires, not exceeding 72 hours from the Contractor's receipt of the Appeal.

2.15.3.5.5. Contractor without a Knox-Keene license may extend the timeframe to resolve an Appeal by up to fourteen (14) days if the Enrollee requests the extension, or Contractor shows that there is a need for additional information and how the delay is in the Enrollee's interest. Contractor must make reasonable efforts to provide the Enrollee prompt oral notice, and provide the Enrollee with written notice of the reason for the extension within 2 calendar days and inform the Enrollee of the right to file a Grievance if they disagree with the delay. Contractor must issue and carry out its determination as expeditiously as the Enrollee's health condition requires and no later than the date the extension expires. Effective January 1, 2020, Contractors with a Knox-Keene license may not allow extensions to resolve Appeals.

2.15.3.5.6. Contractor must provide written notice and must make a reasonable effort to provide oral notice of expedited Appeal decision.

2.15.3.5.7. Contractor must ensure that punitive action is not taken against a provider who either requests an expedited resolution or supports an Enrollee's Appeal.

2.15.3.5.8. If Contractor denies a request for expedited resolution of an Appeal, it must:

2.15.3.5.8.1. Transfer the Appeal to the standard timeframe of no longer than thirty (30) calendar days from the day the Contractor receives the Appeal with a possible fourteen (14) day extension for Contractactors without a Knox-Keene licsense, and

2.15.3.5.8.2. Give the Enrollee prompt oral notice of the denial of a request for expedited resolution and a written notice within two (2) calendar days.

2.15.3.6. Responsibilities in State Fair Hearings Related to Medi-Cal Benefits and Services**.** Contractor shall comply with all regulations and procedures regarding State Fair Hearings, set forth in the Manual of Policies and Procedures issued by the California Department of Social Services, pursuant to Title 22, CCR, Section 50953. Contractor shall have the following responsibilities with respect to State Fair Hearings that are expedited, in compliance with CDSS All County Letter 13-40.

2.15.3.6.1. An Enrollee, or an Enrollee's authorized representative, may request a State Fair Hearing either orally or in writing, consistent with 42 C.F.R. § 431.221.

2.15.3.7. Parties to an internal Medi-Cal Appeal or State Fair Hearing.

2.15.3.7.1. The parties to an internal plan Appeal or the State Fair Hearing related to a Medi-Cal benefit or service include the Contractor as well as the Enrollee and his or her representative or the representative of a deceased Enrollee's estate.

2.15.3.8. Responsibilities in Independent Medical Reviews (IMR) Related to Medi-Cal Benefits and Services. Contractor, except for non-Knox Keene Act licensed COHS plans, shall comply with all statutes, regulations and procedures regarding DMHC's Independent Medical Review System, as set forth in the Knox-Keene Act and the regulations promulgated thereunder, including but not limited to the following requirements:

2.15.3.8.1. Enrollees may request an IMR regarding Medi-Cal services from DMHC within six (6) months of a denial, modification or delay of a Medi-Cal service based on Contractor's determination, in whole or in part, that the service is not medically necessary. Health & Safety Code Section 1374.30.

2.15.3.8.2. Enrollees shall not be required to participate in Contractor's internal Appeal process for more than thirty (30) days before applying for an IMR. Health & Safety Code Section 1368(b)(1)(A).

2.15.3.8.3. Enrollees whose Appeal requires expedited review pursuant to Health & Safety Code Section 1368.01 shall not be required to participate in the Contractor's Internal Grievance process for more than three (3) days before applying for an IMR. Health & Safety Code Section 1374.30(j)(3).

2.15.3.8.4. Enrollees may apply for an IMR without first participating in Contractor's Internal Appeal process in extraordinary and compelling cases, as determined by DMHC, and in cases where Enrollee's request for an experimental treatment was denied. Health & Safety Code Section 1368.03 and 1374.31(a); Title 28, CCR Section 1300.70.4(b)(2).

2.15.3.8.5. Contractor must notify Enrollee in writing of the opportunity to request an IMR of a decision denying an experimental therapy within five (5) business days of the decision to deny coverage. Title 28, CCR Section 1300.70.4(b); Health & Safety Code Section 1370.4(c)(1).

2.15.3.8.6. Enrollees may not request an IMR if a State Fair Hearing has already been held on the issue. Title 28, CCR Section 1300.74.30(f)(3).

2.15.3.8.7. If DMHC determines that Enrollee is not eligible for an IMR, the Enrollee's case will be reviewed through DMHC's consumer complaint process. Health & Safety Code Section 1368(b).

2.15.4. Medicare Appeals rights and protections will be maintained and enhanced for Medicare services only.

2.15.4.1. Federal Regulations and law will continue to govern all Medicare Appeals regarding Medicare services. As outlined in the MOU, Enrollees will continue to have access to the existing Medicare Part C and Part D Appeals processes. The

Medicare Part C process is set forth at 42 C.F.R. Part 422, Subpart M and in Chapter 13 of the Medicare Managed Care Manual. The Medicare Part D process is set forth at 42 C.F.R. Part 423, Subparts M and U and in Chapter 18 of the Medicare Prescription Drug Benefit Manual.

2.15.4.2. Hospital Discharge and other Discharge Appeals

2.15.4.2.1. The Contractor must comply with the hospital discharge Appeal requirements at 42 C.F.R. §§ 422.620-422.622.

2.15.4.2.2. The Contractor must comply with the termination of services Appeal requirements for individuals receiving services from a comprehensive outpatient rehabilitation facility, SNF, or home health agency at 42 C.F.R. §§ 422.624 and 422.626.

2.15.5. Continuation of Benefits Pending an Appeal

2.15.5.1. Medicare Benefits and Services

2.15.5.1.1. The Contractor must continue providing benefits for all prior approved non-Part D Medicare benefits for which a Contractor has issued a NOA for termination or modification pending completion of the internal Contractor Appeal. This means that such benefits will continue to be provided to Enrollees and that the Contractor must continue to pay providers for providing such services or benefits pending an internal Appeal.

2.15.5.1.2. Payments will not be recouped based on the outcome of the Appeal for services covered during all pending Appeals.

2.15.5.2. Medi-Cal Benefits and Services

2.15.5.2.1. The Contractor must continue providing all prior approved Medi-Cal benefits for which a Contractor has issued a NOA for termination or modification pending completion of the internal Contractor Appeal or per timeframes in 42 C.F.R. § 438.420, whichever comes first. This means that such benefits will continue to be provided to

Enrollees and that the Contractor must continue to pay providers for providing such services or benefits until the completion of the hearing process, or until the Enrollee withdraws the Appeal request or fails to file timely per the timeframes in 42 C.F.R. § 438.420, whichever comes first.

2.15.5.2.2. Payments will not be recouped based on the outcome of the Appeal for services covered during all pending Appeals.

2.15.6. In the event that the Enrollee pursues the Appeal in multiple forums (for example, if the Enrollee files for a State Fair Hearing while the IRE decision is pending) and receives conflicting decisions, the Contractor is bound by, and must act in accordance with, the decision favorable to the Enrollee or the decision closest to the Enrollee's relief requested on Appeal.

2.16. Quality Improvement Program

2.16.1. Quality Improvement (QI) Program. The Contractor shall:

2.16.1.1. Deliver quality care that enables Enrollees to stay healthy, get better, manage chronic illnesses and/or disabilities, and maintain/improve their quality of life. Quality care refers to:

2.16.1.1.1. Quality of physical health care, including primary and specialty care;

2.16.1.1.2. Quality of Behavioral Health services focused on recovery, resiliency and rehabilitation;

2.16.1.1.3. Quality of LTSS;

2.16.1.1.4. Adequate access and availability to primary, Behavioral Health services, specialty health care, and LTSS providers and services;

2.16.1.1.5. Continuity and coordination of care across all care and services settings, and for transitions in care; and

2.16.1.1.6. Enrollee experience and access to high quality, coordinated and culturally competent clinical care

and services, inclusive of LTSS across the care continuum.

2.16.2. Apply the principles of Continuous Quality Improvement (CQI) to all aspects of the Contractor's service delivery system through ongoing analysis, evaluation and systematic enhancements based on:

2.16.2.1. Quantitative and qualitative data collection and data-driven decision-making;

2.16.2.2. Up-to-date evidence-based practice guidelines and explicit criteria developed by recognized sources or appropriately certified professionals or, where evidence-based practice guidelines do not exist, consensus of professionals in the field;

2.16.2.3. Feedback provided by Enrollees and providers in the design, planning, and implementation of its CQI activities;

2.16.2.4. Rapid Cycle Quality Improvement, when appropriate, as determined by DHCS;

2.16.2.5. Issues identified by the Contractor, DHCS and/or CMS; and

2.16.2.6. Ensure that the QI requirements of this Contract are applied to the delivery of primary and specialty health care services, Behavioral Health services and LTSS.

2.16.3. QI Program Structure

2.16.3.1. The Contractor shall maintain a well-defined QI organizational and program structure that supports the application of the principles of CQI to all aspects of the Contractor's service delivery system. The QI program must be communicated in a manner that is accessible and understandable to internal and external individuals and entities, as appropriate. The Contractor's QI organizational and program structure shall comply with all applicable provisions of 42 C.F.R. § 438, including Subpart E, Quality Assessment and Performance Improvement, 42 C.F.R. § 422, Subpart D Quality Improvement, and shall meet the quality management and improvement criteria described in the most current NCQA health plan accreditation requirements in 28 CCR Section 1300.70.

2.16.3.2. The Contractor shall:

2.16.3.2.1. Establish a mechanism to detect both underutilization and overutilization of services and assess the quality and appropriateness of care furnished to Enrollees with special health care needs.

2.16.3.2.2. Establish a set of QI functions and responsibilities that are clearly defined and that are proportionate to, and adequate for, the planned number and types of QI initiatives and for the completion of QI initiatives in a competent and timely manner;

2.16.3.2.3. Ensure that such QI functions and responsibilities are assigned to individuals with the appropriate skill set to oversee and implement an organization-wide, cross-functional commitment to, and application of, CQI to all clinical and non-clinical aspects of the Contractor's service delivery system;

2.16.3.2.4. Establish internal processes to ensure that the quality management activities for primary, specialty, Behavioral Health services, and LTSS reflect utilization across the Provider Network and include all of the activities in this Section 2.16 of this Contract and, in addition, the following elements:

2.16.3.2.4.1. A process to utilize Healthcare Plan Effectiveness Data and Information Set (HEDIS), Consumer Assessment of Healthcare Providers and Services (CAHPS), the Health Outcomes Survey (HOS) and other measurement results in designing QI activities;

2.16.3.2.4.2. A medical record review process for monitoring Provider Network compliance with policies and procedures, specifications and appropriateness of care. Such process shall include the sampling method used which shall be proportionate to

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utilization by service type. The Contractor shall submit its process for medical record reviews and the results of its medical record reviews to DHCS;

2.16.3.2.4.3. A process to measure Provider Network and Enrollees, at least annually, regarding their satisfaction with the Contractor's plan. The Contractor shall submit a survey plan to DHCS for approval and shall submit the results of the survey to DHCS and CMS;

2.16.3.2.4.4. A process to measure clinical reviewer consistency in applying clinical criteria to utilization management activities, using inter-rater reliability measures;

2.16.3.2.4.5. A process for including Enrollees and their families in quality management activities, as evidenced by participation in consumer advisory boards; and

2.16.3.2.4.6. In collaboration with and as further directed by DHCS, develop a customized medical record review process to monitor the assessment for and provision of LTSS.

2.16.3.2.5. Have in place a written description of the QI Program that delineates the structure, goals, and objectives of the Contractor's QI initiatives. Such description shall include the following:

2.16.3.2.5.1. Organizational commitment to the delivery of quality health care services as evidenced by goals and objectives which are approved by Contractor's governing body and periodically evaluated and updated.

2.16.3.2.5.2. Organizational chart showing the key staff and the committees and bodies

responsible for quality improvement activities including reporting relationships of QI committee(s) and staff within the Contractor's organization.

2.16.3.2.5.3. Qualifications of staff responsible for quality improvement studies and activities, including education, experience and training.

2.16.3.2.5.4. The role, structure, and function of the Quality Improvement Committee.

2.16.3.2.5.5. The processes and procedures designed to ensure that all Covered Services that are Medically Necessary are available and accessible to all Enrollees regardless of race, color, national origin, creed, ancestry, religion, language, age, gender, marital status, sexual orientation, health status, or disability, and that all Covered Services that are Medically Necessary are provided in a culturally and linguistically appropriate manner.

2.16.3.2.5.6. 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 Enrollees are able to obtain appointments within established standards.

2.16.3.2.5.7. Description of the quality of clinical care services provided, including, but not limited to, preventive services for children and adults, perinatal care, primary care, specialty, emergency, inpatient, and ancillary care services.

2.16.3.2.5.8. Description of the activities, including activities used by persons with chronic

conditions, designed to assure the provision of case management, coordination and continuity of care services. Such activities shall include, but are not limited to, those designed to assure availability and access to care, clinical services and care management.

2.16.3.2.5.9. A description of the mechanisms used to provide feedback to staff and providers regarding QI outcomes.

2.16.3.2.6. Address all aspects of health care, including specific reference to Behavioral Health services and to LTSS, with respect to monitoring and improvement efforts, and integration with physical health care. Behavioral Health and LTSS aspects of the QI program may be included in the QI description, or in a separate QI Plan referenced in the QI description as follows:

2.16.3.2.6.1. Address the roles of the designated physician(s), Behavioral Health clinician(s), and LTSS providers with respect to QI program;

2.16.3.2.6.2. Identify the resources dedicated to the QI program, including staff, or data sources, and analytic programs or IT systems; and

2.16.3.2.6.3. Include organization-wide policies and procedures that document processes through which the Contractor ensures clinical quality, access and availability of health care and services, and continuity and coordination of care. Such processes shall include, but not be limited to, Appeals and Grievances and utilization management.

2.16.3.2.7. Plans in Los Angeles and Orange counties must initiate QI activities for Enrollees in Medicare LTI status per Section 4.2.2.2.6.4.

2.16.3.2.7.1. QI activities under this initiative are subject to CMT approval.

2.16.3.3. Delegation of Quality Improvement Activities

2.16.3.3.1. Contractor is accountable for all QI functions and responsibilities (e.g. utilization management, credentialing and site review) that are delegated to First Tier, Downstream, and Related Entities.

2.16.3.3.2. Contractor shall maintain a system to ensure accountability for delegated QI activities, that at a minimum:

2.16.3.3.2.1. Evaluates First Tier, Downstream and Related Entity's ability to perform the delegated activities including an initial review to assure that the First Tier, Downstream, and Related Entity has the administrative capacity, task experience, and budgetary resources to fulfill its responsibilities;

2.16.3.3.2.2. Ensures First Tier, Downstream, and Related Entity meets standards set forth by the Contractor and DHCS; and

2.16.3.3.2.3. Includes the continuous monitoring, evaluation and approval of the delegated functions.

2.16.3.3.3. Submit to DHCS and CMS an annual QI Work Plan that shall include the following components or other components as directed by DHCS and CMS:

2.16.3.3.3.1. Planned clinical and non-clinical initiatives;

2.16.3.3.3.2. The objectives for planned clinical and non-clinical initiatives;

2.16.3.3.3.3. The short and long term time frames within which each clinical and non-clinical initiative's objectives are to be achieved;

2.16.3.3.3.4. The individual(s) responsible for each clinical and non-clinical initiative;

2.16.3.3.3.5. Any issues identified by the Contractor, DHCS, Enrollees, and providers, and how those issues are tracked and resolved over time;

2.16.3.3.3.6. Program review process for formal evaluations that address the impact and effectiveness of clinical and non-clinical initiatives at least annually; and

2.16.3.3.3.7. Process for correcting deficiencies.

2.16.3.3.4. Evaluate the results of QI initiatives at least annually, and submit the results of the evaluation to DHCS and CMS. The evaluation of the QI program initiatives shall include, but not be limited to, the results of activities that demonstrate the Contractor's assessment of the quality of physical and Behavioral Health services rendered, the effectiveness of LTSS, and accomplishments and compliance and/or deficiencies in meeting the previous year's QI Strategic Work Plan; and

2.16.3.3.5. Contractor shall develop a QI report for submission to DHCS and CMS on an annual basis. The annual report shall include:

2.16.3.3.5.1. An Assessment of the QI activities undertaken and an evaluation of areas of success and needed improvements in services rendered within the QI program, including but not limited to:

2.16.3.3.5.1.1. The collection of aggregate data on utilization;

2.16.3.3.5.1.2. The review of quality of services rendered; and

2.16.3.3.5.1.3. Outcomes/findings from Quality Improvement Projects (QIPs),

consumer satisfaction surveys and collaborative initiatives.

2.16.3.3.5.2. Consistent with 42 C.F.R. § 438.332(b), copies of all final reports of non-governmental accrediting agencies (e.g. JCAHO, NCQA) relevant to the Contractor's Medi-Cal line of business, including accreditation status, any deficiencies noted, and expiration date of the accreditation. Include the corrective action plan developed to address noted deficiencies.

2.16.3.3.5.3. An assessment of First Tier, Downstream and Related Entity's performance of delegated QI activities.

2.16.3.3.6. Maintain sufficient and qualified staff employed by the Contractor to manage the QI activities required under the Contract, and establish minimum employment standards and requirements (e.g. education, training, and experience) for employees who will be responsible for quality management. QI staff shall include:

2.16.3.3.6.1. At least one designated physician, who shall be a medical director or associate medical director, at least one designated Behavioral Health provider, and a professional with expertise in the assessment and delivery of LTSS with substantial involvement in the QI program; and

2.16.3.3.6.2. A qualified individual to serve as the Cal MediConnect QI Director.

2.16.4. QI Activities

2.16.4.1. Performance Measurement

2.16.4.1.1. The Contractor shall engage in performance measurement and performance improvement projects, designed to achieve, through ongoing

measurement and intervention, significant improvements, sustained over time, in clinical care and non-clinical care processes, outcomes and Enrollee experience. The Contractor's QI program must include a health information system to collect, analyze, and report quality performance data as described in 42 C.F.R. §§ 422.516(a), 422.152, 423.514, 438.242(a) and (b), and 330.

2.16.4.1.2. Performance improvement projects must involve:

2.16.4.1.2.1. Measurement of performance using objective quality indicators

2.16.4.1.2.2. Implementation of systems interventions to achieve improvement in quality

2.16.4.1.2.3. Evaluation of the effectiveness of the interventions

2.16.4.1.2.4. Planning and initiation of activities for increasing and sustaining improvement

2.16.4.1.3. Measurement and improvement projects shall be conducted in accordance with requirements in the CFAM-MOU, Figure 7-1 core quality measures, and as specified in this Contract, and shall include, but are not limited to:

2.16.4.1.3.1. All HEDIS, HOS and CAHPS data, as well as all other measures specified in Figure 7-1 core quality measures of the MOU referenced above (Figure 7-1). HEDIS, HOS and CAHPS must be reported consistent with Medicare requirements. All existing Part D metrics will be collected as well. Additional details, including technical specifications, will be provided in annual guidance for the upcoming reporting year.

2.16.4.1.3.2. The Contractor shall collect annual data and contribute to all Demonstration QI-related processes, as directed by DHCS and CMS, as follows:

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2.16.4.1.3.2.1. Collect and submit to DHCS, CMS and/or CMS' contractors, in a timely manner, data for the measures;

2.16.4.1.3.2.2. Contribute to all applicable DHCS and CMS data quality assurance processes, shall include, but not be limited to, responding, in a timely manner, to data quality inadequacies identified by DHCS and rectifying those inadequacies, as directed by DHCS

2.16.4.1.3.2.3. The Contractor shall demonstrate how to utilize results of the measures specified in any CMS and DHCS reporting requirements documents in designing QI initiatives.

2.16.4.2. Consumer Satisfaction Survey:

2.16.4.2.1. At intervals as determined by DHCS, DHCS' contracted EQRO will conduct a consumer satisfaction survey of a representative sample of Enrollees in each county, as determined by the technical specifications of the survey instrument chosen by DHCS. If requested, Contractor shall provide appropriate data to the EQRO to facilitate this survey.

2.16.4.3. Quality Improvement Project (QIP)Requirements

2.16.4.3.1. The Contractor shall implement and adhere to all processes relating to the QIP requirements, as directed by DHCS and CMS, and as follows:

2.16.4.3.1.1. In accordance with 42 C.F.R. § 438.330 (b) and (d) collect information and data in accordance with QIP requirement specifications for its Enrollees; using the format and submission guidelines specified

by DHCS and CMS in annual guidance provided for the upcoming Contract year;

2.16.4.3.1.2. The Contractor is required to conduct or participate in two (2) QIPS approved by DHCS. If Contractor holds multiple managed care contracts with DHCS, Contractor is required to conduct or participate in no more than two (2) QIPS for each Contract.

2.16.4.3.1.2.1. One (1) QIP must be an internal quality improvement project (IQIP), the requirements of which may be met by the completion of the Medicare QIP process.

2.16.4.3.1.2.2. One (1) QIP must be a DHCS facilitated statewide collaborative in accordance with applicable DPL(s) as indicated in Section 2.1.5.

2.16.4.4. Implement the QIP requirements, in a culturally competent manner;

2.16.4.5. Evaluate the effectiveness of QIP interventions, completed in a reasonable time period as to generally allow information on the success of performance improvement projects in the aggregate to produce new information on quality of care every year;

2.16.4.6. Plan and initiate processes to sustain achievements and continue improvements;

2.16.4.7. Submit to DHCS and CMS, if requested by CMS or DHCS, comprehensive written reports, using the format, submission guidelines and frequency specified by DHCS and CMS. Such reports shall include information regarding progress on QIP requirements, barriers encountered and new knowledge gained. As directed by DHCS and CMS, the Contractor shall present this information to DHCS and CMS, if requested, at the end of the QI requirement project cycle as determined by DHCS and CMS; and

2.16.4.8. In accordance with 42 C.F.R. § 422.152 (c), develop a Chronic Care Improvement Program (CCIP) and establish criteria for participation in the program. The CCIP must be relevant to and target the Contractor's plan population. Although the Contractor has the flexibility to choose the design of their CCIPs, DHCS and CMS may require them to address specific topic areas.

2.16.5. External Quality Review (EQR) Activities

2.16.5.1. The Contractor shall take all steps necessary to support the EQRO contracted by DHCS and the QIO to conduct EQR activities, in accordance with 42 C.F.R. § 438.358 and 42 C.F.R. § 422.153. Contractor shall address the findings of the external review through its QI program. Contractor shall develop and implement performance improvement goals, objectives, and activities in response to the EQR findings as part of Contractor's QI program. A description of the performance improvement goals, objectives, and activities developed and implemented in response to the EQRO findings will be included in Contractor's QI program. DHCS may also require separate submission of an improvement plan specific to the findings of the EQRO. EQR activities shall include, but are not limited to the following:

2.16.5.1.1. Annual validation of performance measures reported to DHCS, as directed or calculated by DHCS;

2.16.5.1.2. Annual validation of QI projects required by DHCS and CMS; and

2.16.5.1.3. At least once every three (3) years, review of compliance with standards mandated by 42 C.F.R. Part 438, Subpart D, 42 C.F.R. Part 422, Subpart D, and 42 C.F.R. Part 423, Subpart D, and at the direction of DHCS, regarding access, structure and operations, and quality of care and services furnished to DHCS. The Contractor shall take all steps necessary to support the EQRO and QIO in conducting EQR activities including, but not limited to:

2.16.5.1.3.1. Designating a qualified individual to serve as project director for each EQR activity who shall, at a minimum perform the following activities:

2.16.5.1.3.1.1. Oversee and be accountable for compliance with all aspects of the EQR activity;

2.16.5.1.3.1.2. Coordinate with staff responsible for aspects of the EQRO activity and ensure that staff respond to requests by the EQRO, QIO, DHCS and CMS staff in a timely manner;

2.16.5.1.3.1.3. Serve as the liaison to the EQRO, QIO, DHCS and CMS and answer questions or coordinate responses to questions from the EQRO, QIO, CMS and DHCS in a timely manner; and

2.16.5.1.3.1.4. Ensure timely access to information systems, data, and other resources, as necessary for the EQRO and/or QIO to perform the EQR activity and as requested by the EQRO, QIO, CMS or DHCS.

2.16.5.1.3.2. Maintaining data and other documentation necessary for completion of EQR activities specified above. The contractor shall maintain such documentation for a minimum of ten (10) years;

2.16.5.1.3.3. Reviewing the EQRO's draft EQR report and offering comments and documentation to support the correction of any factual errors or omissions, in a timely manner, to the EQRO or

2.16.5.1.4. Participating in meetings relating to the EQR process, EQR findings, and/or EQR trainings with the EQRO and DHCS;

2.16.5.1.5. Implementing actions, as directed by DHCS and/or CMS, to address recommendations for QI made by the EQRO or QIO, and sharing outcomes and results of such activities with the EQRO or QIO, and CMS in subsequent years; and

2.16.5.1.6. Participating in any other activities deemed necessary by the EQRO and/or QIO and approved by DHCS and CMS.

2.16.6. CMS-Specified Performance Measurement and Performance Improvement Projects

2.16.6.1. The Contractor shall conduct additional performance measurement or performance improvement projects if mandated by CMS pursuant to 42 C.F.R. § 438.330.

2.16.7. Clinical Practice Guidelines

2.16.7.1. The Contractor shall adopt, disseminate, and monitor the use of clinical practice guidelines relevant to Enrollees that are:

2.16.7.1.1. Based on valid and reliable clinical evidence or a consensus of health care professionals;

2.16.7.1.2. Consider the needs of Enrollees;

2.16.7.1.3. Developed in consultation with contracting health care professionals;

2.16.7.2. Contractor will review and update practice guidelines periodically as appropriate

2.16.7.3. Contractor will disseminate the practice guidelines to all affected providers and upon request, to Enrollees and potential Enrollees.

2.16.7.4. Delegated Credentialing: Contractor may delegate credentialing and recredentialing activities. If Contractor delegates these activities, Contractor shall comply with:

2.16.7.4.1. Credentialing Provider Organization Certification: Contractor and their Network Providers (e.g. a medical group or independent physician organization) may obtain credentialing provider organization certification (POC) from the NCQA.

2.16.7.5. Contractor shall ensure that all contracted laboratory testing sites have either a Clinical Laboratory Improvement Act (CLIA) certificate or waiver of a certificate of registration along with a CLIA identification number.

2.16.7.6. Disciplinary Actions: Contractor shall implement and maintain a system for the reporting of serious quality deficiencies that result in suspension or termination of a practitioner to the appropriate authorities. Contractor shall implement and maintain policies and procedures for disciplinary actions including, reducing, suspending, or terminating a practitioner's privileges. Contractor shall implement and maintain a provider Appeal process.

2.16.7.7. Health Plan Accreditation: If Contractor has received a rating of "Excellent," Commendable" or "Accredited" from NCQA, the Contractor shall be "deemed" to meet the DHCS requirements for credentialing and will be exempt from the DHCS medical review audit of credentialing.

2.16.7.8. Deeming of credentialing certification from other private credentialing organizations will be reviewed on an individual basis.

2.16.7.9. Credentialing of Other Non-Physician Medical Practitioners: Contractor shall develop and maintain policies and procedures that ensure that the credentials of nurse practitioners, certified nurse midwives, clinical nurse specialists and physician assistants have been verified in accordance with State requirements applicable to the provider category.

2.16.8. The Contractor's decisions regarding UM, Enrollee education, coverage of services, and other areas included in the practice guidelines must be consistent with the Contractor's clinical practice guidelines.

2.16.9. Quality Improvement Committee: 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 Enrollees and Network Providers, who are representative of the composition of the contracted Provider Network, actively participate on the committee or medical sub-committee that reports to the QIC.

2.16.9.1. The committee shall meet at least quarterly but as frequently as necessary to demonstrate follow-up on all findings and required actions. The activities, findings, recommendations, and actions of the committee shall be reported to the governing body in writing on a scheduled basis.

2.16.9.2. Contractor shall maintain minutes of committee meetings and minutes shall be submitted to DHCS quarterly. Contractor shall maintain a process to ensure rules of confidentiality are maintained in quality improvement discussions as well as avoidance of conflict of interest on the part of committee members.

2.17. Marketing, Outreach, and Enrollee Communications Standards

2.17.1. General Marketing, Outreach, and Enrollee Communications Requirements

2.17.1.1. The Contractor is subject to rules governing marketing and Enrollee Communications as specified under Section 1851(h) of the Social Security Act; 42 C.F.R. §§ 422.111, 422.2260 et. seq., 423.120(b) and (c), 423.128, 423.2260, 438.10; and the Medicare Communications and Marketing Guidelines, with the following exceptions or modifications:

2.17.1.1.1. Contractor may complete an application for enrollment from a potential Cal MediConnect Enrollee and submit it to the State Enrollment Broker;

2.17.1.1.2. If approved to participate in Streamlined Enrollment, the Contractor may collect enrollment information from a potential eligible Enrollee and submit that request to the State per Section 2.3.1.7.

2.17.1.1.3. The Contractor may refer Enrollees and potential Enrollees who inquire about Capitated Financial

Alignment model eligibility or enrollment to the Enrollment Broker, although the Contractor may provide Enrollees and potential Enrollees with information about the Contractor's plan and its benefits prior to referring a request regarding eligibility or enrollment to the Enrollment Broker;

2.17.1.1.4. The Contractor must make available to CMS and DHCS, upon request, current schedules of all educational events conducted by the Contractor to provide information to Enrollees or potential Enrollees;

2.17.1.1.5. The Contractor must convene all educational and marketing/sales events at sites within the Contractor's Service Area that are physically accessible to all Enrollees or potential Enrollees, including persons with disabilities and persons using public transportation.

2.17.1.1.6. The Contractor may not directly or indirectly conduct door-to-door, telephone, or other unsolicited contacts;

2.17.1.1.7. The Contractor does not seek to influence enrollment in conjunction with the sale or offering of any private insurance; and

2.17.1.1.8. The Contractor may not use any Marketing, Outreach, or Enrollee Communications materials that contain any assertion or statement (whether written or oral) that:

2.17.1.1.8.1. The recipient must enroll with the Contractor in order to obtain benefits or in order not to lose benefits;

2.17.1.1.8.2. The Contractor is endorsed by CMS, Medicare, Medi-Cal, the federal government, DHCS, or similar entity.

2.17.2. The Contractor's Marketing, Outreach, and Enrollee Communications materials must be:

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2.17.2.1. Made available in alternative formats, upon request and as needed to assure effective communication for blind and vision-impaired Enrollees;

2.17.2.2. Provided in a manner, format and language that may be easily understood by persons with limited English proficiency, or for those with developmental disabilities or cognitive impairments; and

2.17.2.3. Translated into Threshold Languages for all required vital materials, as specified in the Marketing Guidance for California Medicare-Medicaid Plans and annual guidance to Contractors on specific translation requirements for their Service Areas; and

2.17.2.4. Mailed with a multi-language insert or alternate language taglines that indicate that the Enrollee can access free interpreter services to answer questions about the plan. This message shall be written in the languages required in the Medicare Communications and Marketing Guidelines and Marketing Guidance for California Medicare-Medicaid Plans provisions on the multi-language insert and alternate language taglines.

2.17.2.5. Distributed to the Contractor's entire Service Area, as specified in Appendix I of this Contract.

2.17.3. Submission, Review, and Approval of Marketing, Outreach, and Enrollee Communications Materials

2.17.3.1. The Contractor must receive prior approval of all Marketing, Outreach, and Enrollee Communications in categories of materials that CMS and DHCS require to be prospectively reviewed. Contractor materials may be designated as eligible for the File & Use process, as described in 42 C.F.R. §§ 422.2262(b) and 423.2262(b), and will therefore be exempt from prospective review and approval by both CMS and DHCS. CMS and DHCS may agree to defer to one or the other party for review of certain types of marketing and Enrollee Communications, as agreed in advance by both parties. Contractors must submit all materials that are consistent with the definition of communications materials and marketing materials at 42 C.F.R. § 422.2260, whether prospectively reviewed or not, via the CMS HPMS

Marketing Module. The Contractor that is a non-Knox-Keene licensed COHS plan shall ensure that Marketing, Outreach, and Enrollee Communications involving Medi-Cal based services are consistent with the requirements of the Knox-Keene Act and the regulations promulgated thereunder. The Contractor, unless it is a non-Knox-Keene licensed COHS plan, shall submit to DMHC any Marketing, Outreach, and Enrollee Communications required to be reviewed by DMHC pursuant to the Knox-Keene Act.

2.17.3.2. CMS and DHCS may conduct additional types of review of Contractor's Marketing, Outreach, and Enrollee Communications activities, including, but not limited to:

2.17.3.2.1. Review of on-site marketing facilities, products, and activities during regularly scheduled Contract compliance monitoring visits.

2.17.3.2.2. Random review of actual Marketing, Outreach, and Enrollee Communications pieces as they are used in the marketplace.

2.17.3.2.3. "For cause" review of materials and activities when complaints are made by any source, and CMS or DHCS determine it is appropriate to investigate.

2.17.3.2.4. "Secret shopper" activities where CMS or DHCS request Contractor materials, such as enrollment packets.

2.17.4. Beginning of Marketing, Outreach and Enrollee Communications Activity

2.17.4.1. The Contractor may not begin Marketing, Outreach, and Enrollee Communications activities to Enrollees or potential new Enrollees more than ninety (90) days prior to the effective date of coverage for the following Contract year.

2.17.5. Requirements for Dissemination of Marketing, Outreach, and Enrollee Communications Materials

2.17.5.1. Consistent with the timelines specified in the Marketing Guidance for California Medicare-Medicaid Plans, the Contractor must provide new Enrollees with the following

materials which, with the exception of the materials specified in 2.17.5.4, must also be provided annually thereafter:

2.17.5.1.1. An Evidence of Coverage (EOC)/Member Handbook document, or a distinct and separate notice on how to access the Member Handbook online and how to request a hard copy, that is consistent with the requirements at 42 C.F.R. § 438.10, 42 C.F.R. § 422.111, and 42 C.F.R. § 423.128; includes information about all Covered Services, as outlined below, and that uses the model document developed by CMS and DHCS.

2.17.5.1.1.1. Enrollee rights (see Appendix B);

2.17.5.1.1.2. An explanation of the process by which clinical information, including diagnostic and medication information, will be available to key caregivers;

2.17.5.1.1.3. How to request and obtain a copy of the Enrollee's medical records, and to request that they be amended or corrected;

2.17.5.1.1.4. How to obtain access to services, including specialty, Behavioral Health, pharmacy and LTSS providers;

2.17.5.1.1.5. How to obtain services and prescription drugs for Emergency Conditions and Urgent Care in and out of the Provider Network and in and out of the Service Area; including:

2.17.5.1.1.5.1. What constitutes Emergency Medical Condition, Emergency Services, and Post-Stabilization Care Services, with reference to the definitions in 42 C.F.R. § 438.114(a);

2.17.5.1.1.5.2. The fact that prior authorization is not required for Emergency Services;

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2.17.5.1.1.5.3. The process and procedures for obtaining Emergency Services, including the use of the 911 telephone system or its local equivalent;

2.17.5.1.1.5.4. The locations of any emergency settings and other locations at which providers and hospitals furnish Emergency Services and Post-Stabilization Care Services covered under the Contract;

2.17.5.1.1.5.5. That the Enrollee has a right to use any hospital or other setting for emergency care; and

2.17.5.1.1.5.6. The Post-Stabilization Care Services rules as outlined under 42 C.F.R. § 422.113(c).

2.17.5.1.2. Information about Advance Directives (at a minimum those required in 42 C.F.R. § 489.102 and 42 C.F.R. § 422.128), including Enrollee rights under the law of California; the Contractor's policies respecting the implementation of those rights, including a statement of any limitation regarding the implementation of Advance Directives as a matter of conscience; that complaints concerning noncompliance with the Advance Directive requirements may be filed with DHCS; designating a health care proxy, and other mechanisms for ensuring that future medical decisions are made according to the desire of the Enrollee; and that information provided must reflect changes in State law as soon as possible, but no later than ninety (90) days after the effective date of the change;

2.17.5.1.3. How to obtain assistance from ESRs;

2.17.5.1.4. How to file Grievances and internal and external Appeals, including:

2.17.5.1.4.1. Grievance, Appeal and fair hearing procedures and timeframes;

2.17.5.1.4.2. Toll free numbers that the Enrollee can use to file a Grievance or an Appeal by phone;

2.17.5.1.4.3. A statement that when requested by the Enrollee, benefits will continue at the Contractor level for all benefits during the Contractor Appeal process, and the Enrollee may be required to pay to DHCS the cost of services furnished while the Appeal is pending if the final decision is adverse to the Enrollee; and, how the Enrollee can identify who the Enrollee wants to receive written notices of denials, terminations, and reductions;

2.17.5.1.4.4. How to obtain assistance with the Appeals processes through the ESR and other assistance mechanisms as DHCS or CMS may identify, including an Ombudsperson;

2.17.5.1.5. The extent to which, and how Enrollees may obtain benefits, including family planning services, from out-of-network providers;

2.17.5.1.6. How and where to access any benefits that are available under the State plan but are not covered under the Contract, including any cost sharing, and how transportation is provided;

2.17.5.1.7. How to change providers;

2.17.5.1.8. How to disenroll from Cal Medi-Connect voluntarily;

2.17.5.1.9. How to receive counseling and referral services that are not covered under the Contract because of moral or religious objections;

2.17.5.1.10. The structure and operation of the Contractor; and

2.17.5.1.11. The structure and operation of any physician incentive plans the Contractor may have in place.

2.17.5.2. A Summary of Benefits (SB) that contains a concise description of the important aspects of enrolling in the Contractor's plan, as well as the benefits offered under the Contractor's plan, including any cost sharing, applicable conditions and limitations, and any other conditions associated with receipt or use of benefits, and is consistent with the model document developed by CMS and DHCS. The SB should provide sufficient detail to ensure that Enrollees understand the benefits to which they are entitled. For new Enrollees, the SB is required only for Enrollees enrolled through Passive Enrollment.

2.17.5.3. A combined provider and pharmacy directory that includes all providers of Medicare, Medi Cal, and Flexible Benefits and is consistent with the requirements in Section 2.17.5.10, or a distinct and separate notice on how to access this information online and how to request a hard copy.

2.17.5.4. A single identification (ID) card for accessing all Covered Services under the plan that uses the model document developed by CMS and DHCS.

2.17.5.5. A comprehensive, integrated formulary that includes prescription drugs and over-the-counter products required to be covered by Medicare Part D and DHCS's outpatient prescription drug benefit and that uses the model document developed by CMS and DHCS.

2.17.5.6. The procedures for an Enrollee to change Cal MediConnect Plans or to opt out of Cal MediConnect.

2.17.5.7. The Contractor must provide the following materials to current Enrollees on an ongoing basis:

2.17.5.7.1. An ANOC that summarizes all major changes to the Contractor's covered benefits from one Contract year to the next, and that uses the model document developed by CMS and DHCS.

2.17.5.7.2. As needed to replace old versions or upon an Enrollee's request, a single ID card for accessing all Covered Services under the Contractor;

2.17.5.7.3. The Contractor must provide all Medicare Part D required notices, with the exception of the creditable coverage and late enrollment penalty notices required under Chapter 4 of the Prescription Drug Benefit Manual, and the LIS Rider required under Chapter 13 of the Prescription Drug Benefit Manual.

2.17.5.8. Consistent with the requirement at 42 C.F.R. § 423.120(b)(5), the Contractor must provide Enrollees with at least thirty (30) calendar days advance notice regarding certain changes to the comprehensive, integrated formulary.

2.17.5.9. The Contractor must ensure that all information provided to Enrollees and potential Enrollees (and families when appropriate) is provided in a manner and format that is easily understood and that is:

2.17.5.9.1. Made available in large print (at least 16 point font) to Enrollees as an alternative format, upon request;

2.17.5.9.2. For materials specified in the Medicare-Medicaid marketing guidance, available in Threshold Languages, as provided for in the Marketing Guidance for California Medicare-Medicaid Plans;

2.17.5.9.3. Written with cultural sensitivity and at a sixth grade reading level; and

2.17.5.9.4. Available in alternative formats, according to the needs of Enrollees and potential Enrollees, including Braille, oral interpretation services in non-English languages, as specified in Section 2.3.1.4 of this Contract; audiotape; ASL video clips, and other alternative media, as requested.

2.17.5.10. Provider/Pharmacy Network Directory

2.17.5.10.1. The Contractor must comply with the following maintenance and distribution requirements:

2.17.5.10.1.1. Maintain a combined Provider/Pharmacy Network directory

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that uses the model document developed by CMS and DHCS;

2.17.5.10.1.2. Provide either a print copy or a distinct and separate notice about how to access this information online or request a hard copy, as specified in the Medicare Communications and Marketing Guidelines and the Marketing Guidance for California Medicare-Medicaid Plans, to all new Enrollees at the time of enrollment and annually thereafter;

2.17.5.10.1.3. When there is a significant change to the network, the Contractor must send a special mailing to Enrollees, as specified in Chapter 4 of the Medicare Managed Care Manual, immediately;

2.17.5.10.1.4. The Contractor must ensure an up-to-date copy is available on the Contractor's website, consistent with the requirements at 42 C.F.R. §§ 422.111(h) and 423.128(d);

2.17.5.10.2. Consistent with 42 C.F.R. § 422.111(e), make a good faith effort to provide written notice of termination of a contracted provider or pharmacy consistent with section 2.11.1.5 of this Contract to all Enrollees who regularly use the provider or pharmacy's services; if a contract termination involves a primary care professional, all Enrollees who are patients of that primary care professional must be notified; and

2.17.5.10.3. Include written and oral offers of such Provider/Pharmacy Network directory in its outreach and orientation sessions for new Enrollees.

2.17.5.11. Content of Provider/Pharmacy Network Directory. The Provider/Pharmacy Network directory must include, at a

minimum, the following information for all providers in the Contractor's Provider Network:

2.17.5.11.1. The names, addresses, and telephone numbers of all current Network Providers, and the total number of each type of provider, consistent with 42 C.F.R. § 422.111(h).

2.17.5.11.2. As applicable, Network Providers with training in and experience treating:

2.17.5.11.2.1. Persons with physical disabilities, chronic illness, HIV/AIDS, and/or persons with serious mental illness;

2.17.5.11.2.2. Homeless persons;

2.17.5.11.2.3. Persons who are deaf or hard-of-hearing and blind or visually impaired;

2.17.5.11.2.4. Persons with co-occurring disorders; and

2.17.5.11.2.5. Other conditions.

2.17.5.11.3. For Network Providers that are health care professionals or non-facility based and, as applicable, for facilities and facility-based Network Providers, office hours, including the names of any Network Provider sites open after 5:00 p.m. (Pacific Time) weekdays and on weekends;

2.17.5.11.4. As applicable, whether the health care professional or non-facility based Network Provider has completed cultural competence training;

2.17.5.11.5. For Network Providers that are health care professionals or non-facility based and, as applicable, for facilities and facility-based Network Provides, licensing information, such as license number or National Provider Identifier;

2.17.5.11.6. Whether the Network Provider has specific accommodations for people with physical disabilities, such as wide entry, wheelchair access, accessible exam rooms and tables, lifts, scales, bathrooms and stalls, grab bars, or other accessible equipment;

2.17.5.11.7. Whether the Network Provider is accepting new patients as of the date of publication of the directory;

2.17.5.11.8. Whether the Network Provider is on a public transportation route;

2.17.5.11.9. Any languages other than English, including ASL, spoken by Network Providers or offered by skilled medical interpreters at the provider's site;

2.17.5.11.10. As applicable, whether the Network Provider has access to language line interpreters;

2.17.5.11.11. For Behavioral Health Providers, training in and experience treating trauma, child welfare, and substance use;

2.17.5.11.12. A description of the roles of the PCP and ICT and the process by which Enrollees select and change PCPs.

2.17.5.12. The directory must include, at a minimum, the following information for all pharmacies in the Contractor's Pharmacy Network:

2.17.5.12.1. The names, addresses, and telephone numbers of all current Network Providers and pharmacies; and

2.17.5.12.2. Instructions for the Enrollee to contact the Contractor's toll-free Enrollee services telephone line (as described in Section 2.12.2.1) for assistance in finding a convenient pharmacy.

2.18. Financial Requirements

2.18.1. Financial Viability

2.18.1.1. As specified in the DHCS Request for Solutions procurement, the Contractor must meet and maintain financial viability/standards compliance for each of the following elements:

2.18.1.1.1. Minimum Required Tangible Net Equity

2.18.1.1.1.1. Contractor at all times shall be in compliance with the Tangible Net Equity (TNE) requirements in accordance with 28 CCR 1300.76. If the Contractor does not meet TNE in a given period, the CMT shall have the power and authority to take one or more of the following sanctions against the Contractor for non-compliance:

2.18.1.1.1.1.1. Require the Contractor to submit a Corrective Action Plan within thirty (30) days of request by the CMT;

2.18.1.1.1.1.2. Appointment of temporary management if the Contractor has repeatedly failed to meet the contractual requirements or applicable federal and State law or regulation. The Contractor cannot delay appointment of temporary management to provide a hearing before appointment. Temporary management will not be terminated until DHCS determines that Contractor's sanctioned behavior will not recur; and

2.18.1.1.1.1.3. Take other appropriate action as determined necessary by DHCS.

2.18.1.1.2. Contractor must provide assurances satisfactory to the State showing that its provision against the risk of financial instability is adequate to ensure that its Enrollees will not be liable for the entity's

debts if the entity becomes insolvent. Contractor shall demonstrate fiscal soundness and assumption of full financial risk in accordance with 28 CCR 1300.75.1.

2.18.2. Administrative costs

2.18.2.1. Contractor's administrative costs shall not exceed the guidelines established under 28 CCR section 1300.78.

2.18.2.2. Standards of Organization and Financial Soundness

2.18.2.2.1. Contractor shall maintain an organizational structure sufficient to conduct the proposed operations and ensure that its financial resources are sufficient for sound business operations in accordance with 28 CCR 1300.67.3, 1300.75.1, 1300.76.3, 1300.77.1, 1300.77.2, 1300.77.3, 1300.77.4, and Health and Safety Code Section 1375.1.

2.18.2.3. Working Capital Requirements

2.18.2.3.1. Contractor shall maintain a working capital and current ratio in accordance with 22 CCR 53864, which requires a TNE as defined in Title 28, Section 1300.76, or one of the following:

2.18.2.3.1.1. Current ratio of at least 1:1, or prior demonstration that the Contractor is now meeting financial obligations on a timely basis and has been doing so for at least the preceding two (2) years, or evidence that sufficient noncurrent assets, which are readily convertible to cash, are available to achieve an equivalent working capital ratio of 1:1, if the noncurrent assets are considered current; or

2.18.2.3.1.2. Demonstration through its history of plan operations that the plan's arrangements for health care are financially sound, and provide for the achievement and maintenance of a positive cash flow, including provisions for retirement of

existing and proposed indebtedness, or enrollment growth.

2.18.2.3.2. The Contractor receiving Cal MediConnect enrollment, must demonstrate and maintain adequate working capital as required in California Health and Safety Code Section 1375.1, which requires consideration of:

2.18.2.3.2.1. The financial soundness of the Contractor's arrangements for Covered Services and the schedule of rates and charges used by the Contractor;

2.18.2.3.2.2. The adequacy of working capital; and

2.18.2.3.2.3. Arrangements with providers for the provision of Covered Services.

2.18.3. Financial Stability

2.18.3.1. Throughout the term of the Contract, the Contractor must:

2.18.3.1.1. Remain financially stable;

2.18.3.1.2. Maintain adequate protection against insolvency in an amount determined by the DMHC as described in Title 28, CCR, Section 1300.75.1.

2.18.3.1.3. Demonstrate fiscal soundness and assumption of full financial risk in accordance with 28 CCR 1300.75.1 as follows:

2.18.3.1.3.1. Demonstrate through its history of operations and through projections, (which shall be supported by a statement as the facts and assumptions upon which they are based) that the Contractor's arrangements for health care services and the schedule of its rates and charges are financially sound, and provide for the achievement and maintenance of a positive cash flow, including provisions for retirement of existing and proposed indebtedness; and

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2.18.3.1.3.2. Attest that the Contractor's arrangements for Covered Services and the schedule of its rates and charges are financially sound, and provide for the achievement and maintenance of a positive cash flow, including provisions for retirement of existing and proposed indebtedness.

2.18.3.1.4. Demonstrate that its working capital is adequate, including provisions for contingencies;

2.18.3.1.5. Demonstrate an approach to the risk of insolvency which allows for the continuation of benefits for the duration of the Contract period for which payment has been made, the continuation of benefits to subscribers and Enrollees who are confined on the date of insolvency in an in-patient facility until their discharge, and payments to unaffiliated providers for services rendered; and

2.18.3.1.6. Obtain insurance or make other arrangements:

2.18.3.1.6.1. For the cost of providing to any Enrollee covered health care services the aggregate value of which exceeds $5,000 in any year;

2.18.3.1.6.2. For the cost of Covered Services provided to its Enrollees other than through the Contractor because medical necessity required their provision before they could be secured through the Contractor; and

2.18.3.1.6.3. For not more than ninety percent (90%) of the amount by which its costs for any of its fiscal years exceed one hundred fifteen percent (115%) of its income for such fiscal year.

2.18.4. Insolvency Reserve

2.18.4.1. The insolvency reserve shall have the same definition as minimum required TNE (see 2.18.1.1.1). The minimum TNE is defined by Title 28, CCR, Section 1300.76.

2.18.4.2. According to Title 28, CCR, Section 1300.76(e), California defines TNE as net equity reduced by the value assigned to intangible assets including, but not limited to, goodwill; going concern value; organizational expense; starting-up costs; obligations of officers, directors, owners, or affiliates which are not fully secured, except short-term obligations of affiliates for goods or services arising in the normal course of business which are payable on the same terms as equivalent transactions with non-affiliates and which are not past due; long term prepayments of deferred charges, and non-returnable deposits.

2.19. Data Submissions, Reporting Requirements, and Surveys

2.19.1. General Requirements for Data. The Contractor must provide and require its First Tier, Downstream and Related Entities to provide:

2.19.1.1. All information CMS and DHCS require under the Contract related to the performance of the Contractor's responsibilities, including non-medical information for the purposes of research and evaluation;

2.19.1.2. Any information CMS and DHCS require to comply with all applicable federal or State laws and regulations; and

2.19.1.3. Any information CMS or DHCS require for external rapid cycle evaluation including program expenditures, service utilization rates, rebalancing from institutional to community settings, Enrollee satisfaction, Enrollee complaints and Appeals and enrollment/disenrollment rates.

2.19.2. General Reporting Requirements. The Contractor shall:

2.19.2.1. Submit to DHCS all applicable Medi-Cal reporting requirements in compliance with 42 C.F.R. § 438.602-606.

2.19.2.2. Submit to CMS applicable reporting requirements in compliance with 42 C.F.R. §§ 422.516, 423.514, 438.604, and 438.606.

2.19.2.3. Submit to CMS and DHCS all applicable MMP reporting requirements.

2.19.2.4. Submit to CMS and DHCS all required data in accordance with the specifications, templates and time frames described in this Contract.

2.19.2.5. Report HEDIS, as well as measures related to Long-Term Services and Supports. HEDIS, HOS, and CAHPS measures will be reported consistent with Medicare requirements for HEDIS, plus additional Medi-Cal measures required by DHCS. All existing Part D metrics will be collected as well. Such measures shall include a combined set of core measures that the Contractor must report to CMS and DHCS.

2.19.2.6. Report rates for an under/over-utilization monitoring measure set based upon selected HEDIS use of service measures or any other standardized or DHCS-developed utilization measures selected by DHCS.

2.19.2.7. Submit additional reporting requirements as specified throughout this Contract, relevant regulation or law, or as provided through guidance.

2.19.2.8. Submit to CMS and DHCS all required reports and data in accordance with the specifications, templates, and time frames described in this Contract, unless otherwise directed or agreed to by CMS and DHCS.

2.19.2.9. Submit at the request of CMS or DHCS additional ad hoc or periodic reports or analyses of data related to the Contract.

2.19.2.10. Pursuant to 42 C.F.R. § 438.3(g), comply with any reporting requirements on Provider Preventable Conditions in the form and frequency as may be specified by DHCS in accordance with applicable DPL(s) as indicated in Section 2.5.1.

2.19.2.11. Submit to DHCS Part D subcontractor conflict of interest letters on an annual basis. For Part D PDE data requests, securing and submitting appropriate letter from the First Tier, Downstream Entity to address potential conflicts of interests for First Tier, Downstream Entity users that may be affiliated with Part D Contractor sponsors. Letters should indicate either (a) no affiliation or, (b) if there is affiliation,

how the data will be kept separate and secure from Part D Contractor plan operations.

2.19.3. Management Information Systems Capability. The Contractor shall:

2.19.3.1. Maintain Information Systems that will enable the Contractor to meet all of DHCS's requirements as outlined in this Contract. The Contractor's Systems shall be able to support current DHCS requirements, and any future IT architecture or program changes. Such requirements include, but are not limited to, the following DHCS standards:

2.19.3.1.1. The capability to capture, edit, and utilize various data elements for both internal management use as well as to meet the data completeness, timeliness, reasonability, and accuracy requirements of DHCS's Encounter Data submission. Contractor shall have and maintain a System that provides, at a minimum:

2.19.3.1.1.1. Eligibility data,

2.19.3.1.1.2. Information of Enrollees enrolled in Contractor's plan,

2.19.3.1.1.3. Provider claims status and payment data,

2.19.3.1.1.4. Health care services delivery Encounter Data,

2.19.3.1.1.5. Provider Network information, and

2.19.3.1.1.6. Financial information, as specified by DHCS.

2.19.3.2. Processes that support the interactions between financial, eligibility; provider; encounter claims; quality management/QI/utilization; and report generation subsystems. The interactions of the subsystems must be compatible, efficient and successful.

2.19.3.3. Ensure a secure, HIPAA-compliant exchange of Enrollee information between the Contractor and DHCS and any other entity deemed appropriate by DHCS. Such files shall

be transmitted to DHCS through secure FTP, HTS, or a similar secure data exchange as determined by DHCS;

2.19.3.4. Develop and maintain a website that is accurate and up-to-date, and that is designed in a way that enables Enrollees and providers to quickly and easily locate all relevant information. If directed by DHCS, establish appropriate links on the Contractor's website that direct users back to the DHCS website portal; and,

2.19.3.5. The Contractor shall cooperate with DHCS in its efforts to verify the accuracy of all Contractor data submissions to DHCS.

2.19.3.5.1. The Contractor shall conform to HIPAA compliant standards for data management and information exchange.

2.19.3.5.2. The Contractor shall demonstrate controls to maintain information integrity.

2.19.3.5.3. The Contractor shall maintain appropriate internal processes to determine the validity and completeness of data submitted to DHCS.

2.19.4. Accepting and Processing Assessment Data

2.19.4.1. System Access Management and Information Accessibility Requirements

2.19.4.1.1. The Contractor shall make all systems and system information available to authorized CMS, DHCS and other agency staff as determined by CMS or DHCS to evaluate the quality and effectiveness of the Contractor's data and systems.

2.19.4.1.2. The Contractor is prohibited from sharing or publishing CMS or DHCS data and information without prior written consent from CMS or DHCS.

2.19.5. System Availability and Performance Requirements

2.19.5.1. The Contractor shall ensure that its Enrollee and provider web portal functions and phone-based functions are

available to Enrollees and Providers twenty-four (24) hours a day, seven (7) days a week.

2.19.5.2. The Contractor shall draft an alternative plan that describes access to Enrollee and provider information in the event of system failure. Such plan shall be contained in the Contractor's Continuity of Operations Plan (COOP) and shall be updated annually and submitted to DHCS upon request. In the event of system failure or unavailability, the Contractor shall notify DHCS upon discovery and implement the COOP immediately.

2.19.5.3. The Contractor shall preserve the integrity of Enrollee-sensitive data that resides in both a live and archived environment.

2.20. Encounter Reporting

2.20.1. The Contractor must meet any diagnosis and encounter reporting requirements that are in place for Medicare Advantage plans and Medi-Cal managed care organizations. Furthermore, the Contractor's systems shall generate and transmit Encounter Data files to CMS according to additional specifications as shall be provided by CMS and DHCS and updated from time to time. CMS and DHCS will provide technical assistance to the Contractor for developing the capacity to meet encounter reporting requirements.

2.20.2. Encounter Data Submission

2.20.2.1. Contractor shall implement policies and procedures for ensuring the submission of complete, timely, reasonable, and accurate Encounter Data for all services for which Contractor has incurred any financial liability, whether directly or through subcontracts or other arrangements.

2.20.2.2. Contractor shall require First Tier, Downstream and Related Entities and non-contracting providers to provide claims and Encounter Data to Contractor, which allow Contractor to meet its administrative functions and the requirements set forth in this section. Contractor shall have in place mechanisms, including edits and reporting systems sufficient to assure Encounter Data is complete, timely, reasonable, and accurate prior to submission to CMS.

2.20.2.3. Contractor shall submit complete, timely, reasonable, and accurate Encounter Data to CMS no less than monthly in the form and manner specified by DHCS and CMS. CMS will forward Encounter Data directly to the State.

2.20.2.4. Contractor shall submit Encounter Data that is at a minimum standard for completeness and accuracy as defined by CMS and DHCS. The Contractor must also correct and resubmit denied encounters as necessary.

2.20.2.5. A percentage of the monthly capitation payments will be withheld as described in Section 4.8.1.

3. CMS and DHCS Responsibilities

3.1. Contract Management

3.1.1. Administration. CMS and DHCS will:

3.1.1.1. Designate a CMT that will include at least one (1) contract officer from CMS and at least one (1) contract officer from DHCS authorized and empowered to represent CMS and DHCS about all aspects of the Contract. Generally, the CMS part of the team will include the State Lead from the Medicare Medicaid Coordination Office (MMCO), Regional Office lead from the Consortium for Medicaid and Children's Health Operations (CMCHO), and an Account Manager from the Consortium for Health Plan Operations (CMHPO). The CMS representative and DHCS representatives will act as liaisons between the Contractor and CMS and DHCS for the duration of the Contract. The CMT will:

3.1.1.1.1. Monitor compliance with the terms of the Contract including issuance of joint notices of non-compliance/enforcement.

3.1.1.1.2. Coordinate periodic audits and surveys of the Contractor;

3.1.1.1.3. Receive and respond to complaints;

3.1.1.1.4. Conduct regular meetings with the Contractor;

3.1.1.1.5. Coordinate requests for assistance from the Contractor and assign CMS and DHCS staff with appropriate expertise to provide technical assistance to the Contractor;

3.1.1.1.6. Make best efforts to resolve any issues applicable to the Contract identified by the Contractor, CMS, or DHCS;

3.1.1.1.7. Inform the Contractor of any discretionary action by CMS or DHCS under the provisions of the Contract;

3.1.1.1.8. Coordinate review of marketing materials and procedures;

3.1.1.1.9. Coordinate review of Grievance and Appeals data, procedures; and

3.1.1.1.10. Review, approve, and monitor the Contractor's outreach and orientation materials and procedures.

3.1.1.2. Review, approve, and monitor the Contractor's complaint and Appeals procedures;

3.1.1.3. Apply one or more of the sanctions provided in Section 5.3.13, including termination of the Contract in accordance with Section 5.5, if CMS and DHCS determine that the Contractor is in violation of any of the terms of the Contract stated herein;

3.1.1.4. Conduct site visits as determined necessary by CMS and DHCS to verify the accuracy of reported data; and

3.1.1.5. Coordinate the Contractor's external quality reviews conducted by the EQRO.

3.1.2. Performance Evaluation. CMS and DHCS will, at their discretion:

3.1.2.1. Evaluate, through inspection or other means, the Contractor's compliance with the terms of this Contract, including but not limited to the reporting requirements in Sections 2.18 and 2.19, and the quality, appropriateness, and timeliness of services performed by the Contractor and its Provider Network. CMS and DHCS will provide the Contractor with the written results of these evaluations;

3.1.2.2. Conduct periodic audits of the Contractor, including, but not limited to an annual independent external review and an annual site visit;

3.1.2.3. Conduct annual Enrollee surveys and provide the Contractor with written results of such surveys.

3.2. Enrollment and Disenrollment Systems

3.2.1. CMS and DHCS will maintain systems to provide:

3.2.1.1. Enrollment and disenrollment information to the Contractor;

3.2.1.2. Continuous verification of eligibility status;

3.2.1.3. Identification of individuals determined as at risk or potentially at risk for abuse or overuse of specified prescription drugs per 42 C.F.R. §§ 432.100 and 423.153(f); and

3.2.1.4. For counties operating under COHS, DHCS will facilitate the Contractor in its responsibility for enrollment and disenrollment activities for Cal MediConnect.

3.2.2. Customer Service Team (CST) Enrollment Broker. DHCS or its designee shall assign a staff person(s) who shall have responsibility to:

3.2.2.1. Develop generic materials to assist potential Enrollees in choosing whether to enroll in Cal MediConnect. Said materials shall present the Cal MediConnect in an unbiased manner to potential Enrollees eligible to select a Cal MediConnect Plan. DHCS may collaborate with the Contractor in developing Cal MediConnect-specific materials;

3.2.2.2. Present the Cal MediConnect in an unbiased manner to potential Enrollees or those seeking to transfer from one Cal MediConnect to another. Such presentation(s) shall ensure that Enrollees are informed prior to enrollment of the following:

3.2.2.2.1. The rights and responsibilities of participation in Cal MediConnect;

3.2.2.2.2. The nature of the Contractor's care delivery system, including, but not limited to the Provider Network; and the HRA, and the ICT;

3.2.2.2.3. Orientation and other Enrollee services made available by the Contractor;

3.2.2.3. Ensure that Enrollees are informed at the time of enrollment or transfer of their right to terminate their enrollment voluntarily at any time, unless otherwise provided by federal law or waiver;

3.2.2.4. Be knowledgeable about the Contractor's policies, services, and procedures; and

3.2.2.5. At its discretion, develop and implement processes and standards to measure and improve the performance of the Enrollment Broker staff. The State shall monitor the activities of the Enrollment Broker.

4. Payment and Financial Provisions

4.1. General Financial Provisions

4.1.1. Capitation Payments. CMS and DHCS will each contribute to the total capitation payment. CMS and DHCS will each make monthly payments to the Contractor for their portion of the capitated rate, in accordance with the rates of payment and payment provisions set forth herein and subject to all applicable federal and State laws, regulations, rules, billing instructions, and bulletins, as amended. The Contractor will receive three (3) monthly payments for each Enrollee: one (1) amount from CMS reflecting coverage of Medicare Parts A/B services (Medicare Part A/B Component), one (1) amount from CMS reflecting coverage Medicare Part D services (Medicare Part D Component), and a third amount from DHCS reflecting coverage of Medi-Cal services (Medi-Cal Component).

4.1.1.1. On a regular basis, CMS will provide DHCS with the Contractor-level payment information in the Medicare Plan Payment Report. The use of such information by DHCS will be limited to financial monitoring, performing financial audits, and related activities, unless otherwise agreed to by CMS and the Contractor. On a regular basis, DHCS will also provide to CMS Contractor-level payment information including the Medicaid Capitation Payments.

4.1.2. Demonstration Year Dates. Capitation Rate updates will take place on January 1st of each calendar year for the Medicare components of the rates, with changes to savings percentages applicable on a Demonstration Year basis, as follows. Rate updates for the Medi-Cal component of the rates will take place at least once each calendar year. CMS and DHCS will provide the Contractor with a rate report at least annually to show applicable rates for the upcoming calendar year.

4.1.2.1. Demonstration Year Dates

Figure 4.1: Demonstration Year Dates

Demonstration Year	Calendar Dates
1	April 1, 2014 – December 31, 2015
2	January 1, 2016 – December 31, 2016
3	January 1, 2017 – December 31, 2017
4	January 1, 2018 – December 31, 2018
5	January 1, 2019 – December 31, 2019

Demonstration Year	Calendar Dates
6	January 1, 2020 – December 31, 2020
7	January 1, 2021 – December 31, 2021
8	January 1, 2022 – December 31, 2022

4.2. Capitated Rate Structure

4.2.1. Underlying Rate Structure for the Medi-Cal Component

4.2.1.1. The Medi-Cal component will be paid as a single, blended rate that takes into account the relative risk of the population actually enrolled in the Contractor's Cal MediConnect Plan and is weighted accordingly.

4.2.1.1.1. For Demonstration Years 1-3, the population will be categorized into four risk adjustment population categories:

4.2.1.1.1.1. Institutionalized: Enrollees in long-term care aid codes and/or residing in a long-term care facility for ninety (90) or more days.

4.2.1.1.1.2. HCBS High: Enrollees identified as high utilizers of home and community-based services. These are Enrollees who meet one (1) or more of the following criteria:

4.2.1.1.1.2.1. Enrollees who receive CBAS.

4.2.1.1.1.2.2. Enrollees who are clients of MSSP sites

4.2.1.1.1.2.3. Enrollees who receive IHSS and are classified under the IHSS program as "severely impaired" (SI).

4.2.1.1.1.3. HCBS Low: Enrollees identified as low utilizers of home and community-based services. These Enrollees are IHSS recipients and classified under the IHSS program as "not severely impaired."

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4.2.1.1.1.4. Community Well: All other Enrollees living in the community with no Medi-Cal covered HCBS services. These are all other Enrollees who are not resident in long-term care facilities and do not utilize CBAS, MSSP, or IHSS services.

4.2.1.1.2. For Demonstration Years 4-8, the population will be categorized into four risk adjustment population categories:

4.2.1.1.2.1. Institutionalized: Enrollees in long-term care aid codes and/or residing in a long-term care facility for ninety (90) or more days.

4.2.1.1.2.2. CBAS and MSSP: Enrollees identified as utilizers of CBAS or MSSP services. These are Enrollees who meet one (1) or more of the following criteria:

4.2.1.1.2.2.1. Enrollees who receive CBAS.

4.2.1.1.2.2.2. Enrollees who are clients of MSSP sites.

4.2.1.1.2.3. IHSS Only (no CBAS or MSSP): Enrollees identified as utilizers of IHSS services, who do not receive CBAS and are not clients of MSSP sites.

4.2.1.1.2.4. Community Well: All other Enrollees living in the community with no Medi-Cal covered HCBS services. These are all other Enrollees who are not resident in long-term care facilities and do not utilize CBAS, MSSP, or IHSS services.

4.2.1.1.3. The State may, in consultation with CMS, modify the composition of the risk adjustment population categories upon its determination that such changes are appropriate. The State will inform the Contractor of any changes prior to modifying the risk adjustment population categories.

4.2.1.2. The Medi-Cal component will utilize the risk adjustment methodology in the contracts that support the 1115(a) demonstration for the eligible population.

4.2.1.2.1. The Medi-Cal component will employ the population categories described above. Relative cost factors (RCF) will be established for each of the four (4) populations based on evaluation of the per member per month (PMPM) for each of the individual population groups, relative to the total Medi-Cal rate. As the total Medi-Cal rate incorporates incremental changes in population distribution (e.g. fewer Enrollees in institutional settings, increase in HCBS low for higher cost community well that may be more appropriately served by HCBS benefits), the calculation of the RCFs is also impacted by the assumed population distribution.

4.2.1.2.2. Contractor specific relative mix factors (RMF) will be computed through the use of RCFs and the proportion of each of the population category Enrollees in the plan. The RMFs will be computed by multiplying each Contractor's distribution of each of the population categories with the established RCFs to calculate a weighted average Contractor-specific RMF.

4.2.1.2.3. Contractor RMFs will be multiplied by the established Capitation Rate to determine the risk-adjusted Medi-Cal component payment rate.

4.2.1.3. The risk adjustment process will include three (3) distinct phases to address the stability of enrollment and to establish appropriate financial incentives for Contractor.

4.2.1.3.1. Phase I: The risk adjustment methodology will be applied monthly and retroactively to match actual enrollment into the Contractor's Cal MediConnect Plan. This phase will continue through each county's phase-in enrollment period for a minimum of one (1) year and will end at the start of the next fiscal quarter. For example, in a county with a 12-month phase-in that begins enrollment

in April 2014, this phase would last through the end of March 2015. For the county of San Mateo, due to the different enrollment phasing as described in Appendix K, there will be no Phase I.

4.2.1.3.2. Phase II: This phase will be for one (1) fiscal quarter. The risk adjustment methodology will be prospectively applied at the start of the quarter. Weighting the risk categories will be based on the preceding month to the quarter enrollment snapshot, which will be available after the quarter ends and will be retroactively applied to that period. For example, in a county with a 12-month phase-in that begins enrollment in April 2014, this Phase II would be applicable for the fiscal quarter of April 2015 through June 2015. Enrollment data from March 2015 would be utilized although the rate update would not occur until several months after the quarter to ensure data availability. For the county of San Mateo, due to the different enrollment phasing as described in Appendix K, the county will immediately enter Phase II of the risk adjustment. The Phase II for San Mateo will be done according to a separate timeline, such that the risk adjustment methodology will be prospectively applied at the start of the Demonstration in April 2014 and again for a second quarter from July 2014 through September 2014 after which San Mateo will move into Phase III.

4.2.1.3.3. Phase III: Contractor rates will be based on a targeted relative mix of the population and will not be adjusted during the year. The first year of this phase will be the remaining period in the calendar year. Phase III for the county of San Mateo will begin with the fiscal year starting October 2014. The targeted relative mix of the population for the year would be based on enrollment in the plan leading up to the start of the phase III year and will include an assumed shift in population mix.

4.2.1.3.3.1. Specific to Phase III, a targeted relative mix will be projected by the State and its actuaries. This mix will be designed to be achievable by the Contractor, based on assumptions about the plan's ability to promote community services and prevent or delay institutional placement.

4.2.1.3.3.2. If the population mix for the Contractor for the year results in a greater than 2.5% impact to the Medicaid component of the rate paid as compared to the rate that would have been paid based on the actual mix, then the Contractor and Medicaid would share equally in any cost increases/decreases beyond the 2.5%. Actual plan gain or loss does not factor into this calculation.

4.2.1.4. With the structure as described above, DHCS and its actuaries will establish actuarially sound Capitation Rates for the contracts that support the 1115(a) demonstration program for beneficiaries in the target population for Cal MediConnect. These rates will be consistent with 42 C.F.R. § 438.4 and reviewed by the CMS Regional Office. The CMS approved rates will serve as the baseline Medicaid costs.

4.2.1.5. Upon request prior to and throughout the Demonstration, the State and its actuaries will provide to CMS the underlying data for the rate calculations associated with the contracts that support the 1115(a) demonstration.

4.2.1.6. Medicaid payment rates will be determined by applying annual savings percentages in Figure 4.2 to the applicable Capitation Rates for the contracts that support the 1115(a) demonstration.

4.2.1.7. As allowed under the rates for the contracts that support the 1115(a) demonstration, DHCS and its actuaries will calculate a range of actuarially sound capitation payment rates including lower bound and upper rates. The application of the savings percentage will apply to all rates, including any prospective or retroactive adjustments, within actuarially sound rate range.

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4.2.1.8. Consistent with the Medicare rate updates at 4.2.2.2.6, the impact of the shift of nursing facility residents from MLTSS to Cal MediConnect in Los Angeles and Orange counties beginning in 2017 will be considered during Medicaid rate development for 2017 and subsequent years, as applicable.

4.2.2. Underlying Rate Structure for Medicare Components of the Capitation Rate.

4.2.2.1. Medicare will pay the Contractor a monthly capitation amount for the Medicare Parts A/B services (the Medicare A/B Component), risk adjusted using the Medicare Advantage CMS-HCC Model and the CMS-HCC ESRD Model, except as specified in Section 4.5. Medicare will also pay the Contractor a monthly capitation amount for Medicare Part D services, risk adjusted using the Part D RxHCC Model (the Medicare Part D Component).

4.2.2.2. Medicare A/B Component

4.2.2.2.1. The Medicare baseline spending for Parts A/B services are a blend of the Medicare FFS standardized county rates and the Medicare Advantage projected payment rates for each year, weighted by the proportion of the enrolled population enrolled in each program prior to the Demonstration. The FFS county rates will generally reflect amounts published with the April Medicare Advantage Final Rate Announcement, adjusted to fully incorporate more current hospital wage index and physician geographic practice cost index information; in this Demonstration, this adjustment will be fully applied to the FFS county rates in 2014, but the adjustment will otherwise use the same methodologies and timelines used to make the analogous adjustments in Medicare Advantage. CMS may also further adjust the Medicare FFS standardized county rates as necessary to calculate accurate payment rates for the Demonstration. To the extent that the published FFS county rates do not conform with current law in effect for Medicare during an applicable payment month, and to the extent that such nonconformance would have a significant

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fiscal impact on the Demonstration, CMS will update the baseline (and therefore the corresponding payment rate) to calculate and apply an accurate payment rate for such month. Such update may take place retroactively, as needed.

4.2.2.2.2. Separate baselines will exist for Enrollees meeting the Medicare ESRD criteria. For Enrollees with ESRD in the dialysis or transplant status phases, the Medicare Parts A/B baseline will be the ESRD dialysis state rate. For Enrollees in the functioning graft status phase, the Medicare Parts A/B baseline will be the Medicare Advantage 3.5% bonus county rate (benchmark) for the applicable county as of January 2015 (for CY 2014 the baseline was the 3-star county rate).

4.2.2.2.3. Both baseline spending and payment rates under the Demonstration for Medicare Parts A/B services will be calculated as PMPM standardized amounts for each county participating in the Demonstration for each year. Enrollee risk scores will be applied to the standardized rates at the time of payment.

4.2.2.2.4. The Medicare A/B Component will be updated annually consistent with annual FFS estimates and Medicare Advantage rates released each year with the annual rate announcement.

4.2.2.2.5. If an Enrollee elects to receive the Medicare hospice benefit, the Enrollee may remain in the Cal MediConnect Plan, but will obtain the hospice service through the Medicare FFS benefit and the Cal MediConnect Plan would no longer receive the Medicare Parts A/B component for that Enrollee as described in this section. Medicare hospice services and hospice drugs and all other original Medicare services would be paid for under Medicare FFS. Cal MediConnect Plans and providers of hospice services would be required to coordinate these services with the rest of the Enrollee's care. Cal MediConnect Plans would

continue to receive the Medicare Part D component for all non-hospice covered drugs. Election of hospice services does not change the Medi-Cal component unless otherwise specified in the DHCS 1115(a) demonstration.

4.2.2.2.6. Beginning January 2017, CMS will make an outlier adjustment for the Medicare A/B payments for non-ESRD beneficiaries served by the Contractor in Los Angeles and Orange Counties.

4.2.2.2.6.1. This adjustment will reflect the historical ratio of actual Medicare A/B FFS costs for the long term institutional (LTI) population in this county/counties to the predicted costs for this population, based on the standardized FFS county rates and the HCC risk adjustment model. This payment adjustment will be made retroactively after the end of each demonstration year, beginning in CY 2017 and going forward.

4.2.2.2.6.2. The outlier adjustment is a multiplicative factor equal to 95% of [the historical ratio minus 1 (one)] times the predicted rate for a baseline period. Specifically, the adjustment would be equal to: (the outlier adjustment percentage of 95%) times (this historical ratio from 4.2.2.2.6.1 minus 1(one)) times (the standardized FFS county rate for the applicable calendar year for the applicable county) times (the average final HCC risk score for the applicable calendar year for the population that meets the criteria in 4.2.2.2.6.3) times (the number of member months for the applicable calendar year associated with the population that meets the criteria in 4.2.2.2.6.3).

4.2.2.2.6.3. This adjustment is limited to those new Cal MediConnect members who newly enroll in the CalMediConnect demonstration as of January 1, 2017, or later; were in Medicare LTI status at the time of their Cal

MediConnect enrollment; and were in Medicare FFS at the time of their Cal MediConnect enrollment.

4.2.2.2.6.4. Plans must initiate and report on corresponding quality improvement activities focused on Cal MediConnect members in Medicare LTI status per Section 2.16.3.2.7.

4.2.2.3. Medicare Part D

4.2.2.3.1. The Medicare Part D component is comprised of the Part D direct subsidy set at the Part D national average monthly bid amount (NAMBA) for the calendar year, as well as CMS-estimated average monthly prospective payment amount for the low income cost-sharing subsidy and federal reinsurance amounts; these payments will be reconciled after the end of each payment year in the same manner as for all Part D sponsors.

4.2.2.3.2. The monthly Medicare Part D component for an Enrollee can be calculated by multiplying the Part D NAMBA by the RxHCC risk score assigned to the individual, and then adding to this the estimated average monthly prospective payment amount for the low income cost-sharing subsidy and federal reinsurance amounts.

4.2.3. Aggregate Savings Percentages

4.2.3.1. Aggregate savings percentages will be applied equally, as follows, to the baseline spending amounts for the Medicare A/B and Medi-Cal components of the capitated rate, provided that such savings percentages may be adjusted in accordance with Sections 4.2.3.2 herein.

4.2.3.2. Savings percentages will not be applied to the Part D Component of the rate. CMS will monitor Part D costs closely on an ongoing basis. Any material change in Part D costs relative to the baseline may be factored into future year savings percentages.

Figure 4.2: Savings Percentages

	Demonstration Year 1	Demonstration Year 2	Demonstration Years 3-8
Minimum Savings Percentages	**1.00%**	**2.00%**	**4.00%**
County Specific Interim Savings Percentages: the sum of the minimum savings percentages and the county-specific addition			
Los Angeles	+ 0.00%	+ 1.50%	+ 1.50%
Orange	+ 0.42%	+ 1.50%	+ 1.50%
Riverside	+ 0.22%	+ 1.50%	+ 1.14%
San Bernardino	+ 0.44%	+ 1.50%	+ 1.50%
San Diego	+ 0.23%	+ 1.50%	+ 1.10%
San Mateo	+ 0.47%	+ 0.33%	+ 0.00%
Santa Clara	+ 0.23%	+ 1.45%	+ 0.95%

4.2.3.3. Limited risk corridors will be applied as described in Sections 4.3 and 4.4 on a Contractor basis and be reconciled after application of any risk adjustment methodologies and any other adjustments, as described in Section 4.2.1.2.

4.2.3.3.1. Risk corridors will be reconciled as if the Contractor had received the full quality withhold payment.

4.2.3.3.2. The application of county-specific interim savings percentages in Section 4.2.3.1. establishes the initial Capitation Rates for purposes of the risk corridor calculation for Demonstration Years 1-3, as described in Section 4.3.

4.2.3.3.3. A limited one-sided risk corridor will apply for Demonstration Years 6-8, as described in Section 4.4.

4.3. Risk Corridors for Demonstration Years 1-3

4.3.1. General Provisions

4.3.1.1. Calculation of Gains and Losses: The risk-sharing arrangement described in this section of the Contract may result in payment by the State and CMS to the Contractor or by the Contractor to the State and CMS.

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4.3.1.1.1. All payments to be made by the State and CMS to the Contractor or by the Contractor to the State and CMS will be calculated and determined jointly by the State and CMS.

4.3.1.1.2. All calculations, determined jointly by the State and CMS, will be based on the Contractor's reporting of Adjusted Service Expenditures and Adjusted Non-Service Expenditures, as required in Section 4.3.3 All financial reporting will be subject to review and/or audit at the State's and CMS' discretion. As applicable, all calculations will sum the Contractor's expenditures and revenues across all counties in which the Contractor operates.

4.3.1.1.3. CMS and the State will perform a final settlement of the payments made by the Contractor to CMS and the State, or by CMS and the state to the Contractor, as described in Section 4.3.3.1.

4.3.1.2. Two-sided risk corridors will apply for Demonstration Years 1-3.

4.3.1.3. Allowable Expenditures

4.3.1.3.1. CMS and the State shall jointly determine the Adjusted Service Expenditures and the Adjusted Non-Service Expenditures, based on Encounter Data, cost data, and financial reporting data (including the State's rate development template) submitted by the Contractor (as required by Section 4.3.3, and Section 2.17-2.19 of this Contract). CMS and the State reserve the right to audit Actual Service Expenditure and Actual Non-Service Expenditure data.

4.3.1.3.2. CMS, the State, and the Contractor agree that to the extent there are differences in expenditure data reported across various sources, including the encounter, cost, financial reporting, or other data submitted by the Contractor, CMS, the State and the Contractor will confer and make a good

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faith effort to reconcile those differences before the calculation of the final settlement.

4.3.1.3.3. The review procedures may include a review of the Contractor's Encounter Data and/or audit, to be performed by the CMS and/or the State, or either party's authorized agents, to verify that all paid claims for Enrollees by the Contractor are for Covered Services and/or that provider reimbursement is not excessive. CMS and the State will jointly have the final decision on the resolution of any differences in the expenditure data reported.

4.3.1.3.4. The State and CMS reserve the right to adjust expenditures for services that are reimbursed at more than ten percent (10%) above the median reimbursement rate of all plans within a region. For the purposes of the risk corridor, the Regions are defined as the Northern Counties Region (San Mateo and Santa Clara Counties) and the Southern Counties Region (Los Angeles, Orange, Riverside, San Bernardino, and San Diego Counties).

4.3.1.3.5. The State and CMS reserve the right to adjust non-service expenditures that are greater than 125% of the median PMPM across all participating Contractors during the applicable Demonstration Year. Notwithstanding any contractual provision or legal right to the contrary, the Contractor agrees that there shall be no redress against CMS or the State for a determination to adjust or a failure to adjust expenditures for services of any Contractor.

4.3.2. Risk Corridor Parameters

4.3.2.1. The Demonstration will utilize a limited down-side risk corridor and a limited up-side risk corridor to include all Medicare A/B and Medicaid eligible Adjusted Service and Non-Service Expenditures. The risk corridors will be reconciled after the application of risk adjustment methodologies (e.g., CMS-HCC, Medicaid Relative Cost Factors and Relative Mix Factors), intergovernmental transfers, and as if all Contractors had received the full quality withhold payment.

4.3.2.1.1. Risk Corridor Share: The Medicare and Medicaid contributions to risk corridor payments or recoupments will be in proportion to their contributions to the Adjusted Interim Capitation Rate Revenue. Losses and gains will be determined using the approaches described in Section 4.3.2.1.3.

4.3.2.1.2. Adjusted Interim Capitation Rate Revenue and Adjusted Final Capitation Rate Revenue: As described in Section 4.2.3.1, the application of county-specific interim savings percentages in Figure 4-2, with the adjustments described in Section 4.3.2.1.6, establishes the Adjusted Interim Capitation Rate Revenue. The Adjusted Final Capitation Rate Revenue is the revenue, with the adjustments described under Section 4.3.2.1.6, that the Contractor would have received if the minimum savings percentages, rather that the county-specific interim savings percentages, were applied.

4.3.2.1.3. Definition of Gains/Losses: Gains and losses are defined as the Adjusted Interim Capitation Rate Revenue minus the Total Adjusted Expenditures, with positive figures defined as gains and negative figures defined as losses. The Adjusted Interim Capitation Rate Revenue and the Total Adjusted Expenditures will incorporate Contractor's revenue and expenditures across all counties in which the Contractor operates.

4.3.2.1.4. Down-Side Risk Corridor Payment/Recoupment

4.3.2.1.4.1. Losses will be compared to Contractor's underwriting profit/risk/contingency load. If losses exceed this amount, the difference of the loss less the underwriting profit/risk/contingency load shall be eligible for payment under the risk corridor. No payment shall be made for losses that are less than the underwriting profit/risk/contingency load.

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4.3.2.1.4.2. First Band: For losses in excess of the underwriting profit/risk/contingency load, the State and CMS will make payment to the Contractor of sixty-seven percent (67%) of the loss, with the maximum CMS/State payment to the Contractor not exceeding the Adjusted Final Capitation Rate Revenue minus the Adjusted Interim Capitation Rate Revenue. The share of the payment made by the State and CMS will be as described in Section 4.3.2.1.1. All losses in excess of the CMS/State payment are the responsibility of the Contractor.

4.3.2.1.5. Up-Side Risk Corridor Payment/Recoupment: For gains, the following bands apply:

4.3.2.1.5.1. First Band: The first band is equal to the difference between the Adjusted Interim Capitation Rate Revenue and the Adjusted Final Capitation Rate Revenue. For the purposes of the up-side risk corridor, for Contractors in counties where the interim saving percentage is equal to the minimum savings percentage, for the purposes of the up-side risk corridor, the Adjusted Interim Capitation Rate Revenue shall be further modified by applying savings percentages of one and a half percent (1.5%) in Demonstration Year 1, three and a half percent (3.5%) in Demonstration Year 2 and 5.5% in Demonstration Years 3, where applicable, rather than one percent (1.0%), two percent (2.0%) and four percent (4.0%), respectively; this is determined by multiplying the initial Adjusted Interim Capitation Rate Revenue by (1 – the applicable 1.5%, 3.5% or 5.5% savings percentages above) / (1- Interim Savings Percentage).

4.3.2.1.5.1.1. For the portion of gains in the first band, no payment will be made by

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the Contractor to the State and CMS.

4.3.2.1.5.2. Second Band: The second band is the same size as the first band. For the portion of gains in the second band, the Contractor will make payment to the State and CMS of fifty percent (50%) of this portion of the gain, with the share of the payment made to the State and CMS as described in Section 4.3.2.1.1.

4.3.2.1.5.3. Third Band: For the portion of gains greater than the upper limit of the second band, no payment will be made by the Contractor to the State and CMS.

Figure 4-3 Demonstration Years 1-3 Risk Sharing Corridor Table (for illustrative purposes only)

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Risk Corridor Band	Incremental Loss or Gain[1]	% Contractor Risk Sharing	% the State & CMS Risk Sharing	% CMS Risk Sharing	% the State Risk Sharing[2]
Loss Band 1	All Losses in Excess of Underwriting Profit/Risk/ Contingency Load	33%	67% (up to maximum not exceeding Adjusted Final Capitation Rate Revenue - Adjusted Interim Capitation Rate Revenue)	(67%) * (Medicare A/B Percent of Rate)	(67%)*(Medi-Cal Percent of Rate)
Gain Band 1	Gains ≤ (Adjusted Interim Capitation Rate Revenue – Adjusted Final Capitation Rate Revenue)[3]	100%	0%	0%	0%
Gain Band 2	Gains ≤ Band equal to size of *Gain Band 1*	50%	50%	(50%) * (Medicare A/B Percent of Rate)	(50%)*(Medi-Cal Percent of Rate)
Gain Band 3	Gains > Upper Limit of *Gain Band 2*	100%	0%	0%	0%

[1] Loss and gain reflected on an incremental basis. Gains in Gain Bands 3 still results in risk sharing reconciliation for the gain in Gain Band 2.

[2] All State Risk Sharing shall be treated as Medicaid expenditures eligible for FMAP.

[3] The Adjusted Interim Capitation Rate Revenue is modified for counties in which the Interim Savings Percentage equals the Minimum Savings Percentage.

4.3.3. Risk Sharing Settlement: CMS and the State shall determine a final settlement of payments made by the Contractor to CMS and the State, or by CMS and the State to the Contractor under this section. If any significant determinant of revenues or costs remains outstanding such that the timelines in this section do not apply, CMS and the State will establish reasonable timeframes for reporting payment and related final settlement timeframes.

4.3.3.1. Final settlement: CMS and the State shall determine a final settlement based on fifteen (15) months of claims run-out and an IBNR estimate.

4.3.3.1.1. For the purpose of the final settlement, the Contractor will jointly provide to CMS and the State the following within four hundred eighty (480) calendar days following the end of each applicable Demonstration Year, or within a timeline jointly agreed upon by CMS and the State. A complete and accurate report of Actual Non-Service Expenditures for Enrollees in the applicable Demonstration Year;

4.3.3.1.2. A complete and accurate report of Actual Service Expenditures, based on category of services, for Enrollees based on claims incurred for the applicable Demonstration Year, including fifteen (15) months of claims run-out;

4.3.3.1.3. The Contractor's best estimate of any claims incurred but not reported for claims run-out beyond fifteen (15) months and any IBNR completion factors by category of service;

4.3.3.1.4. A complete and accurate report of Part D revenue and expenditure, as required under 42 C.F.R. § 423.514(a)(1) of this Contract;

4.3.3.1.5. A complete and accurate report reflecting any recoveries from other payors outside of claims adjudication that are not reflected in the reported Actual Service Expenditures, including those pursuant to coordination of benefits, third party liability, rebates, supplemental payments,

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adjustments in claims paid, adjustments from providers including adjustments to claims paid, and Enrollee contributions to care;

4.3.3.1.6. A complete and accurate report of net reinsurance costs that are included in the reported Actual Non-Service Expenditures;

4.3.3.1.7. Financial reports;

4.3.3.1.8. Encounter Data, as required under Section 2.19 of this Contract;

4.3.3.2. CMS and the State shall provide the Contractor with a final reconciliation under the risk corridor arrangement within five hundred ten (510) calendar days following the end of each applicable Demonstration Year, or within a timeline jointly agreed upon by CMS and the State. Any balance due between the Contractor and CMS and the State shall be paid within sixty (60) days of the Contractor receiving the final reconciliation from CMS and the State; and

4.3.3.3. The Contractor shall provide any additional information upon request from CMS and the State necessary to calculate Total Adjusted Expenditures.

4.4. One-sided risk corridors will be established for Demonstration Years 6-8

4.4.1. General Provisions

4.4.1.1. The Demonstration will utilize a one-sided risk corridor for Demonstration Years 6 through 8. The one-sided risk corridor is designed to limit the profits received by Cal MediConnect MMPs to a reasonable percentage of total revenue.

4.4.1.2. Calculation of Gains and Losses: The risk sharing arrangement described in this section of the Contract may result in payment by the Contractor to the State and CMS.

4.4.1.2.1. All payments made by the Contractor to the State and CMS will be calculated and determined jointly by the State and CMS.

4.4.1.2.2. All calculations, determined jointly by the State and CMS, will be based on the Contractor's reporting of Adjusted Non-Service Expenditures and Adjusted Service Expenditures, as required in Section 4.4.3. All financial reporting will be subject to review and/or audit at the State's and CMS' discretion. As applicable, all calculations will sum the Contractor's expenditures and revenues across all counties in which the Contractor operates.

4.4.1.2.3. CMS and the State will perform a final settlement of the payments made by the Contractor to CMS and the State, as described in Section 4.4.3.

4.4.1.3. Allowable Expenditures

4.4.1.3.1. CMS and the State shall jointly determine the Adjusted Service Expenditures and the Adjusted Non-Service Expenditures, based on Encounter Data, cost data, and financial reporting data (including the State's rate development template) submitted by the Contractor (as required by Section 4.4.3 and Section 2.17-2.19 of this Contract). CMS and the State reserve the right to audit Actual Service Expenditure and Actual Non-Service Expenditure data.

4.4.1.3.2. CMS, the State, and the Contractor agree that to the extent there are differences in expenditure data reported across various sources, including the encounter, cost, financial reporting, or other data submitted by the Contractor, CMS, the State and the Contractor will confer and make a good faith effort to reconcile those differences before the calculation of the final settlement. The review procedures may include a review of the Contractor's Encounter Data and/or audit, to be performed by the CMS and/or the State, or either party's authorized agents, to verify that all paid claims for Enrollees by the Contractor are for Covered Services and/or that provider reimbursement is not excessive. CMS and the State

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will jointly have the final decision on the resolution of any differences in the expenditure data reported.

4.4.1.3.3. The State and CMS reserve the right to adjust expenditures for services that are reimbursed significantly above the median reimbursement rate of other comparable plans. The State and CMS reserve the right to adjust non-service expenditures that are greater than 125% of the median PMPM across all participating Contractors during the applicable Demonstration Year. The State and CMS will provide additional detail regarding the methodology for considering adjustments to expenditures in separate technical guidance. Notwithstanding any contractual provision or legal right to the contrary, the Contractor agrees that there shall be no redress against CMS or the State for a determination to adjust or a failure to adjust expenditures for services of any Contractor.

4.4.2. One-Sided Risk Corridor Parameters

4.4.2.1. The Demonstration will utilize a limited up-side risk corridor to include all Medicare A/B and Medicaid eligible Adjusted Service and Non-Service Expenditures. The risk corridors will be reconciled after the application of risk adjustment methodologies (e.g., CMS-HCC, Medicaid Relative Cost Factors and Relative Mix Factors), and intergovernmental transfers. The risk corridor will reflect the actual quality withhold payment received back by the Contractor.

4.4.2.1.1. Risk Corridor Share: The Medicare and Medicaid contributions to risk corridor payments will be in proportion to their contributions to the Adjusted Interim Capitation Rate Revenue. Losses and gains will be determined using the approaches described in Section 4.4.2.1.2.

4.4.2.1.2. Definition of Gains/Losses: Gains and losses are defined as the Adjusted Interim Capitation Rate Revenue minus the Total Adjusted Expenditures,

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with positive figures defined as gains and negative figures defined as losses. The Adjusted Interim Capitation Rate Revenue and the Total Adjusted Expenditures will incorporate Contractor's revenue and expenditures across all counties in which the Contractor operates.

4.4.2.1.3. Up-Side Risk Corridor Payment/Recoupment: For gains, the following bands apply:

4.4.2.1.3.1. First Band: The Contractor will retain all of the gains that are equal to or less than five percent (5%) of the Adjusted Interim Capitation Rate Revenue received by the Contractor.

4.4.2.1.3.2. Second Band: DHCS/CMS and the Contractor will share that portion of the gains that is over five percent (5%) and less than or equal to seven percent (7%) of the Adjusted Interim Capitation Rate revenue received by the Contractor, with seventy-five percent (75%) retained by the Contractor and twenty percent (25%) paid to DHCS/CMS.

4.4.2.1.3.3. Third Band: DHCS/CMS and the Contractor will share that portion of the gains that is over seven percent (7%) and less than or equal to nine percent (9%) of the Adjusted Interim Capitation Rate revenue received by the Contractor, with fifty percent (50%) retained by the Contractor and fifty percent (50%) paid to DHCS/CMS.

4.4.2.1.3.4. Fourth Band: DHCS/CMS and the Contractor will share that portion of the gains that is over nine percent (9%) and less than or equal to twelve percent (12%) of the

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Adjusted Interim Capitation Rate revenue received by the Contractor, with twenty-five percent (25%) retained by the Contractor and seventy-five percent (875%) paid to DHCS/CMS.

4.4.2.1.3.5. Fifth Band: DHCS/CMS will recoup the entire portion of the gains that exceeds twelve percent (12%) of the Adjusted Interim Capitation Rate Revenue received by the Contractor.

Figure 4-4 Demonstration Years 6-8 Risk Sharing Corridor Table (for illustrative purposes only)

Risk Corridor Band	**Incremental Gain[1]**	**% Contractor Gain Sharing**	**% State & CMS Gain Sharing**	**% CMS Gain Sharing**	**% State Gain Sharing**
Gain Band 1	Gains ≤ 5%	100%	0%	0%	0%
Gain Band 2	Gains >5% and ≤7%	75%	25%	(25%) * (Medicare A/B Percent of Rate)	(25%)*(Medi-Cal Percent of Rate)
Gain Band 3	Gains >7% and ≤9%	50%	50%	(75%) * (Medicare A/B Percent of Rate)	(75%)*(Medi-Cal Percent of Rate)
Gain Band 4	Gains >9% and ≤12%	25%	75%	(75%) * (Medicare A/B Percent of Rate)	(75%)*(Medi-Cal Percent of Rate)
Gain Band 5	Gains >12%	0%	100%	(100%) * (Medicare A/B Percent of Rate)	(100%)*(Medi-Cal Percent of Rate)

[1] Gain reflected on an incremental basis. Gains in Gain Band 5 still results in risk sharing reconciliation for the gain in Gain Bands 2-4.

4.4.3. Risk Sharing Settlement

4.4.3.1. CMS and the State shall determine final settlement of payments made by the Contractor to CMS and the State.

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4.4.3.2. Data Submission. The Contractor shall submit to DHCS and CMS, in the form and manner prescribed by DHCS and CMS, the necessary data to calculate and verify the final settlement after the end of each applicable Demonstration Year.

4.4.3.3. In the event the Contractor qualifies to make both a risk corridor payment to CMS and DHCS, as well as an MLR remittance as described in Section 4.12.1, the risk corridor calculation will be net of an MLR remittances.

4.5. Medicare Risk Adjustment Methodology

4.5.1. Medicare Parts A/B: The Medicare A/B Component will be risk adjusted based on the risk profile of each Enrollee. Except as specified below, the existing Medicare Advantage CMS-HCC and CMS-HCC ESRD risk adjustment methodology will be used for Cal MediConnect.

4.5.2. Coding Intensity Adjustment Factor

4.5.2.1. CMS will calculate calendar year 2014 rates as if the coding intensity adjustment factor were not applied, to reflect the fact that virtually all Enrollees were receiving care in FFS Medicare and thus there should be no coding pattern differences for which to adjust. Operationally CMS will still apply the coding intensity adjustment factor to the risk scores but will increase the Medicare A/B baseline for non-ESRD beneficiaries and beneficiaries with an ESRD status of functioning graft, to offset this.

4.5.2.2. In calendar year 2015, CMS will calculate and apply a coding intensity adjustment reflective of all Demonstration Enrollees except as indicated in Section 4.5.2.4. This will apply the prevailing Medicare Advantage coding intensity adjustment, on a county-specific basis, proportional to the anticipated proportion of Cal MediConnect Enrollees in 2015 with Medicare Advantage or Cal MediConnect experience in 2014, prior to September 30, 2014.

4.5.2.3. After calendar year 2015, CMS will apply the prevailing Medicare Advantage coding intensity adjustment to all Cal MediConnect Enrollees, with the exception of Cal MediConnect Enrollees in Orange County given the start date of enrollment in this county.

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4.5.2.3.1. For Orange County in CY 2016, CMS will apply the prevailing Medicare Advantage coding intensity adjustment proportional to the anticipated proportion of Orange County Cal MediConnect Enrollees in 2016 with Medicare Advantage or demonstration experience prior to September 30, 2015. After calendar year 2016, CMS will apply the prevailing Medicare Advantage coding intensity adjustment to Cal MediConnect Enrollees in Orange County.

4.5.2.4. The coding intensity adjustment factor will not be applied during the Demonstration to risk scores for Enrollees with an ESRD status of dialysis or transplant, consistent with Medicare Advantage policy. Medicare Part D: The Medicare Part D NAMBA will be risk adjusted in accordance with existing Part D RxHCC methodology. The estimated average monthly prospective payment amount for the low income cost-sharing subsidy and federal reinsurance amounts will not be risk adjusted.

4.5.3. Medi-Cal Component: For the Medi-Cal Component of the capitated rate, DHCS will rely on the methodology described in Section 4.2.1.3 to account for differences in risk among the eligible population.

4.6. Payment Terms

4.6.1. CMS and DHCS will each make monthly, prospective capitation payments to the Contractor, with retroactive adjustments, as applicable, as described in Sections 4.2.2.2.6, 4.2.2.3.1, 4.7 and 4.14.

4.6.1.1. The Medicare Parts A/B component will be the product of the Enrollee's CMS-HCC risk score multiplied by the relevant standard county payment rate (or the ESRD dialysis state rate by the HCC ESRD risk score, as applicable). The Medicare Part D Component will be the product of the Enrollee's RxHCC risk score multiplied by the Part D NAMBA, with the addition of the estimated average monthly prospective payment amount for the low income cost-sharing subsidy and federal reinsurance amounts. The payment period will commence on the Contract Operational Start Date.

4.6.1.2. DHCS shall remit to the Contractor a capitation payment each month for each Enrollee that appears on the approved

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list of Enrollees supplied to Contractor by DHCS. The Capitation Rate shall be the amount specified in Section 4.2.1.6. The payment period for health care services shall commence on the Contract Operational Start Date.

4.6.1.2.1. DHCS will pay an IHSS interim payment on behalf of the Contractor for IHSS Provider payroll as a portion of the covered Medicaid services. The IHSS interim payment will be reconciled as described in Section 4.14.3.1. This provision shall apply only with respect to IHSS provided on or before December 31, 2017. IHSS is no longer a Covered Service under this contract for service dates on or after January 1, 2018, pursuant to Statutes 2017, chapter 52 (S.B. 97).

4.7. Modifications to Capitation Rates. CMS and DHCS will jointly notify the Contractor in advance and in writing of any proposed changes to the Capitation Rates, and the Contractor shall accept such changes as payment in full as described in Section 4.15.

4.7.1. Rates will be updated using a similar process for each calendar year. Subject to Section 4.7.2., changes to the Medicare and Medicaid baselines outside of the annual Medicare Advantage and Part D rate announcements will be made only if and when CMS and DHCS jointly determine the change is necessary to calculate reasonable, appropriate, and attainable payment rates for Cal MediConnect. Such changes may be based on the following factors: shifts in enrollment assumptions; changes due to litigation; changes or discrepancies in federal law and/or State policy compared to assumptions about federal law and/or State law or policy used in the development of baseline estimates; changes in coding intensity; and other factors as determined appropriate and approved by CMS and the State.

4.7.2. For changes solely affecting the Medicare program baseline, CMS will update baselines by amounts identified by the independent Office of the Actuary necessary to best effectuate accurate payment rates for each month.

4.7.3. Subject to Section 4.7.2, if other statutory changes enacted after the annual baseline determination and rate development process are jointly determined by CMS and DHCS to have a material change in baseline estimates for any given payment year, baseline estimates and

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corresponding standardized payment rates shall be updated outside of the annual rate development process.

4.7.4. Changes to the savings percentages will be made if and when CMS and DHCS jointly determine that changes in Part D spending have resulted in materially higher or lower savings that need to be recouped through higher or lower savings percentages applied to the Medicare A/B baselines or if and when CMS and DHCS jointly determine the change is necessary to calculate reasonable, appropriate and attainable payment rates for Cal MediConnect.

4.7.5. IHSS wage adjustments may occur during Cal MediConnect. Changes to the Medi-Cal Component will be made annually by county and may be retroactively applied to account for IHSS wage adjustments that occurred during the calendar year, subject to CMS review. This provision shall apply only with respect to IHSS provided on or before December 31, 2017. IHSS is no longer a Covered Service under this contract for service dates on or after January 1, 2018, pursuant to Statutes 2017, chapter 52 (S.B. 97).

4.8. Quality Withhold Policy for Medi-Cal and Medicare A/B Components of the Integrated, Risk-Adjusted Rate

4.8.1. Under Cal MediConnect, both payers will withhold a percentage of their respective components of the Capitation Rate, with the exception of Part D component amounts. The withheld amounts will be repaid subject to the Contractor's performance consistent with established quality thresholds.

4.8.1.1. In Demonstration Year 1 of Cal MediConnect, the withhold will be 1% of the respective components of the Capitation Rate. **See Figure 4.5**.

4.8.1.2. For Demonstration Year 1, which crosses calendar years, the Contractor will be evaluated to determine whether it has met quality withhold requirements at the end of CY 2014 and at the end of CY 2015. The determination in CY 2014 will be based solely on those measures that can appropriately be calculated based on the actual enrollment volume during CY 2014. Consistent with such evaluations, the withheld amounts will be repaid separately for each calendar year.

Figure 4.5: Quality Withhold Measures for Demonstration Year 1

Measure	Source	CMS Core Withhold Measure	California Withhold Measure
Assessments	CMS defined process measure	X	
Consumer Governance Board	CMS defined process measure	X	
Getting Appointments and Care Quickly	AHRQ/CAHPS	X	
Customer Service	AHRQ/CAHPS	X	
Behavioral Health Shared Accountability Policies and Procedures	State defined process measure		X
Documentation of Care Goals	State defined process measure		X
Ensuring Physical Access to Buildings, Services and Equipment	State defined process measure		X
Interaction with Care Team	State defined process measure		X

4.8.1.3. The quality withhold will increase to two percent (2%) in Demonstration Year 2, three percent (3%) for Demonstration Years 3-5 and four percent (4%) for Demonstration Years 6-8. **See Figure 4.6.**

4.8.1.4. Payment will be based on performance on the quality withhold measures listed in Figure 4.6 below. The Contractor must report these measures according to the prevailing technical specifications for the applicable measurement year.

4.8.1.5. If the Contractor is unable to report at least three (3) of the quality withhold measures listed in Figure 4.6 for a given year due to low enrollment or inability to meet other reporting criteria, alternative measures will be used in the quality withhold analysis. Additional information about this policy is available in separate technical guidance.

Figure 4.6: Quality Withhold Measures for Demonstration Years 2 -8

Measure	Source	CMS Core Withhold Measure	California Withhold Measure
Encounter Data	CMS defined process measure	X	
Plan All-Cause Readmissions	NCQA/HEDIS	X	

	Source	CMS Core Withhold Measure	California Withhold Measure
Annual Flu Vaccine	AHRQ/CAHPS	X	
Follow-Up After Hospitalization for Mental Illness	NCQA/HEDIS	X	
Reducing the Risk of Falling	NCQA/HEDIS/HOS	X	
Controlling Blood Pressure	NCQA/HEDIS	X	
Part D Medication Adherence for Diabetes Medications	CMS/PDE Data	X	
Behavioral Health Shared Accountability Process Measure (DY 3 Only)	State-defined process measure		X
Behavioral Health Shared Accountability Outcome Measure	State-defined measure		X
Documentation of Care Goals	State defined process measure		X
Interaction with Care Team	State defined process measure		X

4.8.2. CMS and DHCS will evaluate the Contractor's performance according to the specified metrics required in order to earn back the quality withhold for a given year.

4.8.3. Whether or not the Contractor has met the quality requirements in a given year will be made public, as will relevant quality results in all Demonstration Years.

4.9. Shared Financial Accountability Strategy for Incentive Payments for Behavioral Health Services

4.9.1.1. Shared accountability between the Cal MediConnect Plan and county Behavioral Health agencies aims to promote Care Coordination to ensure Enrollees have access to all needed services. Shared accountability builds on the performance-based quality withhold from the plans' Capitation Rates of one percent, two percent, three percent, and four percent (1%, 2%, 3%, and 4%) in years one, two, three through five, and six through eight of the Demonstration. By meeting specified quality measures, the Contractor can earn back the withheld capitation revenue by meeting specified quality objectives. Under this shared accountability strategy, one (1) withhold measure in year

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one, one (1) withhold measure in year two, two (2) withhold measures in year three, and one (1) withhold measure in years four through eight will be tied to Behavioral Health coordination with the county.

4.9.1.2. The Contractor will be required to share with the applicable county Behavioral Health agencies a minimum amount of funds earned back through the shared accountability quality withhold measure each year. Contractor may choose to go above and beyond this minimum. This must be executed as directed in future guidance from DHCS.

4.9.1.3. The Contractor must provide an incentive payment each year to the county Behavioral Health agency that is equal to or greater than the value of each quality withhold measure multiplied by the proportion of Enrollees identified as having Behavioral Health needs and who are receiving county services. The proportion is defined as follows:

4.9.1.3.1. The denominator will be the total number of Enrollees with mental illness or substance use disorders, as defined for the emergency department reduction quality withhold measure for Years 2 through 8. The numerator would be the subset of those Enrollees who are receiving services through the county Behavioral Health agency.

4.9.1.3.2. In all counties except Los Angeles, the mental health and substance use departments are administratively combined. In Los Angeles County, the proportion of Enrollees with substance use disorders receiving county drug and alcohol services would be calculated separately from the Enrollees with mental illness population to identify the incentive payment amount paid to the Department of Public Health.

4.9.1.3.3. Assuming successful completion and equal weighting of each measure, total Behavioral Health shared accountability incentive payments in each year would equal:

- Year 1 Measure A = 0.001 multiplied by the total capitation multiplied by proportion of Enrollees with Behavioral Health disorders who are using county specialty mental health or Drug Medi-Cal services.
- Year 1 Measure B = 0.001 multiplied by the total capitation multiplied by proportion of Enrollees with Behavioral Health disorders who are using county specialty mental health or Drug Medi-Cal services.
- Year 2: ED Measure = 0.002 multiplied by the total capitation multiplied by proportion of Enrollees with Behavioral Health disorders who are using county specialty mental health or Drug Medi-Cal services.
- Year 3-8: ED Measure = 0.003 multiplied by the total capitation multiplied by proportion of Enrollees with Behavioral Health disorders who are using county specialty mental health or Drug Medi-Cal services.

4.10. Medicare A/B Disenrollment Penalty

4.10.1. Beginning in Demonstration Year 5 (CY 2019) CMS will implement a retrospective financial penalty in the Medicare A/B component of the Capitation Rate for Contractors with high disenrollment rates. This penalty is intended to address selection bias that may be impacting Medicare costs for the Cal MediConnect Demonstration and to align incentives for Contractors to improve quality for all Enrollees.

4.10.2. Performance will be evaluated annually using the existing Medicare Part C measure entitled "Members Choosing to Leave Plan." For DYs 5 and 6, CMS intends to maintain the benchmark at the median Contractor performance from measurement year 2017. For DYs 7 and 8, CMS will set the benchmark at the median Contractor performance from the most recent measurement year. Contractors with rates above the benchmark will be subject to the penalty on a sliding scale, starting at one percent (1%) and up to two percent (2%). Additional detail regarding the methodology will be provided in separate technical guidance.

4.10.3. Based on Contractor performance, CMS will recoup the Medicare A/B penalty retroactively, once performance for the applicable Demonstration year has been determined.

4.11. American Recovery and Reinvestment Act of 2009. All payments to the Contractor are conditioned on compliance with the provisions below and all other applicable provisions of the American Recovery and Reinvestment Act of 2009.

4.11.1. Suspension of Payments. DHCS shall suspend payments to Cal MediConnect in accordance with 42 C.F.R. § 455.23as as determined necessary or appropriate by DHCS.

4.11.2. Non-Payment and Reporting of Provider Preventable Conditions. Pursuant to 42 C.F.R. § 438.3(g), all payments to the Contractor are conditioned on the Contractor's compliance with all provisions related to Provider Preventable Conditions in accordance with the applicable DPL(s) as indicated in Section 2.1.5.

4.12. Medical Loss Ratio (MLR)

4.12.1. For Medicaid rating periods beginning on or after July 1, 2017, the Contractor is required to calculate and report their MLR experience for Medicaid, consistent with the requirements at 42 C.F.R. §§ 438.4, 438.5, 438.8 and 438.74, unless a joint MLR covering both Medicare and Medicaid experience is calculated and reported consistent with CMS and DHCS requirements.

4.12.2. Prior to the applicability of the requirements in 4.4.1 for all Demonstration Years in which the risk corridor applies, the Medicare Advantage MLR requirements are waived. To the extent the risk corridor ceases prior to the applicability of the requirements in 4.4.1 the Medicare Advantage MLR requirements will be reinstated for any applicable years in which the risk corridor is not in effect.

4.13. Risk Score Changes

4.13.1. Medicare Risk Score Changes: Medicare CMS-HCC, CMS-HCC ESRD, and RxHCC risk scores will be updated consistent with prevailing Medicare Advantage regulations and processes.

4.14. Reconciliation

4.14.1. CMS and DHCS will implement a process to reconcile enrollment and capitation payments for the Contractor that will take into

consideration the following circumstances: transitions between RCs; retroactive changes in eligibility, RCs, or Enrollee contribution amounts; changes in CMS-HCC and RxHCC risk scores; and changes through new enrollment, disenrollment, or death. The reconciliation may identify underpayments or overpayments to the Contractor.

4.14.2. Identified Overpayments

4.14.2.1. The Contractor shall promptly report to DHCS and CMS any such identified overpayments due to Fraud.

4.14.2.2. The Contractor shall report to DHCS and CMS within sixty (60) calendar days when it has identified the capitation payments or other payments in excess of amounts specified in the contract.

4.14.2.3. Recoveries by the Contractor of overpayments to providers. Consistent with Section 1128J(d) of the Social Security Act, the Contractor must adopt and implement policies for the treatment of recoveries of overpayments from the Contractor to a Network Provider.

4.14.3. Medi-Cal Component Reconciliation. The Medi-Cal Component reconciliation will occur a minimum of once a month. The monthly reconciliation process will reconcile retroactively up to twelve (12) months of historical enrollment changes or up to the effective date of the contract, whichever is sooner.

4.14.3.1. The Contractor is at full risk for IHSS Provider payments. On a quarterly basis, DHCS shall reconcile Actual IHSS expenditures against the IHSS Interim Payment. If Actual IHSS expenditures exceed the Interim Payment amount, DHCS shall invoice the Contractor for the difference with a thirty (30) day due date. DHCS shall pay California Department of Social Services within two (2) weeks of receipt from the Contractor. This provision shall apply only with respect to IHSS provided on or before December 31, 2017. IHSS is no longer a Covered Service under this Contract for service dates on or after January 1, 2018, pursuant to Statutes 2017, chapter 52 (S.B. 97).

4.14.4. Medicare Capitation Reconciliation: Medicare capitation reconciliation will comply with prevailing Medicare Advantage regulations and processes.

4.14.4.1. Final Medicare Reconciliation and Settlement: In the event the Contractor terminates or non-renews this Contract, CMS' final settlement phase for terminating contracts applies. This final settlement phase lasts for a minimum of eighteen (18) months after the end of the calendar year in which the termination date occurs. This final settlement will include reconciliation of any demonstration-specific payments or recoupments, including those related to joint Medicare A/B-Medicaid risk corridors, quality withholds, and medical loss ratios, as applicable, that are outstanding at the time of termination.

4.14.5. Audits/Monitoring: CMS and DHCS will conduct periodic audits to validate RC assignments or other coding. Audits may be conducted by a peer review organization or other entity assigned this responsibility by CMS and DHCS.

4.15. Payment in Full

4.15.1. The Contractor must accept, as payment in full for all Covered Services, the Capitation Rate(s) and the terms and conditions of payment set forth herein.

4.15.2. Notwithstanding any contractual provision or legal right to the contrary, the three (3) parties to this Contract (CMS, DHCS, and the Contractor), for Cal MediConnect agree there shall be no redress against either of the other two (2) parties, or their actuarial contractors, over the actuarial soundness of the Capitation Rates.

4.15.3. By signing this contract, the Contractor accepts that the Capitation Rate(s) offered is reasonable; that operating within this Capitation Rate(s) is the sole responsibility of the Contractor; and that while data is made available by the federal government to the Contractor, any entity participating in Cal MediConnect must rely on their own resource to project likely experience under Cal MediConnect.

5. Additional Terms and Conditions

5.1. Administration

5.1.1. Notification of Administrative Changes. The Contractor must notify CMS and DHCS through HPMS of all changes affecting the key functions for the delivery of care, the administration of its program, or its performance of Contract requirements. The Contractor must notify CMS and DHCS in HPMS no later than thirty (30) calendar days prior to any significant change to the manner in which services are rendered to Enrollees, including but not limited to reprocurement or termination of a First Tier, Downstream and Related Entity pursuant to Appendix C. The Contractor must notify CMS and DHCS in HPMS of all other changes no later than five (5) business days prior to the effective date of such change.

5.1.2. Assignment. The Contractor may not assign or transfer any right or interest in this Contract to any successor entity or other entity without the prior written consent of CMS and DHCS which may be withheld for any reason or for no reason at all.

5.1.3. Independent Contractors

5.1.3.1. The Contractor, its employees, First Tier, Downstream and Related Entities, and any other of its agents in the performance of this Contract, shall act in an independent capacity and not as officers, agents, or employees of the federal government, or DHCS.

5.1.3.2. The Contractor must ensure it evaluates the prospective First Tier, Downstream and Related Entities' abilities to perform activities to be delegated, as provided for in Appendix C.

5.1.4. Subrogation. Subject to CMS and DHCS lien and third-party recovery rights, the Contractor must:

5.1.4.1. Be subrogated and succeed to any right of recovery of an Enrollee against any person or organization, for any services, supplies, or both provided under this Contract up to the amount of the benefits provided hereunder;

5.1.4.2. Require that the Enrollee pay to the Contractor all such amounts recovered by suit, settlement, or otherwise from any third person or his or her insurer for other than Medi-

Cal and Medicare covered benefits, to the extent of the benefits provided hereunder, up to the value of the benefits provided hereunder. The Contractor may ask the Enrollee to:

5.1.4.2.1. Take such action, furnish such information and assistance, and execute such instruments as the Contractor may require to facilitate enforcement of its rights hereunder, and take no action prejudicing the rights and interest of the Contractor hereunder; and

5.1.4.2.2. Notify the Contractor hereunder and authorize the Contractor to make such investigations and take such action as the Contractor may deem appropriate to protect its rights hereunder whether or not such notice is given.

5.1.5. Prohibited Affiliations. In accordance with 42 U.S.C. § 1396 u-2(d)(1), the Contractor shall not knowingly have an employment, consulting, or other agreement for the provision of items and services that are significant and material to the Contractor's obligations under this Contract with any person, or affiliate of such person, who is excluded, under federal law or regulation, from certain procurement and non-procurement activities. Further, no such person may have beneficial ownership of more than five percent (5%) of the Contractor's equity or be permitted to serve as a director, officer, or partner of the Contractor.

5.1.6. Disclosure Requirements. The Contractor must disclose to CMS and DHCS information on ownership and control, business transactions, and persons convicted of crimes in accordance with 42 C.F.R. Part 455, Subpart B. The Contractor must obtain federally required disclosures from all Network Providers and applicants in accordance 42 C.F.R. § 1002.3, and as specified by DHCS, including but not limited to obtaining such information through provider enrollment forms and credentialing and recredentialing packages. The Contractor must maintain such disclosed information in a manner which can be periodically searched by the Contractor for exclusions and provided to DHCS in accordance with this Contract and relevant State and federal laws and regulations. In addition, the Contractor must comply with all reporting and disclosure requirements of 42 U.S.C. § 1396b(m)(4)(A) if the Contractor is not a federally qualified health maintenance organization under the Public Health Service Act. In addition, the Contractor shall make the information reported pursuant to 42 U.S.C. § 1396b(m)(4)(A) available to its Enrollees upon reasonable request.

5.1.7. Physician Incentive Plans.

5.1.7.1. The Contractor and its First Tier, Downstream and Related Entities must comply with all applicable requirements governing physician incentive plans, including but not limited to such requirements appearing at 42 C.F.R. Parts 417, 422, 434, 438.3(i), and 1003. The Contractor must submit all information required to be disclosed to CMS and the DHCS in the manner and format specified by CMS and the DHCS which, subject to federal approval, must be consistent with the format required by CMS for Medicare contracts.

5.1.7.2. The Contractor shall be liable for any and all loss of federal financial participation (FFP) incurred by the DHCS that results from the Contractor's or its First Tier, Downstream, or Related Entities' failure to comply with the requirements governing physician incentive plans at 42 C.F.R. Parts 417, 434 and 1003, however, the Contractor shall not be liable for any loss of FFP under this provision that exceeds the total FFP reduction attributable to Enrollees in the Contractor's plan, and the Contractor shall not be liable if it can demonstrate, to the satisfaction of CMS and the DHCS, that it has made a good faith effort to comply with the cited requirements. Federal financial participation is not available for any amounts paid to the Contractor if the Contractor could be excluded from participation in Medicare or Medicaid under section 1128(b)(8)(B) of the Social Security Act or for any of the reasons listed in 42 C.F.R. § 431.55(h).

5.1.7.3. Contractor may operate a PIP only if no specific payment can be made directly or indirectly under a PIP to a physician or physician group as an inducement to reduce or limit Medically Necessary Services furnished to an individual.

5.1.7.4. Contractor must provide information on its PIP to any Enrollee upon request as provided in 42 C.F.R. § 422.208.

5.1.8. Physician Identifier. The Contractor must require each physician providing Covered Services to Enrollees under this Contract to have a unique identifier in accordance with the system established under 42 U.S.C. § 1320d-2(b). The Contractor must provide such unique identifier to CMS and DHCS for each of its PCPs in the format and time-frame established by CMS and DHCS in consultation with the Contractor.

5.1.9. Timely Provider Payments. The Contractor must make timely payments to its Network Providers consistent with 42 C.F.R. § 447.45. The Contractor must ensure that ninety percent (90%) of claims from Network Providers (including Indian Health Care Providers) who are in individual or group practice, which can be processed without obtaining additional information from the physician or from a third party, will be paid within thirty (30) days of the date of receipt of the claim. In addition, ninety-nine percent (99%) of all clean claims from Network Providers will be paid within ninety (90) days of the date of receipt of the claim. The Contractor and its Network Providers may by mutual agreement, in writing, establish an alternative payment schedule. Generally, the date of receipt is the date the agency receives the claim, as indicated by its date stamp on the claim. The date of payment is the date of the check or other form of payment.

5.1.9.1. Pharmacy providers will be reimbursed in accordance with the prompt payment provisions at 42 C.F.R. § 423. 505(i)(3)(vi).

5.1.9.2. The Contractor shall pay ninety-five percent (95%) of clean claims from non-contracted providers within thirty (30) days of request. All other claims shall be paid or denied within sixty (60) days of request.

5.1.10. Provider Payments. The Contractor shall pay providers in accordance with Medicare and Medi-Cal coordination of benefits, per WIC Section 14182.16 and in accordance with applicable DPL(s) as indicated in Section 2.1.5.

5.1.10.1. Medi-Cal Alignment. The Contractor shall pay providers, including institutional providers, in accordance with the prompt payment provisions in compliance with 42 C.F.R. § 447.45, ARRA 5006(d) and as contained in each Contractor's Medi-Cal managed care contract with DHCS, including the ability to accept and pay electronic claims, excluding Part D.

5.1.10.2. Date of Receipt. The date of receipt is the date the agency receives the claim, as indicated by its date stamp on the claim. The date of payment is the date of the check or other form of payment.

5.1.10.3. Nursing Facility Rates. The Contractor shall not combine the rates of payment for post-acute skilled and rehabilitation care provided by a nursing facility and long-term and

chronic care provided by a nursing facility in order to establish a single payment rate for dual eligible beneficiaries requiring skilled nursing services. The Contractor shall pay nursing facilities providing post-acute skilled and rehabilitation care or long-term and chronic care rates that reflect the different level of services and intensity required to provide these services.

5.1.11. Protection of Enrollee-Provider Communications. In accordance with 42 USC § 1396 u-2(b)(3), the Contractor shall not prohibit or otherwise restrict a clinical First Tier, Downstream or Related Entity from advising an Enrollee about the health status of the Enrollee or medical care or treatment for the Enrollee's condition or disease; information the Enrollee needs in order to decide among all relevant treatment options; risk, benefits and consequences of treatment or non-treatment; and/or the Enrollee's rights to participate in decisions about his or her health care, including the right to refuse treatment and to express preferences about future treatment decisions, regardless of whether benefits for such care or treatment are provided under the Contract, if the clinical First Tier, Downstream, or Related Entity is acting within the lawful scope of practice.

5.1.12. Protecting Enrollee from Liability for Payment. The Contractor must:

5.1.12.1. In accordance with 42 C.F.R. § 438.106, not hold an Enrollee liable for:

5.1.12.1.1. Debts of the Contractor, in the event of the Contractor's insolvency;

5.1.12.1.2. Covered Services provided to the Enrollee in the event that the Contractor fails to receive payment from CMS or DHCS for such services; or

5.1.12.1.3. Payments to a clinical First Tier, Downstream and Related Entity in excess of the amount that would be owed by the Enrollee if the Contractor had directly provided the services;

5.1.12.2. Not charge Enrollees coinsurance, co-payments, deductibles, financial penalties, or any other amount in full or part, for any service provided under this Contract, except as otherwise provided in Appendix A below;

5.1.12.3. Not deny any service provided under this Contract to an Enrollee for failure or inability to pay any applicable charge; and

5.1.12.4. Not deny any service provided under this Contract to an Enrollee who, prior to becoming eligible, incurred a bill that has not been paid.

5.1.13. Third Party Liability (TPL)

5.1.13.1. General Requirements.

5.1.13.1.1. Coordination of Benefits means the process of utilizing TPL resources to ensure that Medi-Cal is the payer of last resort. This is accomplished by either operating a cost avoidance method of paying claims, when the existence of private health coverage is known at the time the claim is processed, or the method of post-payment recovery of the cost of services, if the coverage is identified retroactively.

5.1.13.1.2. DHCS shall refer to the Contractor the Enrollee's name and pertinent information where DHCS knows an Enrollee has been in an accident or had a traumatic event where a liable third party may exist.

5.1.13.1.3. The Contractor shall identify and notify the DHCS's TPL and Recovery Division of all instances or cases in which Contractor believes an action by the Enrollee involving casualty insurance or tort or Workers' Compensation liability of a third party could result in recovery by the Enrollee of funds to which DHCS has lien rights under Article 3.5 (commencing with Section 14124.70), Part 3, Division 9, WIC. Contractor shall make no claim for recovery of the value of Covered Services rendered to an Enrollee in such cases or instances and such case or instance shall be referred to State's TPL Branch within ten (10) calendar days of discovery. To assist DHCS in exercising its responsibility for such recoveries, Contractor shall meet the following requirements:

5.1.13.1.3.1. If DHCS requests service information and/or copies of paid invoices/claims for Covered Services to an Enrollee, Contractor shall deliver the requested information within thirty (30) calendar days of the request. Service information includes First Tier, Downstream, or Related Entity and out of plan 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 First Tier, Downstream, or Related Entity providers or out of plan providers for similar services, whichever is applicable under WIC Section 14124.90(c)(2).

5.1.13.1.3.2. Designate a TPL Benefit Coordinator who shall serve as a contact person for benefit coordination issues related to this Contract.

5.1.13.1.3.3. Designate one or more recoveries specialist(s), whose function shall be to investigate and process all transactions related to the identification of TPL.

5.1.14. Medicaid Drug Rebate

5.1.14.1. Non-Part D covered outpatient drugs dispensed to Enrollees shall be subject to the same rebate requirements as the State is subject under section 1927 of the Social Security Act and that the State shall collect such rebates from pharmaceutical manufacturers.

5.1.14.2. Contractor shall submit to DHCS, on a timely and periodic basis, no later than forty-five (45) calendar days after the end of each quarterly rebate period, information on the total number of units of each dosage form and strength and package size by National Drug Code of each non-Part D covered outpatient drug dispensed to Enrollees for which the Contractor is responsible for coverage and other data as DHCS determines necessary.

5.1.15. Moral or Religious Objections. The Contractor is not required to provide, reimburse for, or provide coverage of, a counseling or referral service that would otherwise be required if the Contractor objects to the service on moral or religious grounds. If the Contractor elects not to provide, pay for, or provide coverage of, a counseling or referral service because of an objection on moral or religious grounds, it must promptly notify DHCS and CMS in writing of its intent to exercise the objection. It must furnish information about the services it does not cover as follows:

5.1.15.1. To the State;

5.1.15.2. With its application for a contract;

5.1.15.3. Whenever it adopts the policy during the term of the Contract; and the information provided must be:

5.1.15.3.1. Consistent with the provisions of 42 C.F.R. § 438.10;

5.1.15.3.2. Provided to Eligible Beneficiaries before and during enrollment; and

5.1.15.3.3. Provided to Enrollees within ninety (90) days after adopting the policy with respect to any particular service.

5.2. Confidentiality

5.2.1. Statutory Requirements. The Contractor understands and agrees that CMS and DHCS may require specific written assurances and further agreements regarding the security and Privacy of protected health information that are deemed necessary to implement and comply with standards under the HIPAA as implemented in 45 C.F.R., Parts 160 and 164. The Contractor further represents and agrees that, in the performance of the services under this Contract, it will comply with all legal obligations as a holder of personal information under the California Information Practices Act (Civil Code Section 1798 et seq.). The Contractor represents that it currently has in place policies and procedures that will adequately safeguard any confidential personal data obtained or created in the course of fulfilling its obligations under

this Contract in accordance with applicable State and federal laws. The Contractor is required to design, develop, or operate a system of records on individuals, to accomplish an agency function subject to the Privacy Act of 1974, Public Law 93-579, December 31, 1974 (5 U.S.C. § 552a) and applicable agency regulations. Violation of the Act may involve the imposition of criminal penalties.

5.2.2. Personal Data. The Contractor must inform each of its employees having any involvement with personal data or other confidential information, whether with regard to design, development, operation, or maintenance, of the laws and regulations relating to confidentiality.

5.2.3. Data Security. The Contractor must take reasonable steps to ensure the physical security of personal data or other confidential information under its control, including, but not limited to: fire protection; protection against smoke and water damage; alarm systems; locked files, guards, or other devices reasonably expected to prevent loss or unauthorized removal of manually held data; passwords, access logs, badges, or other methods reasonably expected to prevent loss or unauthorized access to electronically or mechanically held data by ensuring limited terminal access; limited access to input documents and output documents; and design provisions to limit use of Enrollee names. The Contractor must put all appropriate administrative, technical, and physical safeguards in place before the start date to protect the Privacy and security of protected health information in accordance with 45 C.F.R. § 164.530(c). The Contractor must meet the security standards, requirements, and implementation specifications as set forth in 45 C.F.R. Part 164, subpart C, the HIPAA Security Rule. Contractor must follow the National Institute for Standards and Technology (NIST) Guidelines for the Risk Management Framework (RMF) to establish an information security program in accordance with the Federal Information Security Management Act (FISMA).

5.2.4. Return of Personal Data. The Contractor must return any and all personal data, with the exception of medical records, furnished pursuant to this Contract promptly at the request of CMS or DHCS in whatever form it is maintained by the Contractor. Upon the termination or completion of this Contract, the Contractor shall not use any such data or any material derived from the data for any purpose, and, where so instructed by CMS or DHCS will destroy such data or material.

5.2.5. Research Data. The Contractor must seek and obtain prior written authorization from CMS and DHCS for the use of any data pertaining

to this Contract for research or any other purposes not directly related to the Contractor's performance under this Contract.

5.3. General Terms and Conditions

5.3.1. Applicable Law. The term "applicable law," as used in this Contract, means, without limitation, all federal and California law, and the regulations, policies, procedures, and instructions of CMS and DHCS all as existing now or during the term of this Contract. All applicable law is hereby incorporated into this Contract by reference.

5.3.2. Sovereign Immunity. Nothing in this Contract will be construed to be a waiver by the State of California or CMS of its rights under the doctrine of sovereign immunity and the Eleventh Amendment to the United States Constitution.

5.3.3. Advance Directives. Nothing in this Contract shall be interpreted to require an Enrollee to execute an Advance Directive or agree to orders regarding the provision of life-sustaining treatment as a condition of receipt of services under the Medicare or Medi-Cal program.

5.3.4. Loss of Licensure. If, at any time during the term of this Contract, the Contractor or any of its First Tier, Downstream or Related Entities incurs loss of licensure at any of the Contractor's facilities or loss of necessary federal or State approvals, the Contractor must report such loss to CMS and DHCS. Such loss may be grounds for termination of this Contract under the provisions of Section 5.5.

5.3.5. Indemnification. The Contractor shall indemnify and hold harmless CMS, the federal government, and DHCS from and against any and all liability, loss, damage, costs, or expenses which CMS and or DHCS may sustain, incur, or be required to pay, arising out of or in connection with any negligent action, inaction, or willful misconduct of the Contractor, any person employed by the Contractor, or any of its First Tier, Downstream, or Related Entities provided that:

5.3.5.1. The Contractor is notified of any claims within a reasonable time from when CMS and DHCS become aware of the claim; and

5.3.5.2. The Contractor is afforded an opportunity to participate in the defense of such claims.

5.3.6. Prohibition against Discrimination.

5.3.6.1. In accordance with 42 USC § 1396 u-2(b)(7), the Contractor shall not discriminate with respect to participation, reimbursement, or indemnification of any provider in the Contractor's Provider Network who is acting within the scope of the provider's license or certification under applicable federal or State law, solely on the basis of such license or certification. This section does not prohibit the Contractor: from including providers in its Provider Network to the extent necessary to meet the needs of the Contractor's Enrollees; from using different reimbursement amounts for different specialties or for different practitioners in the same specialty; or from establishing any measure designed to maintain quality and control costs consistent with the responsibilities of the Contractor.

5.3.6.2. Contractor will give written notice of the reason for its decision when it declines to include individual or groups of providers in its network.

5.3.6.3. If a Complaint or claim against the Contractor is presented to DHCS or CMS, the Contractor must cooperate with in the investigation and disposition of such Complaint or claim.

5.3.7. Anti-Boycott Covenant. During the time this Contract is in effect, neither the Contractor nor any affiliated company, as hereafter defined, must participate in or cooperate with an international boycott, as defined in Section 999(b)(3) and (4) of the Internal Revenue Code of 1954, as amended, or engage in conduct declared to be unlawful by DHCS. Without limiting such other rights as it may have, CMS and DHCS will be entitled to rescind this Contract in the event of noncompliance with this Section. As used herein, an affiliated company is any business entity directly or indirectly owning at least fifty-one percent (51%) of the ownership interests of the Contractor.

5.3.8. Other Contracts. Nothing contained in this Contract must be construed to prevent the Contractor from operating other comprehensive health Care Plans or providing health care services to persons other than those eligible for coverage in the Contract; provided, however, that the Contractor must provide CMS and DHCS with a complete list of such plans and services, upon request. CMS and DHCS will exercise discretion in disclosing information that the Contractor may consider proprietary, except as required by law. Nothing in this Contract may be construed to prevent CMS or DHCS

from contracting with other comprehensive health Care Plans, or any other provider, in the same Service Area.

5.3.9. Counterparts. This Contract may be executed simultaneously in two or more counterparts, each of which will be deemed an original and all of which together will constitute one and the same instrument.

5.3.10. Entire Contract. This Contract constitutes the entire agreement of the parties with respect to the subject matter hereof, including all Attachments and Appendices hereto, and supersedes all prior agreements, representations, negotiations, and undertakings not set forth or incorporated herein. The terms of this Contract will prevail notwithstanding any variances with the terms and conditions of any verbal communication subsequently occurring.

5.3.11. No Third-Party Rights or Enforcement. No person not executing this Contract is entitled to enforce this Contract against a party hereto regarding such party's obligations under this Contract.

5.3.12. Corrective Action Plan. If, at any time, CMS and DHCS reasonably determine that the Contractor is deficient in the performance of its obligations under the Contract, CMS and DHCS may require the Contractor to develop and submit a corrective action plan that is designed to correct such deficiency. CMS and DHCS will approve, disapprove, or require modifications to the corrective action plan based on their reasonable judgment as to whether the corrective action plan will correct the deficiency. The Contractor must promptly and diligently implement the corrective action plan as approved by CMS and DHCS. Failure to implement the corrective action plan may subject the Contractor to termination of the Contract by CMS and DHCS or other intermediate sanctions as described in Section 5.3.13.

5.3.13. Intermediate Sanctions.

5.3.13.1. In addition to termination under Section 5.5, CMS and DHCS may, impose any or all of the sanctions in Section 5.3 upon any of the events below; provided, however, that CMS and DHCS will only impose those sanctions they determine to be reasonable and appropriate for the specific violations identified. CMS and DHCS may choose to provide warning notices and/or corrective action plans before sanctions. Sanctions may be imposed in accordance with this section for any failure to comply with this Contract, including but not limited to, if the Contractor:

5.3.13.1.1. Fails substantially to provide Covered Services required to be provided under this Contract to Enrollees;

5.3.13.1.2. Imposes charges on Enrollees in excess of any permitted under this Contract;

5.3.13.1.3. Discriminates among Enrollees or individuals eligible to enroll on the basis of health status or need for health care services, race, color or national origin, or uses any policy or practice that has the effect of discriminating on the basis of race, color, or national origin;

5.3.13.1.4. Misrepresents or falsifies information provided to CMS, DHCS, Enrollees, or its Provider Network;

5.3.13.1.5. Fails to comply with requirements regarding physician incentive plans (see Section 5.1.7);

5.3.13.1.6. Fails to comply with federal or State statutory or regulatory requirements related to this Contract;

5.3.13.1.7. Violates restrictions or other requirements regarding marketing;

5.3.13.1.8. Fails to comply with quality management requirements consistent with Section 2.16;

5.3.13.1.9. Fails to comply with any corrective action plan required by CMS and DHCS;

5.3.13.1.10. Fails to comply with financial solvency requirements;

5.3.13.1.11. Fails to comply with reporting requirements; or

5.3.13.1.12. Fails to comply with any other requirements of this Contract.

5.3.13.2. Such sanctions may include, but are not limited to:

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5.3.13.2.1. Intermediate sanctions and civil monetary penalties consistent with 42 C.F.R. § 422 Subpart O or § 438 Subpart I;

5.3.13.2.2. The appointment of temporary management to oversee the operation of the Contractor in those circumstances set forth in 42 U.S.C. § 1396 u-2(e)(2)(B);

5.3.13.2.3. Suspension of enrollment (including assignment of Enrollees);

5.3.13.2.4. Suspension of payment to the Contractor;

5.3.13.2.5. Disenrollment of Enrollees; and

5.3.13.2.6. Suspension of marketing.

5.3.13.2.7. Denial of payment as set forth in 42 C.F.R. § 438.730.

5.3.13.3. If CMS or DHCS have identified a deficiency in the performance of a First Tier, Downstream or Related Entity and the Contractor has not successfully implemented an approved corrective action plan in accordance with Section 5.3.12, CMS and DHCS may:

5.3.13.3.1. Require the Contractor to subcontract with a different First Tier, Downstream or Related Entity deemed satisfactory by CMS and DHCS; or

5.3.13.3.2. Require the Contractor to change the manner or method in which the Contractor ensures the performance of such contractual responsibility.

5.3.13.4. Additional Administrative Procedures. CMS and DHCS may, from time to time, issue program memoranda, bulletins, and DPLs clarifying, elaborating upon, explaining, or otherwise relating to Contract administration and other management matters. The Contractor must comply with all such program memoranda, bulletins, and letters as may be issued from time to time.

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5.3.13.5. Effect of Invalidity of Clauses. If any clause or provision of this Contract is in conflict with any federal or State law or regulation, that clause or provision will be null and void and any such invalidity will not affect the validity of the remainder of this Contract.

5.3.14. Before imposing any intermediate sanctions, consistent with 42 C.F.R. § 438.710, DHCS and CMS must give the Contractor timely written notice that explains the basis and nature of the sanction and other due process protections that DHCS and CMS elect to provide.

5.3.15. Conflict of Interest. Neither the Contractor, nor any First Tier, Downstream or Related Entity may, for the duration of the Contract, have any interest that will conflict, as determined by CMS and DHCS with the performance of services under the Contract, or that may be otherwise anticompetitive. The Contractor further certifies that it will comply with Section 1932(d) of the Social Security Act.

5.3.16. Insurance for Contractor's Employees. The Contractor must agree to maintain at the Contractor's expense all insurance required by law for its employees, including but not limited to, worker's compensation and unemployment compensation, and must provide CMS and DHCs with certification of same upon request. The Contractor, and its professional personnel providing services to Enrollees, must obtain and maintain appropriate professional liability insurance coverage. The Contractor must, at the request of CMS or DHCS, provide certification of professional liability insurance coverage.

5.3.17. Waiver. The Contractor, CMS, or DHCS shall not be deemed to have waived any of its rights hereunder unless such waiver is in writing and signed by a duly authorized representative. No delay or omission on the part of the Contractor, CMS, or DHCS in exercising any right shall operate as a waiver of such right or any other right. A waiver on any occasion shall not be construed as a bar to or waiver of any right or remedy on any future occasion. The acceptance or approval by CMS and DHCS of any materials including but not limited to, those materials submitted in relation to this Contract, does not constitute waiver of any requirements of this Contract.

5.3.18. Section Headings. The headings of the sections of this Contract are for convenience only and will not affect the construction hereof.

5.4. Record Retention, Inspection, and Audit

5.4.1. The Contractor must maintain books, records, documents, and other evidence of administrative, medical, and accounting procedures and practices for ten (10) years from the end of the final contract period or completion of audit, whichever is later.

5.4.2. The Contractor must make the records maintained by the Contractor and its Provider Network, as required by CMS and DHCS and other regulatory agencies, available to CMS and DHCS and its agents, designees or contractors or any other authorized representatives of the State of California or the United States Government, or their designees or contractors, at such times, places, and in such manner as such entities may reasonably request for the purposes of financial or medical audits, inspections, and examinations, provided that such activities are conducted during the normal business hours of the Contractor.

5.4.3. The Contractor further agrees that the Secretary of the U.S. Department of Health and Human Services or his or her designee, the Governor or his or her designee, Comptroller General, and the State Auditor or his or her designee have the right at reasonable times and upon reasonable notice to examine the books, records, and other compilations of data of the Contractor and its First Tier, Downstream and Related Entities that pertain to: the ability of the Contractor to bear the risk of potential financial losses; services performed; or determinations of amounts payable.

5.4.4. The Contractor must make available, for the purposes of record maintenance requirements, its premises, physical facilities and equipment, records relating to its Enrollees, and any additional relevant information that CMS or DHCS may require, in a manner that meets CMS and DHCS record maintenance requirements.

5.4.5. The Contractor must comply with the right of the U.S. Department of Health and Human Services, the Comptroller General, and their designees to inspect, evaluate, and audit records through ten (10) years from the final date of the Contract period or the completion of audit, whichever is later, in accordance with federal and State requirements.

5.4.6. Disputes. The Disputes procedure set forth in Appendix K will be used by the Contractor as the means of seeking resolution of disputes on contractual issues.

5.5. Termination of Contract

5.5.1. Termination without Prior Notice. In the event the Contractor substantially fails to meet its obligations under this Contract or has otherwise violated the laws, regulations, or rules that govern the Medicare or Medi-Cal programs, CMS or DHCS may take any or all action under this Contract, law, or equity, including but not limited to immediate termination of this Contract in accordance with regulations that are current at the time of the termination.

5.5.2. Without limiting the above, if CMS or DHCS determine that participation of the Contractor in the Medicare or Medi-Cal program or in the Demonstration, may threaten or endanger the health, safety, or welfare of Enrollees or compromise the integrity of the Medicare or Medi-Cal program, CMS or DHCS, without prior notice, may immediately terminate this Contract, suspend the Contractor from participation, withhold any future payments to the Contractor, or take any or all other actions under this Contract, law, or equity. Such action may precede beneficiary enrollment into any Contractor, and shall be taken upon a finding by CMS or DHCS that the Contractor has not achieved and demonstrated a state of readiness that will allow for the safe and efficient provision of Medicare-Medi-Cal services to Medicare-Medi-Cal beneficiaries.

5.5.3. United States law and California law, as appropriate, will apply to resolve any claim of breach of this Contract.

5.5.4. Termination with Prior Notice.

5.5.4.1. CMS or DHCS may terminate this Contract without cause upon no less than one hundred eighty (180) days prior written notice to the other party specifying the termination date, unless applicable law requires otherwise. Per Section 5.8, the Contractor may choose to non-renew this Agreement prior to the end of each term pursuant to 42 C.F.R. § 422.506(a). In considering requests for termination under 42 C.F.R. § 422.508, CMS and DHCS will consider, among other factors, financial performance and stability in granting consent for termination. Any written communications or oral scripts developed to implement the requirements of 42 C.F.R. § 422.506(a) must be submitted to and approved by CMS and DHCS prior to their use.

5.5.4.2. Pursuant to 42 C.F.R. §§ 422.506(a)(4) and 422.508(c), CMS considers Contractor termination of this Contract with prior notice as described in paragraph 5.5.2.1 and non-renewal of

this Contract as described in Section 5.8 to be circumstances warranting special consideration, and will not prohibit the Contractor from applying for new Medicare Advantage contracts or Service Area expansions for a period of two years due to termination.

5.5.5. Termination pursuant to Social Security Act § 1115A(b)(3)(B).

5.5.6. Termination for Cause. Any party may terminate this Agreement upon ninety (90) days' notice due to a material breach of a provision of this Contract unless CMS or DHCS determines that a delay in termination would pose an imminent and serious risk to the health of the individuals enrolled with the Contractor or the Contractor experiences financial difficulties so severe that its ability make necessary health services available is impaired to the point of posing an imminent and serious risk to the health of its Enrollees, whereby CMS or DHCS may expedite the termination.

5.5.6.1. Pre-termination Procedures. Before terminating a contract under 42 C.F.R. § 422.510 and § 438.708, the Contractor may request a pre-termination hearing or develop and implement a corrective action plan. CMS or DHCS must:

5.5.6.1.1. Give the Contractor written notice of its intent to terminate, the reason for termination, and a reasonable opportunity of at least thirty (30) calendar days to develop and implement a corrective action plan to correct the deficiencies; and/or

5.5.6.1.2. Notify the Contractor of its Appeal rights as provided in 42 C.F.R. § 422 Subpart N and § 438.710.

5.5.6.2. If Contractor fails to comply with the provisions of Section 5.5, CMS or DHCS may terminate this agreement upon thirty days' notice.

5.5.7. Termination due to a Change in Law. In addition, CMS or DHCS may terminate this agreement upon thirty (30) days notice due to a material change in law, or by operation of law, including a change in the State law authorizing the State's participation in the program, or with less or no notice if required by law.

5.5.8. Continued Obligations of the Parties.

5.5.8.1. In the event of termination, expiration, or non-renewal of this Contract, or if the Contractor otherwise withdraws from the Medicare or Medi-Cal programs, the Contractor shall continue to have the obligations imposed by this Contract or applicable law. These include, without limitation, the obligations to continue to provide Covered Services to each Enrollee at the time of such termination or withdrawal until the Enrollee has been disenrolled from the Contractor's Plan; provided, however, that CMS and DHCS will exercise best efforts to complete all disenrollment activities within six months from the date of termination or withdrawal.

5.5.8.2. In the event that this Contract is terminated, expires, or is not renewed for any reason:

5.5.8.2.1. If CMS or DHCS, or both, elect to terminate the Contract, CMS and DHCS will be responsible for notifying all Enrollees covered under this Contract of the date of termination and the process by which those Enrollees will continue to receive care under applicable laws, regulations, and provisions of this Contract. If the Contractor elects to terminate or not renew the Contract, the Contractor will be responsible for notifying all Enrollees and the general public, in accordance with federal and State requirements and the terms of this Contract;

5.5.8.2.2. The Contractor must promptly return to CMS and DHCS all payments advanced to the Contractor for Enrollees after the effective date of their disenrollment; and

5.5.8.2.3. The Contractor must supply to CMS and DHCS all information necessary for the payment of any outstanding claims determined by CMS and DHCS to be due to the Contractor, and any such claims will be paid in accordance with the terms of this Contract.

5.6. Impact of Termination

5.6.1. In the event this Contract is terminated, expires, or is not renewed for any reason, the State shall have the authority to crosswalk Enrollees

into a Medi-Cal Managed Care Plan for the purposes of the seamless provision of Medi-Cal managed care Covered Services.

5.6.2. The State shall provide such Enrollees with notice of this crosswalk and of any options Enrollees have to change Medi-Cal managed care plans for the provision of Medi-Cal Covered Services.

5.7. Order of Precedence

5.7.1. The following documents are incorporated into and made a part of this Contract:

5.7.1.1. Capitated Financial Alignment Application, a document issued by CMS and subject to modification each program year;

5.7.1.2. DHCS's Bridge to Health Reform Section 1115 waiver as amended for purposes of this demonstration;

5.7.1.3. CFAM-MOU, a document between CMS and DHCS regarding a Federal-State Partnership to Test a Capitated Financial Alignment Model for Medicare-Medicaid Enrollees (signed March 27, 2013);

5.7.1.4. The Contractor's Medi-Cal managed care contract;

5.7.1.5. All applicable federal and State regulations and laws, as well as DHCS DPLs, applicable DHCS APLs, CMS guidance, including but not limited to enrollment and marketing guidance, the annual rate report, plan letters, bulletins and guidance memoranda.

5.7.1.6. The Contractor's response to the Request for Solutions.

5.7.2. In the event of any conflict among the documents that are a part of this Contract, the order of priority to interpret the Contract shall be as follows:

5.7.2.1. The Contract terms and conditions, including all appendices;

5.7.2.2. Capitated Financial Alignment Application;

5.7.2.3. DHCS's Bridge to Health Reform Section 1115 waiver as amended for purposes of this demonstration;

5.7.2.4. CFAM-MOU, a document between CMS and DHCS Regarding a federal-State partnership to Test a Capitated Financial Alignment Model for Medicare-Medicaid Enrollees (signed March 27. 2013);

5.7.2.5. The Contractor's Medi-Cal managed care contract;

5.7.2.6. All applicable federal and State regulations and laws, as well as DHCS DPLs, applicable DHCS APLs, CMS guidance, including but not limited to enrollment and marketing guidance, bulletins, and guidance memoranda; and

5.7.2.7. The Contractor's response to the RFS.

5.7.3. In the event of any conflict between this Contract and the MOU, the Contract shall prevail.

5.8. Contract Term.

5.8.1. This Contract shall be in effect starting from the date on which all parties have signed the Contract and shall be effective, unless otherwise terminated, through December 31, 2015. The Contract shall be renewed in one-year terms through December 31, 2022, so long as the Contractor has not provided CMS and the State with a notice of intention not to renew, and CMS/State have not provided the Contractor with a notice of intention not to terminate, pursuant to 42 C.F.R. § 422.506 or Section 5.5 above This contract will terminate, or its effectuation will be delayed, unless the State receives all necessary approvals from CMS, including but not limited to § 1115(a) demonstration authority, and unless the Contractor is deemed ready to participate in the MMCO demonstration, as provided for in Section 2.2.1.3 of this Contract. Funds must not be expended or awarded until the State has received all necessary approvals from CMS. No payments will be made nor Medicaid federal Medical assistance payment (FMAP) funds drawn for any services provided or costs incurred prior to the later of the approval date for any necessary § 1115(a) authority, the Readiness Review approval, or the effective date of this Contract.

5.9. Amendments

5.9.1. The parties agree to negotiate in good faith to cure any omissions, ambiguities, or manifest errors herein. By mutual agreement, the parties may amend this Contract where such amendment does not violate federal or State statutory, regulatory, or waiver provisions,

provided that such amendment is in writing, signed by authorized representatives of all three parties, and attached hereto.

5.10. Written Notices

5.10.1. Notices to the parties as to any matter hereunder will be sufficient if given in writing and sent by certified mail, postage prepaid, or delivered in hand to:

To: Centers for Medicare and Medicaid Services
Medicare-Medicaid Coordination Office
7500 Security Boulevard, S3-13-23
Baltimore, MD 21244

To: California Department of Health Care Services
1501 Capitol Avenue, MS 0000, P.O. Box 997413
Sacramento, CA 95899-7413

To: Orange County Health Authority
505 City Parkway West
Orange, CA 92868

Email Copies to:
Silver Ho sho@caloptima.org

Annie Phillips aphillips@caloptima.org

Gisela Gomez ggomez@caloptima.org

Michael Schrader mschrader@caloptima.org

In Witness Whereof, CMS, DHCS, and the Contractor have caused this Agreement to be executed by their respective authorized officers:

Contractor:

	10/3/19
Paul Yost, Chair, CalOptima Board of Directors	Date

Orange County Health Authority

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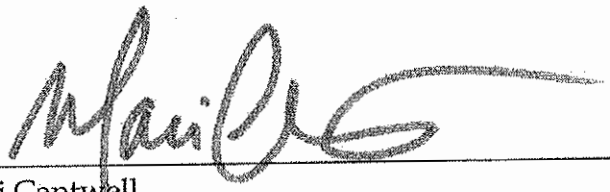
In Witness Whereof, CMS, DHCS, and the Contractor have caused this Agreement to be executed by their respective authorized officers:



Date 9/17/19

Mari Cantwell
Chief Deputy Director
Health Care Programs
State Medicaid Director
California Department of Health Care Services

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In Witness Whereof, CMS, DHCS, and the Contractor have caused this Agreement to be executed by their respective authorized officers:

Trinia J. Hunt

Trinia J. Hunt
Acting Director
Division of Medicaid Field Operations West
Centers for Medicare & Medicaid Services
United States Department of Health and Human Services

9/20/2019
Date

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In Witness Whereof, CMS, DHCS, and the Contractor have caused this Agreement to be executed by their respective authorized officers:

9/16/19
Date

Kathryn A. Coleman
Director
Medicare Drug & Health Plan Contract Administration Group
Centers for Medicare & Medicaid Services
United States Department of Health and Human Services

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SECTION 6: Appendices

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Appendix A: Covered Services

The Contractor shall provide services to Enrollees as follows:

A.1 Medical Necessity. The Contractor shall provide services to Enrollees as follows:

A.1.1 Authorize, arrange, coordinate, and provide to Enrollees all Covered Services that are Medically Necessary as specified in Section 2.4, in accordance with the requirements of the Contract.

A.1.2 Provide all Covered Services that are Medically Necessary, including but not limited to, those Covered Services that:

A.1.2.1. Prevent, diagnose, or treat health impairments;

A.1.2.2. Attain, maintain, or regain functional capacity.

A.1.3 Not arbitrarily deny or reduce the amount, duration, or scope of a required Covered Service solely because of diagnosis, type of illness, or condition of the Enrollee.

A.1.4 Not deny authorization for a Covered Service that the Enrollee or the Provider demonstrates is Medically Necessary.

A.1.5 The Contractor may place appropriate limits on a Covered Service on the basis of Medical Necessity, or for the purpose of utilization management, provided that the furnished services can reasonably be expected to achieve their purpose. The Contractor's Medical Necessity guidelines must, at a minimum, be:

A.1.5.1. Developed with input from practicing physicians in the Cal MediConnect's Service Area;

A.1.5.2. Developed in accordance with standards adopted by national accreditation organizations;

A.1.5.3. Developed in accordance with the definition of Medical Necessity in Section 2.4;

A.1.5.4. Updated at least annually or as new treatments, applications and technologies are adopted as generally accepted professional medical practice;

A.1.5.5. Evidence-based, if practicable; and

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A.1.5.6. Applied in a manner that considers the individual health care needs of the Enrollee.

A.1.6 The Contractor's Medical Necessity guidelines, program specifications and service components must, at a minimum, be submitted to DHCS annually for approval no later than 60 days prior to the start of a new Contract Year, and no later than 60 days prior to any change.

A.1.7 Offer and provide to all Enrollees any and all non-medical programs and services specific to Enrollees for which the Contractor has received CMS and DHCS approval.

A.2 Covered Services. Contractor agrees to provide Enrollees access to the following Covered Services:

A.2.1 All standard Medi-Cal fee-for-service benefits excluding:

A.2.1.1. ICF/MR services;

A.2.1.2. County-administered Medi-Cal Specialty Mental Health Services and substance use disorder services. This does not include Behavioral Health services that become Medi-Cal managed care benefits on January 1, 2014, pursuant to Welfare and Institutions Code Section 14132.03, which will be Covered Services under this contract;

A.2.1.3. State and County activities to administer IHSS, including determining eligibility, assessing, approving, and authorizing each current and new Enrollee's initial and continuing need for services, enrolling providers, conducting provider orientation, and retaining enrollment documentation, conducting criminal background checks on all potential providers, providing assistance to IHSS recipients in finding eligible providers through an established provider registry;

A.2.1.3.1 For dates of service on or before December 31, 2017. IHSS is no longer a Covered Service under this Contract for service dates on or after January 1, 2018, pursuant to Statutes 2017, chapter 52 (S.B. 97);

A.2.1.4. Medi-Cal Dental Services, known as Denti-Cal

A.2.2 All services provided under Medicare Part A

A.2.3 All services provided under Medicare Part B

A.2.4 All services provided under Medicare Part D

A.2.5 Particular pharmacy products that are covered by Medi-Cal and may not be covered under Medicare Part D.

- Contractors are encouraged to offer a broader drug formulary than minimum requirements.

A.3 In addition, Contractor agrees to provide the following:

A.3.1 Vision Benefit

A.3.1.1. $0 copay for one (1) routine eye exam every year

A.3.1.2. Every two years, $100 for eyeglasses (frames and lenses) or up to $100 for contact lenses

A.3.2 Non-Medical Transportation and Non-Emergency Medical Transportation Benefits

A.3.2.1. Contractors must provide transportation services to beneficiaries for Medically Necessary Services.

A.3.2.2. Contractors must provide transportation services pursuant to this Contract, applicable law including but not limited to Welfare & Institutions Code 14132(ad) and the requirements in applicable current and future DPLs.

A.3.3 Care Transitions Assistance provided across facility and community settings. Care Coordination shall be provided for transitions among levels of care and between service locations. Such services facilitate safe and coordinated transitions across care settings, which may be particularly appropriate for Enrollees who have experienced or are expecting an inpatient stay.

A.4 Cost-sharing for Covered Services

A.4.1 Except as described below, cost-sharing of any kind is not permitted in Cal MediConnect.

A.4.1.1. Co-pays charged by Demonstration Plans for Part D drugs must not exceed the applicable amounts for brand and generic drugs established yearly by CMS under the Part D Low Income Subsidy.

A.4.1.2. The Contractor may establish lower cost-sharing for prescription drugs than the maximum allowed.

A.4.1.3. Co-pays charged by Demonstration Plans for supplemental dental benefits.

A.5 Limitations on Covered Services.

A.5.1 – Termination of pregnancy may be provided only as allowed by applicable State and federal law and regulation (42 C.F.R. Part 441, Subpart E).

A.5.2 –Sterilization services may be provided only as allowed by State and federal law (see 42 C.F.R. Part 441, Subpart F).

Appendix B: Enrollee Rights

The Contractor must have written policies regarding the Enrollee rights specified in this appendix, as well as written policies specifying how information about these rights will be disseminated to Enrollees. Enrollees must be notified of these rights and protections at least annually, and in a manner that takes in to consideration cultural considerations, Functional Status and language needs. Enrollee rights include, but are not limited to, those rights and protections provided by 42 C.F.R. § 438.100, 42 C.F.R. §422 Subpart C, and the CFAM-MOU. Specifically, Enrollees must be guaranteed:

A. The right to be treated with dignity and respect.
B. The right to be afforded Privacy and confidentiality in all aspects of care and for all health care information, unless otherwise required by law.
C. The right to be provided a copy of his or her medical records, upon request, and to request corrections or amendments to these records, as specified in 45 C.F.R. part 164.
D. The right not to be discriminated against based on race, ethnicity, national origin, religion, sex, age, sexual orientation, medical or claims history, mental or physical disability, genetic information, or source of payment.
E. The right to have all plan options, rules, and benefits fully explained, including through use of a qualified interpreter if needed.
F. Access to an adequate network of primary and specialty providers who are capable of meeting the Enrollee's needs with respect to physical access, and communication and scheduling needs, and are subject to ongoing assessment of clinical quality including required reporting.
G. The right to choose a plan and provider at any time and have that choice be effective the first calendar day of the following month.
H. The right to participate in all aspects of care and to exercise all rights of Appeal. Enrollees have a responsibility to be fully involved in maintaining their health and making decisions about their health care, including the right to refuse treatment if desired, and must be appropriately informed and supported to this end. Specifically, Enrollees must:
    a. Receive a comprehensive Health Risk Assessment upon date of coverage in a plan and to participate in the development and implementation of an Individualized Care Plan. The assessment must include considerations of social, functional, medical, behavioral, wellness and prevention domains, an evaluation of the Enrollee's strengths and weaknesses, and a plan for managing and coordination of Enrollee's care. Enrollees, or their designated representative, also have the right to request a reassessment by the interdisciplinary team, and be fully involved in any such reassessment.
    b. Receive complete and accurate information on his or her health and

Functional Status by the interdisciplinary team.

c. Be provided information on all program services and health care options, including available treatment options and alternatives, presented in a culturally appropriate manner, taking in to consideration Enrollee's condition and ability to understand. A participant who is unable to participate fully in treatment decisions has the right to designate a representative. This includes the right to have translation services available to make information appropriately accessible. Information must be available:
    i. Before enrollment.
    ii. At enrollment.
    iii. At the time a participant's needs necessitate the disclosure and delivery of such information in order to allow the participant to make an informed choice.
d. Be encouraged to involve caregivers or family members in treatment discussions and decisions.
e. Receive reasonable advance notice, in writing, of any transfer to another treatment setting and the justification for the transfer.
f. Be afforded the opportunity to file an Appeal if services are denied that he or she thinks are medically indicated, and to be able to ultimately take that Appeal to an independent external system of review.

I. The right to receive medical and non-medical care from a team that meets the beneficiary's needs, in a manner that is sensitive to the beneficiary's language and culture, and in an appropriate care setting, including the home and community.
J. The right to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation.
K. Each Enrollee is free to exercise his or her rights and that the exercise of those rights does not adversely affect the way the Contractor and its providers or the DHCS treat the Enrollee.
L. The right to receive timely information about plan changes. This includes the right to request and obtain the information listed in the Orientation materials at least once per year, and, the right to receive notice of any significant change in the information provided in the Orientation materials at least 30 days prior to the intended effective date of the change. See 438.10 for G and H.
M. The right to be protected from liability for payment of any fees that are the obligation of the Contractor.
N. The right not to be charged any cost sharing for Medicare Parts A and B services.
O. The unconditional and exclusive right to hire, fire, and supervise his or her IHSS provider.
P. The right to receive their Medicare and Medi-Cal Appeals rights in a format and language understandable and accessible to them.
Q. The right to opt out of Cal MediConnect at any time, beginning at the first of the

following month.

Appendix C: Relationship with First Tier, Downstream, and Related Entities

A. Contractor shall ensure that any contracts or agreements with First Tier, Downstream and Related Entities performing functions on Contractor's behalf related to the operation of the Medicare-Medicaid plan are in compliance with 42 C.F.R. §§422.504, 423.505, and 438.3(k).

B. Contractor shall specifically ensure:
   1. HHS, the Comptroller General, or their designees have the right to audit, evaluate, and inspect and books, contracts, computer or other electronic systems, including medical records and documentation of the First Tier, Downstream and Related Entities; and
   2. HHS's, the Comptroller General's, or their designees right to inspect, evaluate, and audit any pertinent information for any particular contract period for ten years from the final date of the contract period or from the date of completion of any audit, whichever is later.

C. Contractor shall ensure that all contracts or arrangements with First Tier, Downstream and Related Entities contain the following:
   1. Enrollee protections that include prohibiting providers from holding an Enrollee liable for payment of any fees that are the obligation of the Contractor;
   2. Language that any services or other activity performed by a First Tier, Downstream and Related Entities is in accordance with the Contractor's contractual obligations to CMS and DHCS; including the requirements at 42 C.F.R. § 438.414 in relation to the Grievance system.
   3. Language that specifies the delegated activities and reporting requirements;
   4. Language that provides for revocation of the delegation activities and reporting requirements or specifies other remedies in instances where CMS, DHCS or the Contractor determine that such parties have not performed satisfactorily;
   5. Language that specifies the performance of the parties is monitored by the Contractor on an ongoing basis and the Contractor may impose corrective action as necessary;
   6. Language that specifies the First Tier, Downstream and Related Entities agree to safeguard Enrollee Privacy and confidentiality of Enrollee health records; and
   7. Language that specifies the First Tier, Downstream and Related Entities must comply with all federal and State laws, regulations and CMS instructions.

D. Contractor shall ensure that all contracts or arrangements with First Tier, Downstream and Related Entities that are for credentialing of medical providers contains the following language:
   1. The credentials of medical professionals affiliated with the party or parties will be either reviewed by the Contractor; or
   2. The credentialing process will be reviewed and approved by the Contractor and the Contractor must audit the credentialing process on an ongoing basis.

E. Contractor shall ensure that all contracts or arrangements with First Tier, Downstream and Related Entities that delegate the selection of providers must

include language that the Contractor retains the right to approve, suspend, or terminate any such arrangement.

F. Contractor shall ensure that all contracts or arrangements with First Tier, Downstream and Related Entities shall state that the Contractor shall provide a written statement to a provider of the reason or reasons for termination with cause.

G. Contractor shall ensure that all contracts or arrangements with First Tier, Downstream and Related Entities for medical providers include additional provisions. Such contracts or arrangements must contain the following:

1. Language that the Contractor is obligated to pay contracted medical providers under the terms of the contract between the Contractor and the medical provider. The contract must contain a prompt payment provision, the terms of which are developed and agreed to by both the Contractor and the relevant medical provider;
2. Language that services are provided in a culturally competent manner to all Enrollees, including those with limited English proficiency or reading skills, and diverse culturally and ethnic backgrounds;
3. Language that medical providers abide by all federal and State laws and regulations regarding confidentiality and disclosure of medical records, or other health and enrollment information;
4. Language that medical providers ensure that medical information is released in accordance with applicable federal or State law, or pursuant to court orders or subpoenas;
5. Language that medical providers maintain Enrollee records and information in an accurate and timely manner;
6. Language that medical providers ensure timely access by Enrollees to the records and information that pertain to them; and
7. Language that Enrollees will not be held liable for Medicare Part A and B cost sharing. Specifically, Medicare Parts A and B services must be provided at zero cost-sharing to Enrollees.
8. Language that clearly states the medical providers' EMTALA obligations and must not create any conflicts with hospital actions required to comply with EMTALA.
9. Language prohibiting providers, including, but not limited to PCPs, from closing or otherwise limiting their acceptance of Enrollees as patients unless the same limitations apply to all commercially insured Enrollees.
10. Language that prohibits the Contractor from refusing to contract or pay an otherwise eligible health care provider for the provision of Covered Services solely because such provider has in good faith:
    (a) Communicated with or advocated on behalf of one or more of his or her prospective, current or former patients regarding the provisions, terms or requirements of the Contractor's health benefit plans as they relate to the needs of such provider's patients; or
    (b) Communicated with one or more of his or her prospective, current or former

patients with respect to the method by which such provider is compensated by the Contractor for services provided to the patient.

11. Language that states the provider is not required to indemnify the Contractor for any expenses and liabilities, including, without limitation, judgments, settlements, attorneys' fees, court costs and any associated charges, incurred in connection with any claim or action brought against the Contractor based on the Contractor's management decisions, utilization review provisions or other policies, guidelines or actions.
12. Language that specifies the term of the contract, including the beginning and ending dates as well as methods of extension, renegotiation and termination.
13. Full disclosure of the method and amount of compensation or other consideration to be received from the Contractor.
14. Language that requires the medical provider to assist Contractor in the transfer of care.
15. Language that requires the medical provider to assist Contractor in the transfer of care in the event of sub-subcontract termination for any reason.
16. Notify DHCS in the event the agreement with the 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.
17. Assignment or delegation of the Subcontract will be void unless prior written approval is obtained from DHCS.
18. Timely gather, preserve and provide to DHCS, any records in the subcontractor's possession.
19. Provide interpreter services for Enrollees at all provider sites.
20. Right to submit a Grievance and Contractor's formal process to resolve Provider Grievances.
21. To participate and cooperate in the Contractor's Quality Improvement System.
22. If Contractor delegates Quality Improvement activities, Subcontract shall include provisions as specified by DHCS.

Appendix D: Quality Improvement Requirements

The Contractor will undertake the following quality improvement initiatives with the goal of identifying areas in need of improvement and undertaking quality improvement activities in response to the findings related to each initiative.

1. Emergency Department utilization. The goal of this initiative is to better understand reasons for ED utilization among Cal MediConnect Enrollees, and the impact of LTSS to such usage.
    - Contractor will identify a random sample of Enrollees each year who have utilized ED services. [
    - Contractor will engage an independent quality assurance entity to conduct interviews with each Enrollee in the sample to determine background & causes for ED visits, using a semi-structured interview tool provided by DHCS.
    - Contractor will analyze results of the surveys in order to understand the underlying causes of ED utilization, including the use of and/or or failure of LTSS, or there was a lack of appropriate LTSS to adequately support the Enrollee in his or her environment. Contractor will identify issues within its system of care that require improvement to promote appropriate utilization of both LTSS and emergency department services.
    - Contractor will report results to DHCS and to CMS.

2. Barriers to Health Access. The goal of this initiative is to better understand access issues experienced by Cal MediConnect Enrollees.
    - Contractor will identify a random representative sample size of Enrollees each year.
    - An independent quality assurance entity will conduct interviews with each Enrollee in the sample, using a semi-structured interview tool provided by DHCS, to determine if any barriers to health care were experienced and to understand the nature of those barriers. Examples of barriers include, but are not limited to, the following: inaccessible medical equipment in provider offices, inaccessible signage in provider

offices (i.e. no Braille writing on signs), inaccessible communication from the Cal MediConnect or providers (i.e. no access to ASL interpreters, no written communication in large print or plain language, or no access to someone who can explain information), inadequate access to appropriate physicians for intellectually disabled Enrollees, and incomplete or poor care due to negative attitudes about disability and/or recovery from providers.

Contractor will analyze results of the surveys in order to understand the underlying causes of these barriers to health care access. Contractor will identify issues within its system of care that require improvement to promote access and ADA

3. Other topic areas to be identified through annual guidance by CMS and DHCS in accordance with 42 C.F.R. § 422.152(c) and 422.152(d).

Appendix E: Addendum to Capitated Financial Alignment Contract

PURSUANT TO SECTIONS 1860D-1 THROUGH 1860D-43 OF THE SOCIAL SECURITY ACT FOR THE OPERATION OF A VOLUNTARY MEDICARE PRESCRIPTION DRUG PLAN

The Centers for Medicare & Medicaid Services (hereinafter referred to as "CMS"), the State of California, acting by and through the Department of Health Care Services (DHCS), and Orange County Health Authority, a Medicare-Medicaid managed care organization (hereinafter referred to as Contractor) agree to amend the contract H8016 governing Contractor's operation of a Medicare-Medicaid plan described in § 1851(a)(2)(A) of the Social Security Act (hereinafter referred to as "the Act") to include this addendum under which Contractor shall operate a Voluntary Medicare Prescription Drug Plan pursuant to §§1860D-1 through 1860D-43 (with the exception of §§1860D-22(a) and 1860D-31) of the Act.

Article I

Voluntary Medicare Prescription Drug Plan

A. Contractor agrees to operate one or more Medicare Voluntary Prescription Drug Plans as described in its application and related materials submitted to CMS for Medicare approval, including but not limited to all the attestations contained therein and all supplemental guidance, and in compliance with the provisions of this addendum, which incorporates in its entirety the *2013 Capitated Financial Alignment Application*, released on March 29, 2012 [(hereinafter collectively referred to as "the addendum"). Contractor also agrees to operate in accordance with the regulations at 42 C.F.R. Part 423 (with the exception of Subparts Q, R, and S), §§1860D-1 through 1860D-43 (with the exception of §§1860D-22(a) and 1860D-31) of the Act, and the applicable solicitation identified above, as well as all other applicable federal statutes, regulations, and policies. This addendum is deemed to incorporate any changes that are required by statute to be implemented during the term of this Contract and any regulations or policies implementing or interpreting such statutory or regulatory provisions.

B. CMS agrees to perform its obligations to Contractor consistent with the regulations at 42 C.F.R. Part423 (with the exception of Subparts Q, R, and S), §§1860D-1 through 1860D-43 (with the exception of §§1860D-22(a) and 1860D-31) of the Act, and the applicable solicitation, as well as all other applicable federal statutes, regulations, and policies.

C. CMS agrees that it will not implement, other than at the beginning of a calendar year, regulations under 42 C.F.R. Part 423 that impose new, significant regulatory requirements on Contractor. This provision does not apply to new requirements mandated by statute.

D. This addendum is in no way intended to supersede or modify 42 C.F.R., Parts 417, 422, 423, 431 or 438. Failure to reference a regulatory requirement in this addendum does not affect the applicability of such requirements to Contractor, DHCS, and CMS.

Article II
Functions to be Performed by Contractor

A. ENROLLMENT

1. Contractor agrees to enroll in its Medicare-Medicaid plan only Medicare-Medicaid eligible beneficiaries as they are defined in 42 C.F.R. §423.30(a) and who have elected to enroll in Contractor's Capitated Financial Alignment benefit.

B. PRESCRIPTION DRUG BENEFIT

1. Contractor agrees to provide the required prescription drug coverage as defined under 42 C.F.R. §423.100 and, to the extent applicable, supplemental benefits as defined in 42 C.F.R. §423.100 and in accordance with Subpart C of 42 C.F.R. Part 423. Contractor also agrees to provide Part D benefits as described in Contractor's Part D plan benefit package(s) approved each year by CMS (and in the Attestation of Benefit Plan and Price, attached hereto).

2. Contractor agrees to maintain administrative and management capabilities sufficient for the organization to organize, implement, and control the financial, communication, benefit administration, and quality assurance activities related to the delivery of Part D services as required by 42 C.F.R. §423.505(b)(25).

C. DISSEMINATION OF PLAN INFORMATION

1. Contractor agrees to provide the information required in 42 C.F.R. §423.48.

2. Contractor acknowledges that CMS releases to the public summary reconciled Part D Payment data after the reconciliation of Part D Payments for the Contract year as provided in 42 C.F.R. §423.505(o).

3. Contractor certifies that all materials it submits to CMS under the File and Use Certification authority described in the Medicare Communications and Marketing Guidelines are accurate, truthful, not misleading, and consistent with CMS marketing guidelines.

D. QUALITY ASSURANCE/UTILIZATION MANAGEMENT

1. Contractor agrees to operate quality assurance, drug utilization management, and medication therapy management programs, and to support electronic prescribing in accordance with Subpart D of 42 C.F.R. Part 423.

2. Contractor agrees to address Complaints received by CMS against the Contractor as required in 42 C.F.R. §423.505(b)(22) by:

   (a) Addressing and resolving Complaints in the CMS Complaint tracking system; and

   (b) Displaying a link to the electronic Complaint form on the Medicare.gov Internet Web site on the Part D plan's main Web page.

E. APPEALS AND GRIEVANCES

Contractor agrees to comply with all requirements in Subpart M of 42 C.F.R. Part 423 governing coverage determinations, Grievances and Appeals, and formulary exceptions and the relevant provisions of Subpart U governing reopenings. Contractor acknowledges that these requirements are separate and distinct from the Appeals and Grievances requirements applicable to Contractor through the operation of its Medicare Parts A and B and Medicaid benefits.

F. PAYMENT TO CONTRACTOR

Contractor and CMS and DHCS agree that payment paid for Part D services under the addendum will be governed by the rules in Subpart G of 42 C.F.R. Part 423.

G. PLAN BENEFIT SUBMISSION AND REVIEW

If Contractor intends to participate in the Part D program for the next program year, Contractor agrees to submit the next year's Part D plan benefit package including all required information on benefits and cost-sharing, by the applicable due date, as provided in Subpart F of 42 C.F.R. Part 423 so that CMS, DHCS and Contractor may conduct negotiations regarding the terms and conditions of the proposed benefit plan renewal. Contractor acknowledges that failure to submit a timely plan benefit package under this section may affect the Contractor's ability to offer a plan, pursuant to the provisions of 42 C.F.R. §422.4(c).

H. COORDINATION WITH OTHER PRESCRIPTION DRUG COVERAGE

1. Contractor agrees to comply with the coordination requirements with State Pharmacy Assistance Programs (SPAPs) and plans that provide other prescription drug coverage as described in Subpart J of 42 C.F.R. Part 423.

2. Contractor agrees to comply with Medicare Secondary Payer procedures as stated in 42 C.F.R. §423.462.

I. SERVICE AREA AND PHARMACY ACCESS

1. Contractor agrees to provide Part D benefits in the Service Area for which it has been approved by CMS and DHCS (as defined in Appendix I) to offer Medicare Parts A and B benefits and Medicaid benefits utilizing a pharmacy network and formulary approved by CMS and DHCS that meet the requirements of 42 C.F.R. §423.120.

2. Contractor agrees to provide Part D benefits through out-of-network pharmacies according to 42 C.F.R. §423.124.

3. Contractor agrees to provide benefits by means of point-of-service systems to adjudicate prescription drug claims in a timely and efficient manner in compliance with CMS standards, except when necessary to provide access in underserved areas, I/T/U pharmacies (as defined in 42 C.F.R. §423.100), and long-term care pharmacies (as defined in 42 C.F.R. §423.100) according to 42 C.F.R. §423.505(b)(17).

4. Contractor agrees to contract with any pharmacy that meets Contractor's reasonable and relevant standard terms and conditions according to 42 C.F.R. §423.505(b)(18), including making standard contracts available on request in accordance with the timelines specified in the regulation.

J. EFFECTIVE COMPLIANCE PROGRAM/PROGRAM INTEGRITY

Contractor agrees that it will develop and implement an effective compliance program that applies to its Part D-related operations, consistent with 42 C.F.R. §423.504(b)(4)(vi).

K. LOW-INCOME SUBSIDY

Contractor agrees that it will participate in the administration of subsidies for low-income subsidy eligible individuals according to Subpart P of 42 C.F.R. Part 423.

L. BENEFICIARY FINANCIAL PROTECTIONS

Contractor agrees to afford its Enrollees protection from liability for payment of fees that are the obligation of Contractor in accordance with 42 C.F.R. §423.505(g).

M. RELATIONSHIP WITH FIRST TIER, DOWNSTREAM, AND RELATED ENTITIES

1. Contractor agrees that it maintains ultimate responsibility for adhering to and otherwise fully complying with all terms and conditions of this addendum.

2. Contractor shall ensure that any contracts or agreements with First Tier, Downstream and Related Entities performing functions on Contractor's behalf related to the operation of the Part D benefit are in compliance with 42 C.F.R. §423.505(i).

N. CERTIFICATION OF DATA THAT DETERMINE PAYMENT

Contractor must provide certifications in accordance with 42 C.F.R. §423.505(k).

O. SUBMISSION OF PRESCRIPTION DRUG EVENT DATA

1. Contractor shall submit prescription drug event data in accordance with 42 C.F.R. §423.329(b)(3).

P. CONTRACTOR REIMBURSEMENT TO PHARMACIES

1. If Contractor uses a standard for reimbursement of pharmacies based on the cost of a drug, Contractor will update such standard not less frequently than once every 7 days, beginning with an initial update on January 1 of each year, to accurately reflect the market price of the drug.

2. Contractor will issue, mail, or otherwise transmit payment with respect to all claims submitted by pharmacies (other than pharmacies that dispense drugs by mail order only, or are located in, or contract with, a long-term care facility) within 14 days of receipt of an electronically submitted claim or within 30 days of receipt of a claim submitted otherwise.

3. Contractor must ensure that a pharmacy located in, or having a contract with, a long-term care facility will have not less than 30 days (but not more than 90 days) to submit claims to Contractor for reimbursement.

Article III
Record Retention and Reporting Requirements

A. RECORD MAINTENANCE AND ACCESS

Contractor agrees to maintain records and provide access in accordance with 42 C.F.R. §§ 423.505 (b)(10) and 423.505(i)(2).

B. GENERAL REPORTING REQUIREMENTS

Contractor agrees to submit information to CMS according to 42 C.F.R. §§423.505(f) and 423.514, and the "Final Medicare Part D Reporting Requirements," a document issued by CMS and subject to modification each program year.

C. CMS AND DHCSLICENSE FOR USE OF CONTRACTOR FORMULARY

Contractor agrees to submit to CMS and DHCS the Contractor's formulary information, including any changes to its formularies, and hereby grants to the

Government, and any person or entity who might receive the formulary from the Government, a non-exclusive license to use all or any portion of the formulary for any purpose related to the administration of the Part D program, including without limitation publicly distributing, displaying, publishing or reconfiguration of the information in any medium, including www.medicare.gov, and by any electronic, print or other means of distribution.

Article IV
HIPAA Provisions

A. Contractor agrees to comply with the confidentiality and Enrollee record accuracy requirements specified in 42 C.F.R. §423.136.

B. Contractor agrees to enter into a business associate agreement with the entity with which CMS has contracted to track Medicare beneficiaries' true out-of-pocket costs.

Article V
Addendum Term and Renewal

A. TERM OF ADDENDUM

This addendum is effective from the date of CMS' authorized representative's signature through December 31, 2013. This addendum shall be renewable for successive one-year periods thereafter according to 42 C.F.R. §423.506.

B. QUALIFICATION TO RENEW ADDENDUM

1. In accordance with 42 C.F.R. §423.507, Contractor will be determined qualified to renew this addendum annually only if—

   (a) Contractor has not provided CMS or DHCS with a notice of intention not to renew in accordance with Article VII of this addendum

2. Although Contractor may be determined qualified to renew its addendum under this Article, if Contractor, CMS, and DHCS cannot reach agreement on the Part D plan benefit package under Subpart F of 42 C.F.R. Part 423, no renewal takes place, and the failure to reach agreement is not subject to the Appeals provisions in Subpart N of 42 C.F.R. Parts 422 or 423. (Refer to Article X for consequences of non-renewal on the Capitated Financial Alignment Contract.)

Article VI
Nonrenewal of Addendum By Contractor

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A. Contractor may non-renew this addendum in accordance with 42 C.F.R. 423.507(a).

Article VII
Modification or Termination of Addendum by Mutual Consent

This addendum may be modified or terminated at any time by written mutual consent in accordance with 42 C.F.R. 423.508. (Refer to Article X for consequences of non-renewal on the Capitated Financial Alignment Contract.)

Article VIII
Termination of Addendum by CMS

CMS may terminate this addendum in accordance with 42 C.F.R. 423.509. (Refer to Article X for consequences of non-renewal on the Capitated Financial Alignment Contract.)

Article IX
Termination of Addendum by Contractor

A. Contractor may terminate this addendum only in accordance with 42 C.F.R. 423.510.

B. If the addendum is terminated under section A of this Article, Contractor must ensure the timely transfer of any data or files. (Refer to Article X for consequences of non-renewal on the Capitated Financial Alignment Contract.)

Article X
Relationship between Addendum and Capitated Financial Alignment Contract

A. Contractor acknowledges that, if it is a Capitated Financial Alignment contractor, the termination or nonrenewal of this addendum by any party may require CMS to terminate or non-renew the Contractor's Capitated Financial Alignment Contract in the event that such non-renewal or termination prevents Contractor from meeting the requirements of 42 C.F.R. §422.4(c), in which case the Contractor must provide the notices specified in this contract, as well as the notices specified under Subpart K of 42 C.F.R. Part 422.

B. The termination of this addendum by any party shall not, by itself, relieve the parties from their obligations under the Capitated Financial Alignment Contract to which this document is an addendum.

C. In the event that Contractor's Capitated Financial Alignment Contract is terminated or nonrenewed by any party, the provisions of this addendum shall also terminate.

In such an event, Contractor, DHCS and CMS shall provide notice to Enrollees and the public as described in this Contract as well as 42 C.F.R. Part 422, Subpart K or 42 C.F.R. Part 417, Subpart K, as applicable.

Article XI
Intermediate Sanctions

Consistent with Subpart O of 42 C.F.R. Part 423, Contractor shall be subject to sanctions and civil money penalties.

Article XII
Severability

Severability of the addendum shall be in accordance with 42 C.F.R. §423.504(e).

Article XIII
Miscellaneous

A. DEFINITIONS

Terms not otherwise defined in this addendum shall have the meaning given such terms at 42 C.F.R. Part 423 or, as applicable, 42 C.F.R. Parts 417, 422, 431 or Part 438.

B. ALTERATION TO ORIGINAL ADDENDUM TERMS

Contractor agrees that it has not altered in any way the terms of the Contractor addendum presented for signature by CMS. Contractor agrees that any alterations to the original text Contractor may make to this addendum shall not be binding on the parties.

C. ADDITIONAL CONTRACT TERMS

Contractor agrees to include in this addendum other terms and conditions in accordance with 42 C.F.R. §423.505(j).

D. CMS AND DHCS APPROVAL TO BEGIN MARKETING AND ENROLLMENT ACTIVITIES

Contractor agrees that it must complete CMS operational requirements related to its Part D benefit prior to receiving CMS and DHCS' approval to begin Contractor marketing activities relating to its Part D benefit. Such activities include, but are not limited to, establishing and successfully testing connectivity with CMS and DHCS systems to process enrollment applications (or contracting with an entity qualified to

perform such functions on Contractor's behalf) and successfully demonstrating the capability to submit accurate and timely price comparison data. To establish and successfully test connectivity, Contractor must, 1) establish and test physical connectivity to the CMS data center, 2) acquire user identifications and passwords, 3) receive, store, and maintain data necessary to send and receive transactions to and from CMS, and 4) check and receive transaction status information.

E. Pursuant to §13112 of the American Recovery and Reinvestment Act of 2009 (ARRA), Contractor agrees that as it implements, acquires, or upgrades its health information technology systems, it shall utilize, where available, health information technology systems and products that meet standards and implementation specifications adopted under § 3004 of the Public Health Service Act, as amended by §13101 of the ARRA.

F. Contractor agrees to maintain a fiscally sound operation by at least maintaining a positive net worth (total assets exceed total liabilities) as required in 42 C.F.R. §423.505(b)(23).

Appendix F: Data Use Attestation

The Contractor shall restrict its use and disclosure of Medicare and Medi-Cal data obtained from CMS and DHCS information systems (listed in Attachment A) to those purposes directly related to the administration of the Medicare/Medicaid managed care and/or outpatient prescription drug benefits for which it has contracted with the CMS and DHCS to administer. The Contractor shall only maintain data obtained from CMS and DHCS information systems that are needed to administer the Medicare/Medicaid managed care and/or outpatient prescription drug benefits that it has contracted with CMS and DHCS to administer. The Contractor (or its First Tier, Downstream or other Related Entities) may not re-use or provide other entities access to the CMS information system, or data obtained from the system or DHCS, to support any line of business other than the Medicare/Medicaid managed care and/or outpatient prescription drug benefit for which the Contractor contracted with CMS and DHCS.

The Contractor further attests that it shall limit the use of information it obtains from its Medicare-Medicaid Enrollees to those purposes directly related to the administration of such plan. The Contractor acknowledges two exceptions to this limitation. First, the Contractor may provide its Medicare-Medicaid Enrollees information about non-health related services after obtaining consent. Second, the Contractor may provide information about health-related services without obtaining prior consent, as long as the Contractor affords the Enrollee an opportunity to elect not to receive such information.

CMS may terminate the Contractor's access to the CMS data systems immediately upon determining that the Contractor has used its access to a data system, data obtained from such systems, or data supplied by its Medicare-Medicaid Enrollees beyond the scope for which CMS and DHCS have authorized under this agreement. A termination of this data use agreement may result in CMS or DHCS terminating the Contractor's Medicare-Medicaid contract(s) on the basis that it is no longer qualified as an Integrated Care Organization (Cal MediConnect). This agreement shall remain in effect as long as the Contractor remains a Cal MediConnect sponsor. This agreement excludes any public use files or other publicly available reports or files that CMS or DHCS make available to the general public on their websites.

Attachment A

The following list contains a representative (but not comprehensive) list of CMS information systems to which the Data Use Attestation applies. CMS will update the list periodically as necessary to reflect changes in the agency's information systems

Automated Plan Payment System (APPS)
Common Medicare Environment (CME)
Common Working File (CWF)
Coordination of Benefits Contractor (COBC)
Drug Data Processing System (DDPS)
Electronic Correspondence Referral System (ECRS)
Enrollment Database (EDB)
Financial Accounting and Control System (FACS)
Front End Risk Adjustment System (FERAS)
Health Plan Management System (HPMS), including Complaints Tracking and all other modules
HI Master Record (HIMR)
Individuals Authorized Access to CMS Computer Services (IACS)
Integrated User Interface (IUI)
Medicare Advantage Prescription Drug System (MARx)
Medicare Appeals System (MAS)
Medicare Beneficiary Database (MBD)
Payment Reconciliation System (PRS)
Premium Withholding System (PWS)
Prescription Drug Event Front End System (PDFS)
Retiree Drug System (RDS)
Risk Adjustments Processing Systems (RAPS)

Appendix G: Model File & Use Certification Form

Pursuant to the Contract between the Centers for Medicare & Medicaid Services (CMS), the State of California, acting by and through the Department of Health Care Services (DHCS) and Plan hereafter referred to as the Contractor, governing the operations of the following health plan: Orange County Health Authority, the Contractor hereby certifies that all qualified materials for the Demonstration is accurate, truthful and not misleading. Organizations using File & Use Certification agree to retract and revise any materials (without cost to the government) that are determined by CMS or DHCS to be misleading or inaccurate or that do not follow established Medicare Communications and Marketing Guidelines, Regulations, and sub-regulatory guidance. In addition, organizations may be held accountable for any beneficiary financial loss as a result of mistakes in marketing materials or for misleading information that results in uninformed decision by a beneficiary to elect the plan. Compliance criteria include, without limitation, the requirements in 42 C.F.R. §§422.2260 – 422.2276 and 42 C.F.R. §422.111 for Cal MediConnect and the Medicare Communications and Marketing Guidelines.

I agree that CMS or DHCS may inspect any and all information including those held at the premises of the Contractor to ensure compliance with these requirements. I further agree to notify CMS and DHCS immediately if I become aware of any circumstances that indicate noncompliance with the requirements described above.

I possess the requisite authority to make this certification on behalf of the Contractor.

Appendix H: Medicare Mark License Agreement

THIS AGREEMENT is made and entered into January 1, 2018

by and between

THE CENTERS FOR MEDICARE & MEDICAID SERVICES (hereinafter "Licensor"),
with offices located at 7500 Security Blvd., Baltimore, MD 21244

and

Orange County Health Authority (hereinafter "Licensee"),
with offices located at 505 City Parkway West, Orange, CA 92868.

CMS Contract ID: H8016

WITNESSETH

WHEREAS, Licensor is the owner of the Medicare Prescription Drug Benefit program, a program authorized under Title XVIII, Part D of the Social Security Act (Part D), Mark (the "Mark").

WHEREAS, Licensee desires to use the Mark on Part D marketing materials (including the identification card) beginning September 1, 2019.

WHEREAS, both parties, in consideration of the premises and promises contained herein and other good and valuable consideration which the parties agree is sufficient, and each intending to be legally bound thereby, the parties agree as follows:

1. Subject to the terms and conditions of this Agreement, Licensor hereby grants to Licensee a non-exclusive right to use the Mark in their Part D marketing materials.
2. Licensee acknowledges Licensor's exclusive right, title, and interest in and to the Mark and will not, at any time, do or cause to be done any act or thing contesting or in any way impairing or tending to impair any part of such right, title, and interest. Licensee acknowledges that the sole right granted under this Agreement with respect to the Mark is for the purposes described herein, and for no other purpose whatsoever.
3. Licensor retains the right to use the Mark in the manner or style it has done so prior to this Agreement and in any other lawful manner.
4. This Agreement and any rights hereunder are not assignable by Licensee and any attempt at assignment by Licensee shall be null and void.
5. Licensor, or its authorized representative, has the right, at all reasonable times, to inspect any material on which the Mark is to be used, in order that Licensor may satisfy itself that the material on which the Mark appears meets with the standards, specifications, and instructions submitted or approved by Licensor. Licensee shall use the Mark without modification and in accordance with the Mark usage policies described within the Medicare Communications and Marketing Guidelines. Licensee shall not take any action inconsistent with the Licensor's ownership of the Mark, and any goodwill accruing from use of such Mark shall automatically vest in Licensor.
6. This agreement shall be effective on the date of signature by the Licensee's authorized representative through December 31, 2019, concurrent with the execution of the Part D addendum to the three way contract. This Agreement may be terminated by either party upon written notice at any time. Licensee agrees, upon written notice from Licensor, to discontinue any use of the Mark immediately. Starting December 31, 2019, this agreement shall be renewable for

successive one-year periods running concurrently with the term of the Licensee's Part D contract. This agreement shall terminate, without written notice, upon the effective date of termination or non-renewal of the Licensee's Part D contract (or Part D addendum to a Capitated Financial Alignment Demonstration contract).

7. Licensee shall indemnify, defend and hold harmless Licensor from and against all liability, demands, claims, suits, losses, damages, infringement of proprietary rights, causes of action, fines, or judgments (including costs, attorneys' and witnesses' fees, and expenses incident thereto), arising out of Licensee's use of the Mark.
8. Licensor will not be liable to Licensee for indirect, special, punitive, or consequential damages (or any loss of revenue, profits, or data) arising in connection with this Agreement even if Licensor has been advised of the possibility of such damages.
9. This Agreement is the entire agreement between the parties with respect to the subject matter hereto.
10. Federal law shall govern this Agreement.

Appendix I: Service Area

The Service Area outlined below is contingent upon the Contractor meeting all Readiness Review requirements in each county. CMS and DHCS reserve the right to amend Appendix I to revise the Service Area based on final Readiness Review results or subsequent determinations made by CMS and DHCS.

County Service Area:

Orange

Appendix J: Eligible Populations

Enrollment into Cal MediConnect will be available to individuals who meet all of the following criteria:

- Age 21 and older at the time of enrollment;
- Entitled to, or enrolled for, benefits under Part A of title XVIII of the Social Security Act, or enrolled for benefits under Part B of title XVIII of such Act, and is eligible for medical assistance under a State plan under title XIX of such Act or under a waiver of such plan;
- Eligible for full Medicaid (Medi-Cal), including
    - Individuals enrolled in the Multipurpose Senior Services Program (MSSP).
    - Individuals who meet the share of cost provisions described below:
        - Nursing facility residents with a share of cost,
        - MSSP Enrollees with a share of cost, and
        - IHSS recipients with a share of cost.
    - Individuals eligible for full Medicaid (Medi-Cal) per the spousal impoverishment rule codified at section 1924 of the Social Security Act as described below:
        - For those Enrollees who are nursing facility level of care, subacute facility level of care, or intermediate care facility level of care and reside or could reside outside of a hospital or nursing facility, the Department or its designee shall make a Medi-Cal eligibility determination "as if" the beneficiary were in a long-term care facility. Specifically, the spousal impoverishment rule codified section 1924 of the Act will apply to Enrollees. The terms "intermediate care facility level of care" and "nursing facility level of care" and "subacute facility level of care" shall have the same meaning as defined in Title 22 of the California Code of Regulations sections 51120, 51124, and 52224.5.
- Reside in one of the following Demonstration counties: Los Angeles, Orange, Riverside, San Bernardino, San Diego, San Mateo, and Santa Clara.
    - Up to 200,000 individuals in Los Angeles may be enrolled in the Demonstration. CMS and the State will monitor the enrollment and stop participation when this enrollment cap is met.
- Individuals residing in San Mateo or Orange county with a diagnosis of end stage renal disease (ESRD) at the time of enrollment.

The following populations will be excluded from enrollment:

- Individuals under age 21;
- Individuals with other private or public health insurance;
- Individuals receiving services through California's regional centers or State developmental centers or intermediate care facilities for the developmentally

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disabled in Los Angeles, Orange, Riverside, San Bernardino, San Diego, and Santa Clara counties;

- Individuals with a share of cost that do not meet the requirements outlined above;
- Individuals residing in one of the Veterans' Homes of California;
- Individuals living in the following rural zip codes:
    - San Bernardino County – 92242, 92267, 92280, 92323, 92332, 92363, 92364, 92366, 93562, 92280, 93592, and 93558
    - Los Angeles County - 90704
    - Riverside County - 92225, 92226, 92239;
- Individuals with a diagnosis of end stage renal disease (ESRD) at the time of enrollment and residing in Los Angeles, Riverside, San Bernardino, San Diego, and Santa Clara, unless they are already enrolled in a separate line of business operated by the Contractor. Individuals enrolled in the Demonstration who are subsequently diagnosed with ESRD, as with all Enrollees, may choose to disenroll from the Demonstration or may choose to stay enrolled.

Individuals that may enroll but may not be passively enrolled include (see section C.2 for a description of Passive Enrollment):

- Individuals residing in the following rural zip codes in San Bernardino County in which only one Cal MediConnect Plan operates: 92252, 92256, 92268, 92277, 92278, 92284, 92285, 92286, 92304, 92305, 92309, 92310, 92311, 92312, 92314, 92315, 92317, 92321, 92322, 92325, 92326, 92327, 92333, 92338, 92339, 92341, 92342, 92347, 92352, 92356, 92365, 92368, 92372, 92378, 92382, 92385, 92386, 92391, 92397, and 92398;
- Individuals enrolled in Medicare Advantage in 2014;
- Individuals in one of the following programs may enroll only after they have disenrolled from the program:
    - Individuals enrolled in the following 1915(c) waivers: Nursing Facility/Acute hospital Waiver, HIV/AIDS Waiver, Assisted Living Waiver, and In Home Operations Waiver; and
    - Individuals enrolled in Program of All-Inclusive Care for the Elderly (PACE) or the AIDS Healthcare Foundation.

Appendix K: Disputes

Contractor also agrees to the following:

1. This Disputes section will be used by the Contractor as the means of seeking resolution of disputes on contractual issues. It shall not be used with respect to any dispute regarding the actuarial soundness of the capitated rate, as provided in paragraph 4.6.2. Filing a dispute will not preclude DHCS and CMS from recouping the value of the amount in dispute from the Contractor or from offsetting this amount from subsequent capitation payment(s). If the amount to be recouped exceeds twenty-five (25) percent of the capitation payment, amounts of up to twenty-five (25) percent will be withheld from successive capitation payments until the amount in dispute is fully recouped.
2. Disputes Resolution by Negotiation
    a. DHCS, CMS and Contractor agree to try to resolve all contractual issues by negotiation and mutual agreement at the Contract Management Team (CMT) without litigation. The parties recognize that the implementation of this policy depends on open-mindedness, and the need for both sides to present adequate supporting information on matters in question.
3. Notification of Dispute
    a. Within fifteen (15) calendar days of the date the dispute concerning performance of this Contract arises or otherwise becomes known to the Contractor, the Contractor will notify the CMT in writing of the dispute, describing the conduct (including actions, inactions, and written or oral communications) which it is disputing.
    b. The Contractor's notification will state, on the basis of the most accurate information then available to the Contractor, the following:
        i. That it is a dispute pursuant to this section.
        ii. The date, nature, and circumstances of the conduct which is subject of the dispute.
        iii. The names, phone numbers, function, and activity of each Contractor, subcontractor, DHCS/State official or CMS employee involved in or knowledgeable about the conduct.
        iv. The identification of any documents and the substances of any oral communications involved in the conduct. Copies of all identified documents will be attached.
        v. The reason the Contractor is disputing the conduct.
        vi. The cost impact to the Contractor directly attributable to the alleged conduct, if any.
        vii. The Contractor's desired remedy.

c. The required documentation, including cost impact data, will be carefully prepared and submitted with substantiating documentation by the Contractor. This documentation will serve as the basis for any subsequent Appeal.

d. Following submission of the required notification, with supporting documentation, the Contractor will comply with the requirements of Title 22 CCR Section 53851(d) and diligently continue performance of this Contract, including matters identified in the Notification of Dispute, to the maximum extent possible.

4. CMT or Alternate Dispute Officer's Decision

a. Pursuant to a request by Contractor, the CMT may provide for a dispute to be decided by an alternate dispute officer designated by DHCS and CMS, who is not a member of the CMT and is not directly involved in Medicare or the Medi-Cal Managed Care Program, as appropriate for the issue involved. Any disputes concerning performance of this Contract shall be decided by the CMT or the alternate dispute officer in a written decision stating the factual basis for the decision. Within thirty (30) calendar days of receipt of a Notification of Dispute, the CMT or the alternate dispute officer, shall either:

i. Find in favor of Contractor, in which case the CMT or alternate dispute officer may:

A. Countermand the earlier conduct which caused Contractor to file a dispute; or

ii. Or,

A. Deny Contractor's dispute and, where necessary, direct the manner of future performance; or

B. Request additional substantiating documentation in the event the information in Contractor's notification is inadequate to permit a decision to be made under 1) or 2) above, and shall advise Contractor as to what additional information is required, and establish how that information shall be furnished. Contractor shall have 30 calendar days to respond to the CMT or alternate dispute officer's request for further information. Upon receipt of this additional requested information, the CMT or alternate dispute officer shall have 30 calendar days to respond with a decision. Failure to supply additional information required by the CMT or alternate dispute officer within the time period specified above shall constitute waiver by Contractor of all claims in accordance with Paragraph F. Waiver of Claims, below. A copy of the decision shall be served on Contractor.

5. Appeal of CMT or Alternate Dispute Officer's Decision

a. Contractor shall have thirty (30) calendar days following the receipt of the decision to file an Appeal of the decision to the Director and the Medicare Drug & Health Plan Contract Administration Group Director, Center for Medicare. All Appeals

shall be governed by Health and Safety Code Section 100171, except for those provisions of Section 100171(d)(1) relating to accusations, statements of issues, statement to respondent, and notice of defense. All Appeals shall be in writing and shall be filed with DHCS' Office of Administrative Hearings and Appeals. An Appeal shall be deemed filed on the date it is received by the Office of Administrative Hearings and Appeals. An Appeal shall specifically set forth each issue in dispute, and include Contractor's contentions as to those issues. However, Contractor's Appeal shall be limited to those issues raised in its Notification of Dispute filed pursuant to Paragraph B. Notification of Dispute above. Failure to timely Appeal the decision shall constitute a waiver by Contractor of all claims arising out of that conduct, in accordance with Paragraph 7, Waiver of Claims below, Contractor shall exhaust all procedures provided for in this Appendix K, Disputes, prior to initiating any other action to enforce this Contract.

6. Contractor Duty to Perform

    a. Pending final determination of any dispute hereunder, Contractor shall comply with the requirements of Title 22 CCR Section 53851(d) and proceed diligently with the performance of this Contract and in accordance with the CMT or alternate dispute officer's decision. If pursuant to an Appeal under Paragraph 5, Appeal of CMT or Alternate Dispute Officer's Decision above, the CMT or alternate dispute officer's decision is reversed, the effect of the decision pursuant to Paragraph 5. shall be retroactive to the date of the CMT or alternate dispute officer's decision, and Contractor shall promptly receive any benefits of such decision. CMS and DHCS shall not pay interest on any amounts paid pursuant to a CMT or alternate dispute officer's decision or any Appeal of such decision, or any subsequent court decision or court order regarding the subject matter of the Notification of Dispute.

7. Waiver of Claims

    a. If Contractor fails to submit a Notification of Dispute, supporting and substantiating documentation, any additionally required information, or an Appeal of the CMT or alternate dispute officer's decision, in the manner and within the time specified in this Appendix K, Disputes, that failure shall constitute a waiver by Contractor of all claims arising out of that conduct, whether direct or consequential in nature.

Appendix L: Additional Medicare Waivers

In addition to the waivers granted for the Cal MediConnect demonstration in the MOU, CMS hereby waives Section 1860-D1 of the Social Security Act, as implemented in 42 C.F.R. § 423.38(c)((4)(i), and extend Sections 1851(a), (c), (e), and (g) of the Social Security Act, as implemented in 42 C.F.R. Part 422, Subpart B only insofar as such provisions are inconsistent with allowing dually eligible beneficiaries to change enrollment on a monthly basis.

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,

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.

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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.

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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

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- 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

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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

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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

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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.

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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

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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

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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.

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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.

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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.

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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.

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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.

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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.

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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

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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;

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- 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.

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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.

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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

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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.

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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.

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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;

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- 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.

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- 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.

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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

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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.

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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

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- 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

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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;

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- 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.

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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.

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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.

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- 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

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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

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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

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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

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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

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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

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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.

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- 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

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- 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

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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:

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- **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.

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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.

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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.

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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

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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

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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

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- 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

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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.

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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.

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- 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.

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- **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.

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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

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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

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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

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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,

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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.

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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.

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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.

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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.

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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

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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.

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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.

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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

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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

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- 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.

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- **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.

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- **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

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  - 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

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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

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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

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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:

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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

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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.

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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

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- **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

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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:

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- 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.**

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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.

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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:**

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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

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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

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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;

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- 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.

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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

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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

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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

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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*

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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

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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,

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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

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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;

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- 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;

o 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.

o 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

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(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.

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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):

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- 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

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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:

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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:

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(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

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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

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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

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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.

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- 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:

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- 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.

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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

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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.

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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

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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

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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.

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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

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- 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.

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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.

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- 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

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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

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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;

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- 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

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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

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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;

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        - 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 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.

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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.

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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:

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- 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

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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

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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

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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.

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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.

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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

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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;

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        - 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

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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

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- 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.

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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

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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

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- 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.

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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

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- 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.

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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

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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.

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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.

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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

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- 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.

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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.

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- 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.

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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

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- 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

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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.

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- 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

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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.

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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

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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

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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.

AMENDMENT # TO
PROFESSIONAL SERVICES CONTRACT

THIS AMENDMENT # TO THE PROFESSIONAL SERVICES CONTRACT ("Amendment #") shall become effective on January 1, 2023 by and between Orange County Health Authority, a Public Agency, dba CalOptima ("CalOptima"), and _____ ("Professional"), with respect to the following facts:

RECITALS

A. CalOptima and Professional entered into a Professional Services Contract, by which Professional has agreed to provide or arrange for the provision of Covered Services to Members.

B. CalOptima and Professional desire to amend this Contract on the terms and conditions set forth herein.

NOW, THEREFORE, the parties agree as follows:

1. Recital E shall be added to the Contract as follows and subsequent Recitals will be renumbered:

"E. CalOptima has entered into a contract with the Department of Health and Human Services ("HHS"), Centers for Medicare and Medicaid Services ("CMS"), (CMS Contract") to operate a Medicare Advantage ("MA") plan and to offer Medicare covered items and services to eligible individuals (referred to herein as the "OneCare Program". CalOptima may only enroll those dual eligible individuals who meet all applicable Medicare Advantage eligibility requirements, and who are eligible to be enrolled in CalOptima's Medi-Cal Managed Care plan, as described in the contract between CalOptima and DHCS.

2. Article 1, Section 1.2, "Addendums" shall be deleted in its entirety and replaced with the following:

"1.2 Addendums

1.2.1 The Addendums are terms and conditions that apply specifically to items and services provided to Members under the CalOptima Programs as follows:

1.2.1.1 Addendum 1: Medi-Cal Program Requirements
1.2.1.2 Addendum 2: PACE Program Requirements
1.2.1.3 Addendum 3: Medicare Advantage Program Requirements
1.2.1.4 Addendum 4: Certification Regarding Lobbying"

3. Article 2, Section 2.14 "CalOptima Programs(s)" shall be deleted and replaced with the following:

"2.14 "CalOptima Programs(s)" means the Medi-Cal, PACE, and Medicare Advantage Programs administered by CalOptima. Professional participates in the specific CalOptima program(s) identified on Attachment A."

4. Article 3, Section 3.1.4 shall be deleted and replaced with the following:

"3.1.4 Only Practitioners who CalOptima has determined meet applicable CalOptima credentialing criteria may be listed as contracted. This Contract may be amended for the addition or deletion of Practitioners credentialed by CalOptima upon Professional giving CalOptima written notice of such addition or deletion at least

forty five (45) days prior to the effective date of such addition or deletion. Professional shall provide an updated list of its Practitioners as needed or upon request from CalOptima."

5. Attachment A, Section 1.1 shall be deleted and replaced with the following:

"1.1 CalOptima Program. Professional shall furnish Covered Services to eligible Members in the following CalOptima Programs:

_____ Medi-Cal Program (CalOptima Community Network and CalOptima Direct-Administrative)

_____ PACE Program

_____ Medicare Advantage Program (CalOptima Community Network)"

6. Attachment B, "Compensation" shall be deleted in its entirety and replaced with "Attachment B-Amendment {# } - Compensation".

7. Addendum 3, "Cal MediConnect Program Requirements" shall be deleted in its entirety and replaced with Addendum 3, "Medicare Advantage Program Requirements" attached herewith.

8. CONTRACT REMAINS IN FULL FORCE AND EFFECT – Except as specifically amended by this Amendment, all other conditions contained in the Contract as previously amended shall continue in full force and effect.

IN WITNESS WHEREOF, CalOptima and _____ have executed this Amendment.

FOR PROFESSIONAL:	FOR CALOPTIMA:
_____	_____
SIGNATURE	SIGNATURE
_____	Ladan Khamseh
PRINT NAME	PRINT NAME
_____	Interim Chief Operating Officer
TITLE	TITLE
_____	_____
DATE	DATE

ATTACHMENT B – Amendment I

COMPENSATION

CalOptima shall reimburse Professional and Professional shall accept as payment in full from CalOptima, the lesser of billed charges or the following amounts:

I. MEDI-CAL PROGRAM

A. Primary Care Services

For Covered Services provided to Assigned COD-Administrative and Community Network Members, or as otherwise noted below, CalOptima shall reimburse Professional, and Professional shall accept as payment in full from CalOptima, the lesser of:

1. Billed charges, or

    1.1. **XX%** of the **Current CalOptima Medi-Cal Fee Schedule** on a fee-for-service basis for **primary care**, as defined in CalOptima Policies.

    1.2. **XX%** of the **Current CalOptima Medi-Cal Fee Schedule** on a fee-for-service basis for **non professional services**, as defined in CalOptima Policies.

2. Services with Unestablished Fees. If a fee has not been established by Medi-Cal for a particular procedure, and CalOptima has provided authorization for Professional to provide such service, CalOptima shall reimburse Professional under the following guidelines:

    2.1. "By Report & Unlisted" codes that CalOptima has provided authorization for Professional to provide such service will be paid according to Medi-Cal billing and payment guidelines.

    2.2. Professional shall utilize current payment codes and modifiers for Med-Cal.

    2.3. CPT or HCPC codes not contained in the Medi-Cal fee schedule at the time of service are not reimbursable.

    2.4. If the billed charges are determined to be unallowable, in excess of usual and customary charges, or inappropriate pursuant to a medical review by CalOptima, CalOptima will contact Professional for additional justification and these will be handled on a case-by-case basis.

3. Supplemental Pay-for-Performance Payment. CalOptima may authorize supplemental payments to PCP yearly or quarterly based on PCP's quality performance and achievement of specified program goals which are determined by CalOptima. The amount of supplemental compensation may be a certain percentage of Community Network's annual fee-for-service payments made to the PCP. CalOptima shall not pay PCP any supplemental payments if this Contract is terminated.

B. Specialist Services

For Covered Services provided to referred Community Network Members in accordance with CalOptima referral Policies, and as to COD Administrative Members as noted below, CalOptima shall reimburse Professional, and Professional shall accept as payment in full from CalOptima, the lesser of:

1. Billed charges, or

1.1. **Specialist Professional** services shall be paid at **XX%** of the **Current CalOptima Medi-Cal Fee Schedule** on a fee-for-service basis for, as defined in the CalOptima Policies.

1.2. **Non Professional** services shall be paid at **XX%** of the **Current CalOptima Medi-Cal Fee Schedule** on a fee-for-service basis, as defined in the CalOptima Policies.

1.3. For **Professional services** provided by a qualifying **CCS paneled Specialist Professional** to a Community Network or COD-Administrative Member less than 21 years of age, CalOptima shall pay Professional **XX%** of the **Current Medi-Cal Fee Schedule**, as defined in CalOptima Policy, for services for which CalOptima is financially responsible. **Non Professional** services shall be paid at **XX%** of the **Current Medi-Cal Fee Schedule** on a fee-for-service basis, as defined in the CalOptima Policies.

1.4. For Specialist Physician Services provided to an **Adult Expansion Member** in accordance with CalOptima Policies, and as noted below, CalOptima shall reimburse Professional, and Professional shall accept as payment in full from CalOptima, the lesser of billed charges, or

CPT Code Range	Type of Service	Fee Schedule
10000-69999	**Surgical Range**	**XX% of Medi-Cal**
70000-79999	**Radiology and Radiation Therapy Professional and Technical Components**	**XX% of Medi-Cal**
80000-89999	**Lab and Pathology**	**XX% of Medi-Cal**
90000-99999	**Professional Services**	**XX% of Medi-Cal**
HCPC Codes		**XX% of Medi-Cal**

1.4.1. Rates for Adult Expansion Members may be different than those included herein as determined by DHCS. Should DHCS make a change in future payments to CalOptima, CalOptima will adjust payments made to Professional.

2. Professional shall not be paid for services provided to **Community Network Members** if Member is not referred by a Participating PCP to Professional in accordance with CalOptima referral Policies, except with regard to Emergency Services and CHDP Services, as provided in this Contract. This shall be effective upon the implementation of the Community Network program. Professional will be advised by CalOptima on the implementation date of the Community Network program.

3. Services with Unestablished Fees. If a fee has not been established by Medi-Cal for a particular procedure, and CalOptima has provided authorization for Professional to provide such service, CalOptima shall reimburse Professional under the following guidelines:

3.1. "By Report & Unlisted" codes that CalOptima has provided authorization for Professional to provide such service will be paid according to Medi-Cal billing and payment guidelines.

3.2. Professional shall utilize current payment codes and modifiers for Med-Cal.

3.3. CPT or HCPC codes not contained in the Medi-Cal fee schedule at the time of service are not reimbursable.

3.4. If the billed charges are determined to be unallowable, in excess of usual and customary charges, or inappropriate pursuant to a medical review by CalOptima, CalOptima will contact Professional for additional justification and these will be handled on a case-by-case basis.

II. PACE PROGRAM

1. For Covered Services provided to PACE Members, CalOptima shall reimburse Professional, and Professional shall accept as payment in full from CalOptima, the lesser of billed charges or **{xxxxx}** percent **(XX%)** of the Current CalOptima Medicare Allowable Participating Provider Fee Schedule for locality 26.

2. Prior authorization rules apply for payment of services.

3. Medicare billing rules and payment Policies and guidelines for billing and payment will apply.

4. Services with Unestablished Fees. If a fee has not been established by Medicare for a particular procedure, and CalOptima has provided authorization for Professional to provide such service, CalOptima shall reimburse Professional under the following guidelines:

   4.1 "By Report & Unlisted" codes that CalOptima has provided authorization for Professional to provide such service will be paid according to Medicare billing and payment guidelines.

   4.2 Professional shall utilize current payment codes and modifiers for Medicare.

   4.3 CPT or HCPC codes not contained in the Medicare fee schedule at the time of service are not reimbursable.

   4.4 If the billed charges are determined to be unallowable, in excess of usual and customary charges, or inappropriate pursuant to a medical review by CalOptima, CalOptima will contact Professional for additional justification and these will be handled on a case-by-case basis.

5. Should Medicare consider a service as non-covered, then Medi-Cal guidelines shall be applied. Provider may need to resubmit claim in accordance with Medi-Cal codes, billing rules, Policies, and guidelines for reimbursement.

III. MEDICARE ADVANTAGE

1. For Covered Services provided to Medicare Advantage Member, CalOptima shall reimburse Professional, and Professional shall accept as payment in full from CalOptima, the lesser of billed charges, or **{xxxxx}** percent **(XX%)** of the Current CalOptima Medicare Allowable Participating Provider Fee Schedule for locality 26.

2. Prior authorization rules apply for payment of services.

3. Medicare billing rules and payment Policies and guidelines for billing and payment will apply.

4. Services with Unestablished Fees. If a fee has not been established by Medicare for a particular procedure, and CalOptima has provided authorization for Professional to provide such service, CalOptima shall reimburse Professional under the following guidelines:

   4.1 "By Report & Unlisted" codes that CalOptima has provided authorization for Professional to provide such services will be paid in accordance to Medicare billing and payment guidelines .

   4.2 Professional shall utilize current payment codes and modifiers for Medicare.

   4.3 CPT or HCPCS codes not contained in the Medicare fee schedule at the time of service are not reimbursable.

   4.4 Should Medicare consider a service as non-covered, then Medi-Cal guidelines and reimbursement shall be applied in accordance with the guidelines identified in this contract. Professional may need to resubmit claim in accordance with Medi-Cal codes, billing rules, Policies, and guidelines for reimbursement.

   4.5 If the billed charges are determined to be unallowable, in excess of usual and customary charges, or inappropriate pursuant to a medical review by CalOptima, CalOptima will contact Professional for additional justification and these will be handled on a case-by-case basis.

IV. PAYMENT PROCEDURES

1. CalOptima agrees to grant Professional access to Member management information systems. Professional agrees to verify each Member's eligibility to receive Covered Services on the date of service. In addition, for PCP services, Professional must verify that CalOptima has not assigned Member receiving Covered Services from Professional to a Provider other than Professional prior to providing such services.

2. Billing and Claims Submission. Professional shall submit Claims for Covered Services in accordance with CalOptima Policies applicable to the Claims submission process.

3. Prompt Payment. CalOptima shall make payments to Professional in the time and manner set forth in CalOptima Policies and Procedures.

4. Claim Completion and Accuracy. Professional shall be responsible for the completion and accuracy of all Claims submitted, whether on paper forms or electronically, including claims submitted for the Professional by other parties. Use of a billing agent does not abrogate Professional's responsibility for the truth and accuracy of the submitted information. A Claim may not be submitted before the delivery of service. Professional acknowledges that Professional remains responsible for all Claims and that anyone who misrepresents, falsifies, or causes to be misrepresented or falsified, any records or other information relating to that Claim may be subject to legal action.

5. Claims Deficiencies. Any Claim that fails to meet CalOptima requirements for claims processing shall be denied and Professional notified of denial pursuant to CalOptima Policies and applicable

Federal and/or State laws and regulations.

6. Coordination of Benefits (COB). Professional shall coordinate benefits with other programs or entitlements recognizing where Other Health Coverage (OHC) is primary coverage in accordance with CalOptima Program requirements. Professional acknowledges that Medi-Cal is the payor of last resort.

7. Crossover Claims – Dual Eligible Members. "Crossover Claims" are claims for Dual Eligible Members where Medi-Cal is the secondary payer and Medicare or other health care coverage (OHC) is the Primary payor for dates of service during which the Dual Eligible Member was not assigned to one of CalOptima's Programs. California law limits Medi-Cal's reimbursement for a crossover claim to an amount that, when combined with the Medicare payment, should not exceed Medi-Cal's maximum allowed for similar services (Refer to Welfare and Institutions Code, Section 14109.5.)

   "Dual Eligible Members" are members who are eligible for both Medicare or other health care coverage (OHC) and Medi-Cal benefits.

   The Medi-Cal reimbursement rates in this contract will not apply to Crossover Claims for Dual Eligible Members. For Crossover Claims payment CalOptima will reimburse in accordance with CalOptima Policies, and state and federal regulations.

8. Member Financial Protections. Professional shall comply with Member financial protections as follows:

   8.1 Professional agrees to indemnify and hold Members harmless from all efforts to seek compensation and any claims for compensation from Members for Covered Services under this Contract. In no event shall a Member be liable to Professional for any amounts which are owed by, or are the obligation of, CalOptima.

   8.2 Professional agrees to hold Member harmless and not liable for Medicare Part A and B cost sharing when the State is responsible for paying such amounts. Professional agrees that Members will not be held liable for Medicare Part A and B cost sharing when the State is responsible for paying such amounts and that the provider will (A) accept the plan payment as payment in full, or (B) bill the appropriate State source as required at 42 CFR §422.504(g)(1)(iii). Professional will:

      1) accept the plan payment as payment in full, or

      2) bill the appropriate State source.

   8.3 In no event, including, but not limited to, non-payment by CalOptima, CalOptima's or the Professional's insolvency, or breach of this contract by CalOptima, shall the Professional, or any of its Practitioners, bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against the State of California or any Member or person acting on behalf of a Member for Covered Services pursuant to this Contract. Notwithstanding the foregoing, Professional may collect SOC, co-payments, and deductibles if, and to the extent, required under a specific CalOptima Program and applicable law.

   8.4 This provision does not prohibit Professional from billing and collecting payment for non-Covered Services if the CalOptima Member agrees to the payment in writing prior to the actual delivery of non-Covered Services and a copy of such agreement is given to the Member and placed in the Member's medical record prior to rendering such services.

   8.5 Upon receiving notice of Professional invoicing or balance billing a Member for the

difference between the Professional's billed charges and the reimbursement paid by CalOptima for any Covered Services, CalOptima may sanction the Professional or take other action as provided in this Contract.

This section shall survive the termination of this Contract for Covered Services furnished to CalOptima Members prior to the termination of this Contract, regardless of the cause giving rise to termination, and shall be construed to be for the benefit of Members. This section shall supersede any oral or written contrary agreement now existing or hereafter entered into between Professional and its Practitioners. Language to ensure the foregoing shall be included by Professional in all of Professional's Subcontracts.

ADDENDUM 3
MEDICARE ADVANTAGE PROGRAM REQUIREMENTS

The following additional terms and conditions apply to items and services furnished to Members under the CalOptima Medicare Advantage Program (OneCare):

1. Record Retention. Professional and it Subcontractors agree to retain books, records, contracts, computer or other electronic systems information, medical records, and documents related to this Contract and/or CMS Contract for at least ten (10) years from the final date of the CMS Contract period, or the date of completion of any audit, whichever is later, unless a longer period is required by law.

2. Right of Inspection, Evaluation, Audit of Records. Professional and its Subcontractors agree:

   2.1 To maintain and make available contracts, books, computer or other electronic systems, medical records, documents, and records related to this Contract and/or CMS Contract to CalOptima, DMHC, HHS, the Comptroller General, the U.S. General Accounting Office ("GAO"), any Quality Improvement Organization ("QIO") or accrediting organizations, including NCQA, and other representatives of regulatory agency or accrediting organizations or their designees to inspect, evaluate, collect, and audit for ten (10) years from the final date of the CMS Contract period or from the date of completion of any audit, whichever is later.

   2.2 For purposes of utilization management, quality improvement and other CalOptima administrative purposes, CalOptima and officials referred to in Section 2.1 of this Addendum 5, shall have access to, and copies of, at reasonable time upon request, the medical records, books, charts, and papers relating to the Professional's provision of health care services to Members, the cost of such services, and payments received by Professional from Members (or from others on their behalf). Medical records shall be provided at no charge to Members or CalOptima.

   2.3 For records subject to review under Section 2.1 of this Addendum 5 by HHS, the Comptroller General, or their designees, CMS will, except in exceptional circumstances, provide notification to CalOptima that a direct request for information has been initiated.

3. Accountability Acknowledgement. Professional further agrees and acknowledges that CalOptima oversees and is accountable to CMS for functions or responsibilities described in MA regulations; that CalOptima may only delegate activities or functions in a manner consistent with the MA program delegation requirements; and that any services or other activities performed by Professional pursuant to the Contract relative to the OneCare Program are consistent and comply with CalOptima's contractual obligations under the CMS Contract and adhere to delegation requirements set forth by MA statutes, regulations and/or other guidance. Where delegated responsibilities are identified in this Contract, the following shall apply:

   (a) Delegation by CalOptima. To the extent that responsibilities are delegated to Professional under this Contract, Professional warrants that it meets CalOptima delegation criteria set forth in the Attachment to this Contract and agrees to accept delegated responsibility for those listed activities. Professional agrees to perform the delegated activities in a manner consistent with the delegation criteria. Professional agrees to notify CalOptima of any change in its eligibility under the delegation criteria within twenty-four (24) hours from the date it fails to meet such delegation criteria. Professional

acknowledges that delegation to another entity does not alter Professional's ultimate obligations and responsibilities set forth in this Contract. Professional acknowledges and agrees that CalOptima retains final authority and responsibility for activities delegated under this Contract. Activities not expressly delegated herein by CalOptima or for which delegation is terminated are the responsibility of CalOptima.

(b) Reports on Delegated Activities. Professional agrees to provide CalOptima with periodic reports on delegated activities performed by Professional as provided in the delegation criteria. The report shall be in a form and contain such information as shall be agreed upon between the parties. Professional agrees to take those corrective actions identified by CalOptima through the audit review process.

(c) CalOptima Oversight of Delegation. The delegation of the functions and responsibilities stated herein does not relieve CalOptima of any of its accountability to CMS and obligations to its Members under applicable law. CalOptima is authorized to perform and remains liable for the performance of such obligations, notwithstanding any delegation of some or all of those obligations by Professional, which will be monitored by CalOptima on an ongoing basis. In the event Professional breaches its obligation to perform any delegated duties, CalOptima shall have all remedies set forth in this Contract, including, but not limited to, penalties or termination of the delegation of such functions to Professional as set forth in this Contract. Moreover, CalOptima shall have the right to require Professional to terminate any Subcontracting Professional for good cause, including but not limited to breach of its obligations to perform any delegated duties.

(d) Review of Credentials. Professional shall ensure that the credentials of medical professionals affiliated with the Professional are reviewed by it. Professional agrees that CalOptima will review and approve Professional's credentialing process on ongoing basis.

4. COB Requirements.

(a) MSP Obligations. Professional agrees to comply with MSP requirements. Professional shall coordinate with CalOptima for proper determination of COB and to bill and collect from other payers and third party liens such charges for which the other payer is responsible. Professional agrees to establish procedures to effectively identify, at the time of service and as part of their claims payment procedures, individuals and services for which there may be a financially responsible party other than MA Program. Professional will bill and collect from other payers such amounts for Covered Services for which the other payer is responsible.

(b) Professional Authority to Bill Third Party Payers. Professional may bill other individuals or entities for Covered Services for which Medicare is not the primary payer, as specified herein. If a Medicare Member receives from Professional Covered Services that are also covered under State or Federal workers' compensation, any no-fault insurance, or any liability insurance policy or plan, including a self-insured plan, Professional may bill any of the following— (1) the insurance carrier, the employer, or any other entity that is liable for payment for the services under section 1862(b) of the Act and 42 C.F.R. part 411 or (2) the Medicare enrollee, to the extent that he or she has been paid by the carrier, employer, or entity for covered medical expenses.

5. Reporting Requirements. Professional shall comply with CalOptima's reporting requirements in order that it may meet the requirements set forth in MA laws and regulations for submitting

encounter and other data including, without limitation, 42 CFR § 422.516. Professional also agrees to furnish medical records that may be required to obtain any additional information or corroborate the encounter data.

6. Submission and Prompt Payment of Claims. Professional agrees to submit claims to CalOptima in such format as CalOptima may require (but at minimum the CMS forms 1500, UB 04 or other form as appropriate) within ninety (90) days after the services are rendered. CalOptima reserves the right to deny claims that are not submitted within ninety (90) days of the date of service, except where Professional bills a third party payor as primary. Professional agrees to refrain from duplicate billing any claims submitted to CalOptima, unless expressly approved by CalOptima in order to process coordination of benefit claims. CalOptima shall provide payment to Professional within forty-five (45) business days of CalOptima's receipt of a clean and uncontested claim from Professional, or, CalOptima will contest or deny Professional's claim within forty-five (45) business days following CalOptima's receipt thereof.

7. In addition to Section 2.26 of this Contract, Professional and its Subcontractors shall ensure that payments are not made to individuals or entities included on the Preclusion List.

8. Additional Subcontractor Requirements. If any Covered Services relative to the OneCare Program under this Contract are to be provided by a Subcontractor on behalf of Professional, Professional shall ensure that such subcontracts are in writing and include the following:

8.1 An agreement to comply with the HHS and the Comptroller General, or their designees' right to directly audit, evaluate, collect, and inspect Subcontractors books, contracts, computer or other electronic systems, including medical records and documentation related to CMS' OneCare contract with CalOptima, for any particular contract period for ten (10) years from the final date of the contract period or from the date of completion of any audit, whichever is later.

8.2 For records subject to review under Section 8.1 of this Addendum 5, except in exceptional circumstances, CMS will provide notification to CalOptima that a direct request for information has been initiated.

8.3 An agreement to Member financial protections in accordance with Section 4.6 of the Contract, including prohibiting Subcontractors from holding a Member liable for payment of any fees that are the legal obligation of Professional.

8.4 An agreement to provide for continuation of health care benefits for the duration of the contract period for which CMS payments have been made; and for Members who are hospitalized on the date its contract with Professional terminates, or, in the event of Professional's insolvency, through the date of discharge.

8.5 An agreement that CalOptima may only delegate activities or functions to a Subcontractor in a manner consistent with requirements set forth in Section 8.7 of this Addendum 5.

8.6 An agreement to ensure that delegated activities or functions are consistent with CalOptima's OneCare contract requirements set forth by CMS.

8.7 If any of CalOptima's activities or responsibilities under this Contract are delegated to a Subcontractor, the following requirements apply and such subcontract must specify:

8.7.1 the delegated activities and reporting responsibilities.

8.7.2 either a provision for revocation of the delegation activities and reporting requirements or specify other remedies in instances where CMS or CalOptima determine that such parties have not performed satisfactorily.

8.7.3 that performance of the parties is monitored by CalOptima on an ongoing basis.

8.7.4 that the credentials of medical professionals affiliated with Subcontractor will be either reviewed by CalOptima; or the credentialing process will be reviewed and approved by CalOptima, and CalOptima must audit the credentialing process on an ongoing basis.

8.7.5 an agreement to comply with all applicable Medicare laws, regulations and CMS instructions.

8.8 If CalOptima delegates selection of Professionals, contractors, or subcontractors to Professional or Subcontractor, CalOptima retains the right to approve, suspend, or terminate such arrangement

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken June 2, 2022
Regular Meeting of the CalOptima Board of Directors

Report Item

22. Approve Amendment to Ancillary Services Contract to Extend Coverage of Temporary Alternative Services for Community-Based Adult Services

Contact

Yunkyung Kim, Chief Operating Officer 714-246-8408

Recommended Action

Approve amendment to Ancillary Services Contract to extend reimbursement for in-home Community-Based Adult Services (CBAS) through December 31, 2022.

Background and Discussion

Staff requests authorization to amend the Ancillary Services Contract for CBAS to reflect continued coverage of Temporary Alternative Services (TAS) by CalOptima following discontinuation of coverage by the California Department of Health Care Services (DHCS) on June 30, 2022. The amendment extends TAS coverage through December 31, 2022.

At the onset of the COVID-19 pandemic, in-person visits to CBAS centers were markedly decreased following the Governor's executive stay at home orders and social distancing requirements. In March 2020, DHCS obtained approval for waivers of certain member requirements related to the CBAS benefit and issued guidance to Managed Care Plans (MCP) for the provision of TAS. TAS are a means of providing CBAS services that remove barriers to access resulting from COVID-19 restrictions. In accordance with TAS authorization, CalOptima implemented several measures for its members, including waiver of the four-hour minimum required stay at the CBAS facility, as well as expanded types of services qualifying for reimbursement, including telephonic and live video visits, meal delivery, and in-home physical and occupational therapy. These measures were operationalized on March 13, 2020, via a contract amendment approved by the CalOptima Board of Directors (Board).

Per the most recent State guidance, flexibility of regulatory requirements for CBAS services and reimbursement for TAS will end on June 30, 2022. CalOptima is conducting the transition of its members back to CBAS centers between April 1, 2022, and December 31, 2022. The process will be gradual, returning members in a phased-in manner so as to not overwhelm the CBAS provider network. Preserving flexibility of the CBAS program requirements and extending TAS until the end of 2022 will enable staff to conduct this transition without compromising access to CBAS services. Staff therefore requests authorization to amend the Ancillary Services Contract for CBAS to extend coverage of TAS until December 31, 2022, ensuring continuous member access to CBAS services during this transition. In the event CalOptima reimburses contracted CBAS centers for TAS beyond the DHCS end date, those payments may be disallowed in future rate development submissions to DHCS.

Fiscal Impact

The recommended action is a budgeted item as part of professional medical costs under the proposed CalOptima Fiscal Year (FY) 2022-23 Operating Budget.

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Rationale for Recommendation
Continuation of additional provider payments will help ensure providers continue to remain accessible to members.

Concurrence
Troy R. Szabo, Outside General Counsel, Kennaday Leavitt

Attachments
1. Entities Covered by this Recommended Board Action
2. Previous Board Action dated April 2, 2020: "Consider Actions Related to Coronavirus (COVID-19) Pandemic"
3. Amendment to Ancillary Services Contract (CBAS) for extended coverage of Temporary Alternative Services (Proposed)

/s/ Michael Hunn — *05/27/2022*
Authorized Signature — **Date**

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ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
ABC Westminster Day Health Center	202 Hospital Circle	Westminster	CA	92683
Alzheimer's Family Services Center	9451 Indianapolis Ave.	Huntington Beach	CA	92646
Anaheim VIP Adult Day Health Care	1158 North Knollwood Circle	Anaheim	CA	92801
Commonwealth Adult Day Health Care Center	7811 Commonwealth Ave.	Buena Park	CA	90621
Cypress Adult Day Health Care Center	4470 Lincoln Ave., Units 1, 2, 3	Cypress	CA	90630
El Toro Adult Day Services	24300 El Toro Rd. Bldg. A	Laguna Woods	CA	92637
Emerald Health Services, Inc	17520 Castleton St., #103	City of Industry	CA	91748
Evergreen World ADHC	9856 Westminster Ave.	Garden Grove	CA	92844
GetTogether Adult Day Health Care	16636 South Crenshaw Blvd.	Torrance	CA	90504
Happy (Brea) Adult Day Health Care	595 W. Lambert #101	Brea	CA	92821
Helping Hands for Better Living, Inc.	10281 Chapman Ave.	Garden Grove	CA	92840
HMS ADHCC	740 E. Washington Blvd.	Pasadena	CA	91104
Home Avenue Adult Day Health Care	8114 Telegraph Road	Downey	CA	90240
Irvine Adult Day Health Services, Inc.	20 Lake Road	Irvine	CA	92604
Joy ADHC	11832 E. Rosecrans Ave., #137	Norwalk	CA	90650
Joyful Adult Day Health Care	18951 Colima Rd.	Rowland Heights	CA	91748
Laguna Adult Day Health Center	23551 Moulton Pkwy.	Laguna Hills	CA	92653
La Puente Adult Day Health Care	656 Glendora Ave.	La Puente	CA	91744
New Life Adult Health Care Center	12220 South St.	Artesia	CA	90701
North County Senior Services, LLC	2515 McCabe Way	Irvine	CA	92614
Regent West Adult Day Health Care Center	8341 Garden Grove Blvd.	Garden Grove	CA	92844
Rehabilitation Institute of Southern California	130 Laguna Road	Fullerton	CA	92835
Rehabilitation Institute of Southern California	1800 East La Veta Ave.	Orange	CA	92866
Santa Ana/Tustin VIP Adult Day Health Care	1101 South Grand Ave., Suite L	Santa Ana	CA	92705
Sarang Adult Day Health Care	5171 Lincoln Ave.	Cypress	CA	90630
Smile Adult Day Health Care, Inc.	12220 South Street	Artesia	CA	90701
South County Adult Day Services	24300 El Toro Road, Bldg. A, #200	Laguna Woods	CA	92637
Southern California Health Cares	13000 San Antonio Drive, Room 6	Norwalk	CA	90650
Spring Adult Day Health Care, Inc.	18555 Farjardo St.	Rowland Heights	CA	91748
St. Christopher Adult Day Health Care Center	4180 Green River Rd.	Corona	CA	92880
Well and Fit Adult Day Health Care, Inc.	820 N. Diamond Bar Blvd.	Diamond Bar	CA	91765
Whittier Adult Day Health Care Center, Inc.	14268 E. Telegraph Road	Whittier	CA	90604

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken April 2, 2020
Regular Meeting of the CalOptima Board of Directors

Report Item
4. Consider Actions Related to Coronavirus (COVID-19) Pandemic

Contact
Nancy Huang, Chief Financial Officer (714) 246-8400
Michelle Laughlin, Executive Director Network Operations (714) 246-8400

Recommended Actions
1. Authorize Health Network Medi-Cal capitation rate increases for contracted Physician Hospital Consortia (PHC), Shared Risk Group (SRG), and Health Maintenance Organizations (HMO) by 5% from current levels for the period of April 1, 2020, through June 30, 2020;

2. Authorize waiver of the minimum stay requirement and expand types of services eligible for per diem payments for contracted Community-Based Adult Services (CBAS) providers for Medi-Cal and OneCare Connect;

3. Authorize unbudgeted expenditures from existing reserves of up to $14 million to provide funding for rates adjustments for Health Network capitation rates;

~~4. Authorize interim Medi-Cal rate for coronavirus testing for dates of service on or after February 4, 2020;~~ Amended 4/2/20

5. Authorize the Chief Executive Officer (CEO), with the assistance of Legal Counsel, to:

    a. Amend the Medi-Cal PHC, SRG, and HMO Health Network contracts to implement the 5% capitation rate increase; and
    b. Amend Medi-Cal and OneCare Connect contracts with CBAS providers effective March 13, 2020 to provide flexibility for services, in accordance with the Department of Health Care Services' (DHCS) section 1135 Waiver application.

Background
On January 31, 2020, the Secretary of Health and Human Services declared a public health emergency under section 319, of the Public Health Service Act (42 U.S.C. 247d) in response to a novel coronavirus known as SARS-CoV-2 (coronavirus). On March 13, 2020, the President of the United States declared a national emergency based on the spread of this coronavirus. Along with federal, state, and local agencies, CalOptima is taking action to continue efforts to protect the health and safety of our providers and members.

As an unprecedented safety measure, the state has issued self-quarantine and social distancing requirements for an unknown period of time. These requirements have and continue to affect CalOptima's provider networks as the coronavirus pandemic develops. One immediate downstream effect of these measures has been CBAS closures as a result of a reduction of in-person utilization. Left

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unaddressed, this can rapidly jeopardize the viability of CalOptima's CBAS provider network. Moreover, it underscores the need for CalOptima to take necessary measures to ensure there is limited disruption of care and access to services for our members, which includes vulnerable individuals.

Discussion

CalOptima management recognizes that healthcare service delivery to our members has undergone significant changes during the coronavirus pandemic. Management recommends the following actions in order to provide immediate aid and service authorization flexibilities to CalOptima's provider network in order to ensure that members received access to covered, medically necessary health care services:

Medi-Cal Rate Enhancement for Health Networks

To provide immediate aid and support and maintain the viability of the health networks, Management proposes to:

1. Provide a 5% increase from current levels to contracted PHC, SRG and HMO Medi-Cal capitation rates for the period of April 1, 2020, through June 30, 2020. The estimated aggregate monthly fiscal impact is approximately $4.4 million.

2. Amend the Medi-Cal Health Network contracts to reflect this increase for the period stated above.

Special Reimbursement to CBAS providers

Staff anticipates face-to-face visits at CBAS centers to continue decreasing due to the Governor's stay at home executive order issued on March 19, 2020, and the County of Orange's social distancing requirements. CalOptima currently holds contracts with 31 CBAS centers, serving approximately 2,580 members. Preventing this is critical at this time, as CBAS centers serve CalOptima's most vulnerable senior members On March 19, 2020, the California Department of Health Care Services (DHCS) submitted a request for additional Section 1135 Waiver flexibilities related to coronavirus. This request included additional flexibilities related to the CBAS benefit and individual plan of care. In order to continue uninterrupted access to CBAS services, effective March 13, 2020, Management proposes to:

1. Waive the 1115 waiver requirement of a minimum of a four-hour stay at the center. This change will enable CalOptima members to receive appropriate services at home and remove barriers to access.

2. Expand the types of services eligible for per diem payments. Pursuant to DHCS' 1135 Waiver request, CalOptima will provide per diem payments to CBAS providers who provide:
   - Telephonic or live video interactions in lieu of face-to-face social/therapeutic visits and/or assessments;
   - Arrange for home delivered meals in absence of meals provided at the CBAS center; and/or
   - Provide physical therapy or occupational therapy in the home

3. Amend CBAS contracts to reflect the waiver of the minimum four-hour stay requirement and expansion of services pursuant to DHCS 1135 Waiver request.

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~~Interim Medi-Cal Rate for Coronavirus Testing~~

~~The Centers for Medicare & Medicaid Services (CMS) established, for the Medicare program, procedure codes and provider reimbursement rates for coronavirus testing conducted on or after February 4, 2020. DHCS adopted these same procedure codes for the Medi-Cal program effective February 4, 2020. As of this writing, DHCS has not established Medi-Cal reimbursement rates for coronavirus testing.~~ Amended 4/2/20

~~Management proposes to adopt the Medicare provider reimbursement rates on an interim basis for CalOptima's Medi-Cal program for dates of service on or after February 4, 2020. Once DHCS establishes Medi-Cal reimbursement rates for coronavirus testing, CalOptima will make retroactive adjustments to Medi-Cal claims, as appropriate.~~ Amended 4/2/20

Fiscal Impact

The total funds for the Health Network Medi-Cal capitation rates for contracted PHCs, SRGs and HMOs will not exceed 5% of total medical capitation expenditures, in aggregate, in the CalOptima Fiscal Year (FY) 2019-20 Operating Budget. Staff projects the monthly incremental funding at approximately $4.4 million. An allocation of up to $14 million from existing reserves will fund this action.

The CalOptima FY 2019-20 Operating Budget includes funding for Professional medical expenditures for contracted CBAS providers. Currently, the net fiscal impact for the recommended action is unknown. However, assuming current utilization levels will continue, Staff anticipates the recommended action will not have an additional fiscal impact to the operating budget.

~~The fiscal impact for the recommended action to authorize an interim Medi-Cal rate for coronavirus testing is unknown at this time, since both utilization and costs estimates are difficult to quantify. However, Staff anticipates future funding received from DHCS for this purpose will fully offset expenses incurred by CalOptima.~~ Amended 4/2/20

Rationale for Recommendation

Providing additional provider payments during the coronavirus pandemic will ensure providers remain viable and accessible to our members, as well as increased financial security for the Orange County safety net system.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. DHCS Request for Additional Section 1135 Waiver Flexibilities Related to Novel Coronavirus Disease (COVID-19) National Emergency/Public Health Emergency dated March 19, 2020

/s/ Michael Schrader — **Authorized Signature**

03/26/2020 — **Date**

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State of California—Health and Human Services Agency
Department of Health Care Services

BRADLEY P. GILBERT, MD, MPP
DIRECTOR

GAVIN NEWSOM
GOVERNOR

March 19, 2020

Jackie Glaze
CMS Acting Director
Medicaid & CHIP Operations Group Center for Medicaid & CHIP
Services 7500 Security Boulevard
Baltimore, MD 21244
Jackie.Glaze@cms.hhs.gov

REQUEST FOR ADDITIONAL SECTION 1135 WAIVER FLEXIBILITIES RELATED TO NOVEL CORONAVIRUS DISEASE (COVID-19) NATIONAL EMERGENCY/PUBLIC HEALTH EMERGENCY

Dear Ms. Glaze:

The Department of Health Care Services (DHCS) writes to request approval for the below-detailed additional flexibilities under Section 1135 of the Social Security Act (42 U.S.C. § 1320b-5) as related to the Novel Coronavirus Disease (COVID-19). These flexibilities are in addition to the request submitted from DHCS on March 16, 2020. As you know, the COVID-19 outbreak was declared a national emergency on March 13, 2020, and was previously declared a nationwide public health emergency on January 31, 2020 (retroactive to January 27, 2020).

The below list represents California's additional requested flexibilities under the Section 1135 authority in connection with the COVID-19 outbreak and emergency based on further exploration of need. Because circumstances surrounding the COVID-19 emergency remain quite fluid, DHCS may subsequently request approval for additional flexibilities, which we can commit to doing promptly as soon as the need is discovered. Consistent with Section 1 of the President's March 13, 2020, national emergency declaration, DHCS requests a retroactive effective date of January 27, 2020, for the requested Section 1135 flexibilities to coincide with the effective start date of the Public Health Emergency, unless otherwise specified. In the event a requested flexibility below is not approvable under the Section 1135 authority, DHCS requests CMS technical assistance to identify any other authority (e.g. under the State Plan or Section 1115) for which approval may be available. Per our discussion with CMS on March 19, 2020, DHCS will request the flexibilities associated with Inmate and Institutions for Mental Disease (IMD) funding exclusions in the Section 1115 context (according to the forthcoming CMS instructions/Section 1115 template).

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In addition, DHCS requests confirmation that any approved flexibility granted with respect to fee-for-service Medi-Cal benefits and providers would apply equally, to the extent applicable, to our various federally approved delivery systems, such as Medi-Cal managed care plans (MCPs), county organized health systems, county mental health plans, and Drug Medi-Cal organized delivery systems (DMC-ODS) and to the State's standalone Children's Health Insurance Program.

1. **Service authorization and utilization controls**, including but not necessarily limited to:

- Waiver of Attachment 3.1 – A.1, page 2 of the State Plan, exclusion of adult receipt of acetaminophen-containing and cough/cold products.

- For individuals with developmental disabilities receiving services under the State Plan 1915(i) authority, the state requests retainer payments. Retainer payments are available only for absences (maximum 30 consecutive days) in excess of the average number of absences experienced by the provider during the 12 month period prior to 2020.

- For Community-Based Adult Services (CBAS) – CBAS Benefit and Individual Plan of Care (IPC), the state requests:
    - Flexibility to reduce day center activities/gatherings and limit exposure to vulnerable populations.
    - Flexibility to utilize telephonic or live video interactions in lieu of face-to-face social/therapeutic visits.
    - Flexibility to utilize telephonic or live video interactions in lieu of face-to-face assessments.
    - Flexibility to allow following services to be provided at a beneficiary's home:
        - Physical Therapy
        - Occupational Therapy
    - Flexibility to provide or arrange for home delivered meals in absence of meals provided at the CBAS Center.
    - Flexibility for DHCS and MCPs to provide per diem payments to CBAS providers who provide telephonic or live video interactions in lieu of face-to-face social/therapeutic visits and/or assessments, arrange for home delivered meals in absence of meals provided at the CBAS Center, and/or provide physical therapy or occupational therapy in the home.

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2. **Eligibility Flexibilities**, including but not necessarily limited to:

    - Flexibility in the hospital presumptive eligibility (HPE) program to cover more than one HPE period in a given 12-month timeframe. To the extent a beneficiary seeks care for coronavirus but has already used an HPE period in the last 12 months, or tests negative and then seeks care for a suspected episode later in the same 12-month period, HPE can provide a fast, low-barrier way to provide immediate, temporary coverage during the emergency period.

3. **Telehealth/Telephonic/Virtual Visits**, including but not necessarily limited to:

    - Waiver of 42 C.F.R. §438.6(c)(1), as necessary, to permit the State to direct MCO and PIHP payments to network providers, where telehealth/telephonic service is medically appropriate and feasible, at the same rate the MCO or PIHP would pay if the service was provided in person, unless the MCO/PIHP and the provider otherwise agree to a different rate for the telehealth modality.

    - Similar to flexibility granted at the federal level, DHCS requests authority for the State not to impose penalties for noncompliance with the regulatory requirements under the Health Insurance Portability and Accountability Act (HIPAA) against covered health care providers in connection with the good faith provision of telehealth during the COVID-19 emergency.

4. **Administrative Activities**, regarding deadlines and timetables for performance of required activities, DHCS requests extension of time for activities conducted by the state, MCPs, and/or county mental health and substance use disorder prepaid inpatient health plans (PIHPs), as applicable, due to social distancing to reduce the spread of COVID-19 and to allow the state, MCP, and/or PIHP resources to prioritize COVID-19 response efforts including:

    - Waiver of the two-year claiming submission limit (42 USC §1320b-2; 45 CFR §95.1, et seq.) for federal financial participation or claiming adjustments with respect to medical assistance and administrative expenditures.

    - Waiver of the requirement in 42 CFR §447.45(d)(1), that DHCS require providers to submit all claims no later than 12 months from the date of service. DHCS is requesting authority to extend the 12-month timeframe for services provided with dates of service during this emergency.

    - Modification of the federal deadlines for submission of cost reports for Medicare and Medicaid (currently due Nov. 2020) by at least 6 months, with no late penalties, so that providers have time to file the appropriate documents. Many provider and hospital staff have been told to work remotely or have been reassigned to

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emergency response activities, which will cause delays in meeting reporting timelines.

- Waiver of the timeframe required for financial oversight and medical compliance audits for PIHPs and State Plan Drug Medi-Cal counties. DHCS requests this waiver to allow flexibility regarding deploying staff resources to manage the emergency.

5. **Payment Rates**, including but not necessarily limited to:

- Waiver of the county interim rate setting methodology described beginning on page 10 of the Certified Public Expenditure (CPE) protocol approved through the 1915(b) waiver. The CPE protocol requires DHCS to calculate county interim rates using prior year cost reports trended forward using the Home Health Agency Market Basket Index or a CMS approved cost of living index. As utilization drops and costs increase during this emergency, DHCS is requesting authority to use alternative methodologies, at DHCS's discretion, to temporarily increase county interim rates.

- Waiver of the interim rate setting methodology described on page 5 and 6 of the Drug Medi-Cal Organized Delivery System (DMC ODS) Certified Public Expenditure protocol approved through the 1115 demonstration. The CPE protocol requires DHCS to reimburse DMC ODS counties on an interim basis pursuant to county developed and DHCS approved interim rates for each service, which are expected to be based upon the most recently calculated or estimated county costs for the specific service. DHCS is requesting authority, if counties reimburse DMC providers up to actual cost, to reimburse counties the federal and state share of their certified public expenditures for services rendered during this emergency.

- Waiver of the Statewide Maximum Allowance (SMA) rate limitation on interim reimbursement and final settlement for Drug Medi-Cal (DMC) services provided in state plan counties. California's State Plan describes the reimbursement methodology for DMC services in Attachment 4.19-B, pages 38-41b (SPA 09-022 and SPA 15-013), which limits interim payments to DMC providers to the lower of the SMA or the USDR (Section E.1, page 41). Furthermore, the Medicaid State Plan also limits final reimbursement to lower of actual cost, usual and customary charges, or the SMA for DMC providers. DHCS is requesting authority to waive the SMA and usual and customary charge limitations on interim and final reimbursement for DMC state plan services.

6. **Clarification of Previous Requests**:

- Item 2 in the March 16, 2020 1135 Waiver requested to waive various federal and State Plan requirements pertaining to service authorization and utilization controls

imposed on covered benefits. DHCS seeks to clarify that the requested waivers would extend to any limitations for elective procedures and informed consent (including, but not necessarily limited, to 42 C.F.R. § 441.253) to enable provider to postpone elective procedures to prioritize COVID-19 response activities. DHCS suggests extending the current 180-day limit for beneficiary informed consent to 360 days.

- Item 5 in the March 16, 2020 1135 Waiver requested to waive restrictions existing restrictions on individual counseling sessions under the Drug Medi-Cal state plan. DHCS wants to clarify that we are requesting to waive Supplement 3 to Attachment 3.1-B, to allow individual visits in lieu of group visits, and that these visits may be conducted by telephone, telehealth, and/or in-person. Waive the current restriction on individual visits (only allowed for intake, crisis intervention, collateral services, and treatment and discharge planning). Allow individual visits to be used for counseling focused on short-term personal, family, job/school and other problems and their relationship to substance use. This waiver is needed so the services previously provided in groups can be done in individual sessions during the emergency, to prevent COVID-19 exposure.

- Item 6 in the March 16, 2020 1135 Waiver requested to waive State Plan Attachment 4.19-D, including any applicable Supplements, which establishes the payment methodology for Intermediate Care Facilities for the Developmentally Disabled (ICF-DD) and skilled nursing facilities (SNFs). The state wanted to clarify that the waiver being requested would apply to all SNF and ICF-DD facility types and the reimbursement flexibilities would not be limited solely to the costs associated with suspension of Day Programs. SNFs and ICF-DDs are experiencing increased cost pressures in a variety of areas as a result of the COVID-19 response and the state is seeking flexibility to allow consideration of all costs being incurred by facilities to ensure the health and safety of residents.

7. Flexibilities to be Requested under Section 1115 Authority (according to forthcoming CMS guidance):

- Waiver of the inmate exclusion (42 U.S.C. §1396d(a)(30)(A)) to allow for Medi-Cal claiming for services provided ***in*** jails and prisons for the testing, diagnosis and treatment of COVID-19 or services to ensure other care is provided in a safe way without transporting individuals to acute care facilities.

- Waiver of the 16-bed limitation/prohibition on receipt of federal financial participation for patients residing in Institutions for Mental Disease (IMD) pursuant to 42 U.S.C. §1396d(a)(30)(B). DHCS believes waiver of the IMD exclusion is necessary to temporarily increase bed capacity for affected beneficiaries and to allow facilities to claim for services provided for these

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additional beds. Evaluation of less restritictive settings would be completed prior to placement.

During such difficult times for California and the nation, DHCS greatly appreciates the prompt attention exhibited by CMS to these matters and we look forward to the continued partnership.

Sincerely,
Original Signed By:

Jacey Cooper
Chief Deputy Director
Health Care Programs
State Medicaid Director

cc: Bradley P. Gilbert, MD, MPP
Director
Department of Health Care Services

Erika Sperbeck
Chief Deputy Director
Policy & Program Support
Department of Health Care

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AMENDMENT ___

ANCILLARY SERVICES CONTRACT

THIS AMENDMENT ___ TO THE ANCILLARY SERVICES CONTRACT ("Amendment") is effective as of ____ between CalOptima, the county organized health system for the County of Orange, California ("CalOptima"), and _____, ("Provider"), with respect to the following facts:

RECITALS

A. CalOptima and Provider entered into an Ancillary Services Contract ("Contract"), by which Provider has agreed to provide or arrange for the provision of Covered Services to members.

B. CalOptima and Provider Amended the Contract on March 13, 2020, to provide a mechanism by which Community-Based Adult Services ("CBAS") would be provided to members remaining at home during COVID-19 emergency. On June 30, 2022, the Department of Health Care Services ("DHCS") ended the waiver and funding for in-home, telephonic, and virtual video CBAS.

C. CalOptima desires to amend the Contract so that CalOptima can reimburse Provider for in-home, telephonic, and virtual video CBAS through December 31, 2022.

NOW, THEREFORE, the parties agree to the following amendment to the Contract:

1. Attachment C-1 "FLEXIBILITY OF SERVICES – COVID-19 PUBLIC HEALTH EMERGENCY COMPENSATION" shall be added to the Contract and is attached hereto.

2. CONTRACT REMAINS IN FULL FORCE AND EFFECT- Except as specifically amended by this Amendment, all other conditions contained in the Contract shall continue in full force and effect. After the effective date of this Amendment, any reference to the Contract shall mean the Contract as amended and supplemented by this Amendment. Notwithstanding anything to the contrary in the Contract, in the event of a conflict between the terms and conditions of this Amendment and those contained within the Contract, the terms and conditions of this Amendment shall prevail. Capitalized terms not otherwise defined in this Amendment shall have the meanings ascribed to them in the Contract.

IN WITNESS WHEREOF, parties have executed this Amendment.

FOR PROVIDER:	FOR CALOPTIMA:
_____	_____
SIGNATURE	SIGNATURE
_____	Yunkyung Kim
PRINT NAME	PRINT NAME
_____	Chief Operating Officer
TITLE	TITLE
_____	_____
DATE	DATE

ATTACHMENT C-1

FLEXIBILITY OF SERVICES – COVID-19 PUBLIC HEALTH EMERGENCY COMPENSATION

Provider will receive its existing contract rate, as identified in Attachment C of the Contract, for the temporary flexibility to provide CBAS telephonically, in members' homes, and via live virtual video conferencing, as identified in Attachment A-1 ("**temporary alternative services**" or "**TAS**"). CalOptima's reimbursement of Provider for TAS shall extend through December 31, 2022, and be paid by CalOptima to Provider as follows:

1. Effective July 1, 2022, through September 30, 2022, TAS shall be paid at 100% of current Contract rate.

2. Effective October 1, 2022, through December 31, 2022:

    a) In-center services shall be paid at one hundred percent (100%) of current Contract rate.
    b) TAS (billed with Modifier 26) shall be paid at fifty percent (50%) of current Contract rate.

3. Effective January 1, 2023:

    a) In-center services shall be paid at one hundred percent (100%) of current Contract rate.
    b) TAS billed (with Modifier 26) will no longer be reimbursable.

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken June 2, 2022
Regular Meeting of the CalOptima Board of Directors

Report Item

23. Authorize Extension of a Temporary, Short-Term Supplemental Payment Increase for Certain Contracted CalOptima Fee-for-Service Providers for COVID-Related Expenses for Services Provided to CalOptima Community Network and CalOptima Direct Medi-Cal Members

Contact

Yunkyung Kim, Chief Operating Officer (714) 246-8408

Recommended Actions

Authorize:

1. Extension of a temporary, short-term supplemental payment increase of 5% from Fiscal Year (FY) 2021-22 original budgeted funding 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 (COD) Medi-Cal members for dates of service July 1, 2022, through June 30, 2023; and
2. Extension of a temporary, short-term supplemental payment increase of 5% from FY 2021-22 original budgeted funding levels for compliant, contracted Medi-Cal FFS behavioral health providers for services provided to all CalOptima Medi-Cal members for dates of service July 1, 2022, through June 30, 2023.

Background & Discussion

Staff requests that the CalOptima Board of Directors (Board) authorize an extension of a temporary, supplemental payment increase to FFS primary care, specialist, ancillary, and behavioral health providers for COVID-19related expenses between July 1, 2022, and June 30, 2023.

In response to COVID-19, the Board authorized three temporary, short-term supplemental increases for contracted CalOptima Medi-Cal providers for certain medically necessary services provided to CCN and COD members. The increases were implemented between January 1, 2021, to June 30, 2021; September 1, 2021, to December 31, 2021; and January 1, 2022, to June 30, 2022. The Board also expanded the payments for behavioral health providers to include services provided to all CalOptima Medi-Cal members, rather than only CCN and COD members.

This supplemental payment increase under consideration is intended to continue supporting providers in anticipation of higher expense levels, promote and improve vaccination rates, address additional variants of the COVID-19 virus, cover increased expenses for testing and treatment, and ensure uninterrupted, medically necessary Medi-Cal covered services for CalOptima members.

To continue supporting providers with COVID-19-related expenses and members' access to care, staff recommends authorizing extension of the temporary, short-term supplemental payment increase, excluding those services listed in Attachment 2, for dates of service July 1, 2022, through June 30, 2023. This action will help preserve the viability of CalOptima's Medi-Cal FFS provider network and strengthen members' access to care in anticipation of higher expense levels post-pandemic.

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Fiscal Impact

The recommended actions are budgeted items in the proposed CalOptima FY 2022-23 Operating Budget. The projected aggregate fiscal impact is approximately $11.2 million for Medi-Cal FFS providers and approximately $5.4 million for Medi-Cal FFS behavioral health providers.

Rationale for Recommendation

Authorizing extension of the temporary, COVID-19-related supplemental payment increase for contracted CCN and COD Medi-Cal FFS providers will preserve the viability of CalOptima's provider network, strengthen members' access to care and support the safety net system serving CalOptima members.

Concurrence

Troy R. Szabo, Outside General Counsel, Kennaday Leavitt

Attachments

1. Board Action dated February 3, 2022: Ratify Extension of a Temporary, Short-Term Supplemental Payment Increase for Certain Contracted CalOptima Fee-for-Service Providers for COVID-Related Expenses for Services Provided to CalOptima Community Network and CalOptima Direct Medi-Cal Members. This Board action includes the following:
    - Board Action dated September 2, 2021: 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
    - Board Action dated March 4, 2021: Consider Authorizing a Temporary, Short-Term Supplemental Payment Increase for Certain Contracted CalOptima Medi-Cal Community Network and CalOptima Direct-Administrative Medi-Cal Fee-for-Service Providers, except those affiliated with Providence St. Joseph Heritage Healthcare, for Mitigation of COVID-19-Related Expenses
    - Board Action dated March 4, 2021: Consider Authorizing a Temporary, Short-Term Supplemental Payment Increase for Certain Contracted Medi-Cal Providers Affiliated with Providence St. Joseph Heritage Healthcare, for Mitigation of COVID-19-Related Expenses
2. Services Excluded from Temporary Increase

/s/ Michael Hunn — *05/27/2022*
Authorized Signature — **Date**

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Rev. 2/3/2022

Action To Be Taken February 3, ~~2021~~ 2022
Regular Meeting of the CalOptima Board of Directors

Report Item

50. Ratify Extension of a Temporary, Short-Term Supplemental Payment Increase for Certain Contracted CalOptima Fee-for-Service Providers for COVID-Related Expenses for Services Provided to CalOptima Community Network and CalOptima Direct Medi-Cal Members

Contact

Yunkyung Kim, Chief Operating Officer (714) 246-8408

Recommended Actions

Ratify:

1. Extension of a temporary, short-term supplemental payment increase of 5% from Fiscal Year (FY) 2021-22 original budgeted funding 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 (COD) Medi-Cal members on dates of service January 1, 2022, through June 30, 2022;
2. Extension of a temporary, short-term supplemental payment increase of 5% from FY 2021-22 original budgeted funding levels, for compliant, contracted Medi-Cal FFS behavioral health providers for services provided to all CalOptima Medi-Cal members on dates of service January 1, 2022, through June 30, 2022; and
3. Use of unbudgeted expenditures up to $8.3 million from existing reserves to provide funding for the recommended supplemental payment increases.

Background & Discussion

Staff requests that the CalOptima Board of Directors (Board) ratify an extension of a temporary, supplemental payment increase to FFS primary care, specialist, ancillary, and behavioral health providers for COVID-related expenses between January 1, 2022 and June 30, 2022, as well as use of unbudgeted reserve funds to support the increase.

In response to COVID-19, the Board, at its March 4, 2021, meeting, authorized a temporary, short-term supplemental increase of 5% to contracted CalOptima Medi-Cal providers for certain medically necessary services provided to CCN and COD-A members between January 1, 2021, and June 30, 2021. At its September 2, 2021, meeting, the Board authorized resuming the supplemental increase through December 31, 2021. The Board also expanded the payments for behavioral health providers to include services provided to all CalOptima Medi-Cal members, rather than only CCN and COD-A members.

The supplemental payment increase under consideration is intended to support providers in anticipation of higher expense levels, promote and improve vaccination rates, address additional variants of the COVID-19 virus, cover increased expenses for testing and treatment, and ensure uninterrupted, medically necessary Medi-Cal covered services for CalOptima members.

To continue supporting providers with COVID-related expenses and members' access to care, staff recommends ratifying extension of the temporary, short-term supplemental payment increase, excluding those services listed in Attachment 4, for dates of service January 1, 2022, through June 30, 2022. This

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action will help preserve the viability of CalOptima's Medi-Cal FFS provider network and strengthen members' access to care in anticipation of higher expense levels post-pandemic.

Fiscal Impact

The recommended action to ratify extension of a temporary, short-term supplemental payment increase of 5% from FY 2021-22 original budgeted funding levels for the period of January 1, 2022, through June 30, 2022, for compliant, contracted Medi-Cal FFS primary care, specialist, behavioral health, and ancillary providers is an unbudgeted item.

The projected aggregate fiscal impact of the temporary, short-term supplemental payment increase to Medi-Cal FFS providers is approximately $5.6 million for the six-month period. The projected aggregate fiscal impact of the temporary, short-term supplemental payment increase to Medi-Cal FFS behavioral health providers is approximately $2.7 million. An allocation of up to $8.3 million from existing reserves would fund these actions.

Rationale for Recommendation

Ratifying extension of the temporary, COVID-related supplemental payment increase for contracted CCN and COD Medi-Cal FFS providers will preserve the viability of CalOptima's provider network, strengthen members' access to care and support the safety net system serving CalOptima members.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. Board Action dated September 2, 2021: 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
2. Board Action Dated March 4, 2021: Consider Authorizing a Temporary, Short-Term Supplemental Payment Increase for Certain Contracted CalOptima Medi-Cal Community Network and CalOptima Direct-Administrative Medi-Cal Fee-for-Service Providers, except those affiliated with Providence St. Joseph Heritage Healthcare, for Mitigation of COVID-19-Related Expenses
3. Board Action Dated March 4, 2021: Consider Authorizing a Temporary, Short-Term Supplemental Payment Increase for Certain Contracted CalOptima Medi-Cal Providers Affiliated with Providence St. Joseph Heritage Healthcare for Mitigation of COVID-19-Related Expenses
4. Services Excluded from Temporary Increase

/s/ Michael Hunn *01/27/2022*
Authorized Signature **Date**

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken September 2, 2021
Regular Meeting of the CalOptima Board of Directors

Report Item

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

Contacts

Ladan Khamseh, Chief Operations Officer, (714) 246-8866
Michelle Laughlin, Executive Director, Network Operations, (657) 900-1116

Recommended Actions

1. Authorize 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. Authorize 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. Authorize unbudgeted expenditures up to $5.5 million from existing reserves to provide funding for the recommended supplemental payment increases.

Background

On January 31, 2020, the Secretary of Health and Human Services declared a public health emergency (PHE) under section 319, of the Public Health Service Act (42 U.S.C. 247d) in response to a novel coronavirus known as SARS-CoV-2 (coronavirus). On March 13, 2020, the President of the United States declared a national emergency based on the spread of this coronavirus. Subsequently, the Governor and the Orange County Health Officer have similarly taken steps to slow the spread of the coronavirus and protect the public. As with federal, state, and local agencies, CalOptima is taking action to continue efforts to support providers serving CalOptima members during the pandemic.

At its March 4, 2021, meeting, the Board authorized a short-term supplemental increase of 5% from current levels to contracted CalOptima Medi-Cal primary care, specialist, behavioral health and ancillary providers for certain medically necessary services provided to CCN and COD-A members between January 1, 2021, and June 30, 2021.

Discussion

Management recognizes that the coronavirus pandemic continues to place significant stress on the healthcare providers and delivery system serving CalOptima members. In late June, the Centers for Disease Control and Prevention (CDC) issued new guidance and data related to the more contagious Delta variant. Orange County has experienced a surge of Delta variant cases leading to increased hospitalizations and strain on health care resources.

In mid-July, the California Department of Health Care Services (DHCS) released its Medi-Cal COVID-19 Vaccine Incentive Program. This program will use $350 million dollars statewide to improve the vaccination rates among Medi-Cal beneficiaries. The focus populations include members who:

1. Are homebound and unable to travel to vaccination sites;
2. Are 50-64 years of age with multiple chronic diseases;
3. Self-identify as persons of color; and
4. With the return to school, are youth 12-25 years old.

This additional funding will assist providers to address the latest surge in Delta variant cases and to help improve vaccination rates for CalOptima's members by promoting an increase in vaccinations within the Medi-Cal focus populations, consistent with DHCS's COVID-19 vaccination strategy.

The prior supplemental payments to behavioral health provides included medically necessary services provided only to CCN and COD-A members. This recommended action is to expand these supplemental payments to behavioral health to include all CalOptima Medi-Cal members.

In recognition of the demands the pandemic has placed on providers, providing the supplemental payment increase for the referenced period for medically necessary Medi-Cal services, is recommended. The increase will help preserve the viability of CalOptima's Medi-Cal FFS provider network, and strengthen access to care in light of the higher utilization levels, including COVID-19-related treatment.

Staff recommends that the Board approve a resumption of the temporary, supplemental 5% increase for providers, excluding those services listed in Attachment 3, and necessary unbudgeted expenditures to implement this increase for dates of service from September 1, 2021, through December 31, 2021.

Fiscal Impact

The recommended action to authorize resuming a temporary, short-term supplemental payment increase of 5% from current levels for the period of September 1, 2021, through December 31, 2021, for compliant, contracted Medi-Cal FFS primary care, specialist, behavioral health and ancillary providers is an unbudgeted item.

The projected aggregate fiscal impact of the temporary, short-term supplemental payment increase to Medi-Cal FFS providers is approximately $3.7 million for the four-month period. The projected aggregate fiscal impact of the temporary, short-term supplemental payment increase to Medi-Cal FFS behavioral health providers is approximately $1.8 million. An allocation of up to $5.5 million from existing reserves will fund these actions.

As of this writing, DHCS has not released detailed guidance on their Medi-Cal COVID-19 Vaccine Incentive Program. Management anticipates that the use of reserves may be reduced depending on actual funding provided by DHCS for this purpose.

Rationale for Recommendation

Resuming the temporary, PHE-related supplemental payment for contracted CCN and COD-A Medi-Cal FFS providers is intended to ensure the viability of CalOptima's FFS Medi-Cal providers, strengthens access to member care and supports the safety net system serving CalOptima members during the pandemic.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. Board Action Dated March 4, 2021: Consider Authorizing a Temporary, Short-Term Supplemental Payment Increase for Certain Contracted CalOptima Medi-Cal Community Network and CalOptima Direct-Administrative Medi-Cal Fee-for-Service Providers, except those affiliated with Providence St. Joseph Heritage Healthcare, for Mitigation of COVID-19-Related Expenses
2. Board Action Dated March 4, 2021: Consider Authorizing a Temporary, Short-Term Supplemental Payment Increase for Certain Contracted CalOptima Medi-Cal Providers Affiliated with Providence St. Joseph Heritage Healthcare for Mitigation of COVID-19-Related Expenses
3. Services Excluded from Temporary Increase

/s/ Richard Sanchez — *08/26/2021*

Authorized Signature — **Date**

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken March 4, 2021
Regular Meeting of the CalOptima Board of Directors

Report Item

24. Consider Authorizing a Temporary, Short-Term Supplemental Payment Increase for Certain Contracted CalOptima Medi-Cal Community Network and CalOptima Direct-Administrative Medi-Cal Fee-for-Service Providers, except those affiliated with Providence St. Joseph Heritage Healthcare, for Mitigation of COVID-19-Related Expenses

Contacts

Ladan Khamseh, Chief Operations Officer (714) 246-8866
Michelle Laughlin, Executive Director, Network Operations, (657) 900-1116

Recommended Actions

1. Authorize a temporary, short-term supplemental payment increase of 5% from current levels, for compliant, contracted CalOptima Medi-Cal Community Network (CCN) and CalOptima Direct-Administrative (COD-A) Medi-Cal Fee-for-Service (FFS) Primary Care, Specialist, Behavioral Health and Ancillary Providers, except those affiliated with Providence St. Joseph Heritage Healthcare, for certain medically necessary services provided retroactive to dates of service January 1, 2021, through June 30, 2021; and

2. Authorize the additional 5% in unbudgeted expenditures to provide funding for the recommended supplemental payment increase.

Background

On January 31, 2020, the Secretary of Health and Human Services declared a public health emergency under Section 319 of the Public Health Service Act (42 U.S.C. 247d) in response to a novel coronavirus known as SARS-CoV-2 (coronavirus). On March 13, 2020, the President of the United States declared a national emergency based on the spread of this coronavirus. Subsequently, the Governor and the Orange County Health Officer have taken similar steps to slow the spread of the coronavirus and protect the public. In collaboration with federal, state and local agencies, CalOptima is taking action to continue efforts to support providers serving CalOptima members during the pandemic.

In response to the public health emergency, the Board authorized a Medi-Cal capitation rate increase to CalOptima's health networks on April 2, 2020. Following receipt of the final Calendar Year 2021 Medi-Cal capitation rates from the California Department of Health Care Services (DHCS) (which included an updated rate component for COVID-19-related adjustments), the Board authorized a second capitation rate increase for Medi-Cal health networks on January 7, 2021.

Discussion

In recognition of the unprecedented and dynamic nature of the pandemic, and the strain it has placed on providers, a supplemental payment increase for contracted CCN and COD-A Medi-Cal FFS providers, except those affiliated with Providence St. Joseph Heritage Healthcare, is recommended. CalOptima staff recommends that the Board approve a supplemental payment increase for certain medically necessary services provided retroactive to the period of January 1, 2021, through June 30, 2021. The increase is intended to support CalOptima's Medi-Cal FFS providers and strengthen access to care,

given potential utilization changes and COVID-19-related testing and treatment in the current environment. In some cases, groups and/or categories of services/providers not included here have separately received COVID-19-related increases based on direction from the Department of Health Care Services (e.g., long term care providers), prior CalOptima Board action (health networks), or staff recommendations for other actions on today's Board agenda (e.g., hospitals and community health centers). Attachment 1 provides additional details regarding exclusions from the Temporary, Short-Term Supplemental Payment increase.

Pending Board approval, the supplemental payment increase will be administered to eligible providers for identified services through the claims payment system. Staff will give notice to the providers covered by this recommended action of the 5% increase. Staff proposes making supplemental payment increases beginning in March 2021. Adjudicated and paid claims between January 1, 2021, and the processing date (a March date to be determined) will receive a 5% supplemental payment adjustment. Moving forward, the 5% supplemental payment will be made monthly, for paid claims identified subsequent to the prior monthly supplemental payment. Staff plans to identify and process the supplemental payments at the claim line level that, at a minimum, identifies the eligible date of service, service code and payment. CalOptima staff anticipates that supplemental payments will be issued to eligible providers monthly from prior month's payment by the end of each month. Supplemental payments on identified claims will be made so long as timely filing requirements have been met. Since supplemental payments are provided as an additional payment to already adjudicated and paid claims, timely payment requirements, such as interest, will not be applied. Staff will monitor the process to ensure that the supplemental payment adjustments are processed and paid appropriately. Additionally, current policies and procedures related to provider payment recoupment, grievance and appeals, and provider dispute resolution will be followed where applicable.

Fiscal Impact

The recommended action to authorize a temporary, short-term supplemental payment increase of 5% from current levels for contracted CCN and COD-A Medi-Cal FFS Primary Care, Specialist, Behavioral Health and Ancillary Providers, except those affiliated with Providence St. Joseph Heritage Healthcare, is an unbudgeted item.

The projected aggregate fiscal impact of the temporary, short-term supplemental payment increase to Medi-Cal FFS providers is approximately $5.1 million for the six-month period. Staff anticipates the net fiscal impact will be budget neutral, as decreased utilization of certain services within the Medi-Cal program in the current fiscal year will be sufficient to support the additional costs in unbudgeted FFS payments.

Rationale for Recommendation

The temporary, public health emergency-related supplemental payment for contracted CCN and COD-A Medi-Cal FFS providers is intended to ensure the viability of certain CalOptima's FFS Medi-Cal providers, strengthens access to member care and supports the safety net system serving CalOptima members during the pandemic.

Concurrence

Gary Crockett, Chief Counsel

Attachment

1. Services excluded from Temporary, Short-Term Supplemental Payment Increase

/s/ Richard Sanchez — *02/24/2021*
Authorized Signature — **Date**

Services excluded from Temporary, Short-Term Supplemental Payment Increase
▪ Pharmacy and Pharmacy Benefit Management Services, and other contracted Administrative Service providers for which CalOptima covers the cost of claims
▪ Non-pharmacy administered drugs
▪ Long Term Care facilities
▪ Durable Medical Equipment; Orthotics and Prosthetics and other medical devices
▪ Members in CalOptima's Program for All Inclusive Care for the Elderly (PACE), OneCare, and OneCare Connect
▪ Crossover Claims
▪ Other supplemental or directed payments, such as Proposition 56
▪ Claims paid by Letter of Agreement (LOA)

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken March 4, 2021
Regular Meeting of the CalOptima Board of Directors

Report Item

23. Consider Authorizing a Temporary, Short-Term Supplemental Payment Increase for Certain Contracted to Medi-Cal Providers Affiliated with Providence St. Joseph Heritage Healthcare for Mitigation of COVID-19-Related Expenses

Contacts

Ladan Khamseh, Chief Operations Officer, (714) 246-8866
Michelle Laughlin, Executive Director, Network Operations, (657) 900-1116

Recommended Actions

1. Authorize a temporary, short-term supplemental Medi-Cal payment increase of 5% from current levels to certain Providers affiliated with Providence St. Joseph Heritage Healthcare for certain medically necessary services provided retroactive to dates of service January 1, 2021, through June 30, 2021; and
2. Authorize the additional 5% unbudgeted expenditures to provide funding for the recommended supplemental payment increase.

Background

On January 31, 2020, the Secretary of Health and Human Services declared a public health emergency under Section 319 of the Public Health Service Act (42 U.S.C. 247d) in response to a novel coronavirus known as SARS-CoV-2 (coronavirus). On March 13, 2020, the President of the United States declared a national emergency based on the spread of this coronavirus. Subsequently, the Governor and the Orange County Health Officer have taken similar steps to slow the spread of the coronavirus and protect the public. In collaboration with federal, state and local agencies, CalOptima is taking action to continue efforts to support providers serving CalOptima members during the pandemic.

In response to the public health emergency, the Board authorized a Medi-Cal capitation rate increase to CalOptima's health networks on April 2, 2020. Following receipt of the final Calendar Year 2021 Medi-Cal capitation rates from the California Department of Health Care Services (DHCS) (which included an updated rate component for COVID-19-related adjustments), the Board authorized a second capitation rate increase for Medi-Cal health networks on January 7, 2021.

Discussion

In recognition of the unprecedented and dynamic nature of the pandemic, and the strain it has placed on providers, a supplemental payment increase for certain providers affiliated with Providence St. Joseph Heritage Healthcare is recommended. CalOptima staff recommends that the Board approve a supplemental payment increase for certain medically necessary services provided retroactive to the period of January 1, 2021, through June 30, 2021. The increase is intended to support certain providers affiliated with Providence St. Joseph Heritage Healthcare and strengthen access to care, given potential utilization changes and COVID-19-related testing and treatment in the current environment. In some cases, groups and/or categories of services/providers not included here have separately received COVID-19-related increases based on direction from the Department of Health Care Services (e.g., long term care providers), prior CalOptima Board action (health networks), or staff recommendations for

other actions on today's Board agenda (e.g., hospitals and community health centers). Attachment 1 provides additional details regarding exclusions from the Temporary, Short-Term Supplemental Payment increase.

Pending Board approval, the supplemental payment increase will be administered to certain providers affiliated with Providence St. Joseph Heritage Healthcare for identified services through the claims payment system. Staff will give notice to certain providers affiliated with Providence St. Joseph Heritage Healthcare of the 5% increase. Staff proposes making supplemental payment increases beginning in March 2021. Adjudicated and paid claims between January 1, 2021, and the processing date (a March date to be determined) will receive a 5% supplemental payment adjustment. Moving forward, the 5% supplemental payment will be made monthly, for paid claims identified subsequent to the prior monthly supplemental payment. Staff plans to identify and process the supplemental payments at the claim line level that, at a minimum, identifies the eligible date of service, service code and payment. CalOptima staff anticipates that supplemental payments will be issued to certain providers affiliated with Providence St. Joseph Heritage Healthcare monthly from prior month's payment by the end of each month. Supplemental payments on identified claims will be made so long as timely filing requirements have been met. Since supplemental payments are provided as an additional payment to already adjudicated and paid claims, timely payment requirements, such as interest, will not be applied. Staff will monitor the process to ensure that the supplemental payment adjustments are processed and paid appropriately. Additionally, current policies and procedures related to provider payment recoupment, grievance and appeals, and provider dispute resolution will be followed where applicable.

Fiscal Impact

The recommended action to authorize a temporary, short-term supplemental payment increase of 5% from current levels to certain providers affiliated with Providence St. Joseph Heritage Healthcare is an unbudgeted item.

The projected aggregated fiscal impact of the temporary, short-term supplemental payment increase to Medi-Cal fee-for-service providers is approximately $5.1 million for the six-month period. Staff anticipates the net fiscal impact will be budget neutral, as decreased utilization of certain services within the Medi-Cal program in the current fiscal year will be sufficient to support the additional costs in unbudgeted FFS payments.

Rationale for Recommendation

The temporary, public health emergency-related supplemental payment for St. Joseph Heritage Healthcare is intended to ensure the viability of certain CalOptima's FFS Medi-Cal providers, strengthen access to member care and support the safety net system serving CalOptima members during the pandemic.

Concurrence
Gary Crockett, Chief Counsel

Attachment
1. Services excluded from Temporary, Short-Term Supplemental Payment Increase

/s/ Richard Sanchez *02/24/2021*
Authorized Signature **Date**

Services excluded from Temporary, Short-Term Supplemental Payment Increase
▪ Pharmacy and Pharmacy Benefit Management Services, and other contracted Administrative Service providers for which CalOptima covers the cost of claims
▪ Non-pharmacy administered drugs
▪ Long Term Care facilities
▪ Durable Medical Equipment; Orthotics and Prosthetics and other medical devices
▪ Members in CalOptima's Program for All Inclusive Care for the Elderly (PACE), OneCare, and OneCare Connect
▪ Crossover Claims
▪ Other supplemental or directed payments, such as Proposition 56
▪ Claims paid by Letter of Agreement (LOA)

Services Excluded from Temporary, Short-Term Supplemental Payment Increase

Services excluded from Temporary, Short-Term Supplemental Payment Increase
▪ Pharmacy and Pharmacy Benefit Management Services, and other contracted Administrative Service providers for which CalOptima covers the cost of claims
▪ Non-pharmacy administered drugs
▪ Long Term Care facilities
▪ Durable Medical Equipment; Orthotics and Prosthetics and other medical devices
▪ Members in CalOptima's Program for All Inclusive Care for the Elderly (PACE), OneCare, and OneCare Connect
▪ Crossover Claims
▪ Other supplemental or directed payments, such as Proposition 56
▪ Claims paid by Letter of Agreement (LOA)

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken March 4, 2021
Regular Meeting of the CalOptima Board of Directors

Report Item

24. Consider Authorizing a Temporary, Short-Term Supplemental Payment Increase for Certain Contracted CalOptima Medi-Cal Community Network and CalOptima Direct-Administrative Medi-Cal Fee-for-Service Providers, except those affiliated with Providence St. Joseph Heritage Healthcare, for Mitigation of COVID-19-Related Expenses

Contacts

Ladan Khamseh, Chief Operations Officer (714) 246-8866
Michelle Laughlin, Executive Director, Network Operations, (657) 900-1116

Recommended Actions

1. Authorize a temporary, short-term supplemental payment increase of 5% from current levels, for compliant, contracted CalOptima Medi-Cal Community Network (CCN) and CalOptima Direct-Administrative (COD-A) Medi-Cal Fee-for-Service (FFS) Primary Care, Specialist, Behavioral Health and Ancillary Providers, except those affiliated with Providence St. Joseph Heritage Healthcare, for certain medically necessary services provided retroactive to dates of service January 1, 2021, through June 30, 2021; and

2. Authorize the additional 5% in unbudgeted expenditures to provide funding for the recommended supplemental payment increase.

Background

On January 31, 2020, the Secretary of Health and Human Services declared a public health emergency under Section 319 of the Public Health Service Act (42 U.S.C. 247d) in response to a novel coronavirus known as SARS-CoV-2 (coronavirus). On March 13, 2020, the President of the United States declared a national emergency based on the spread of this coronavirus. Subsequently, the Governor and the Orange County Health Officer have taken similar steps to slow the spread of the coronavirus and protect the public. In collaboration with federal, state and local agencies, CalOptima is taking action to continue efforts to support providers serving CalOptima members during the pandemic.

In response to the public health emergency, the Board authorized a Medi-Cal capitation rate increase to CalOptima's health networks on April 2, 2020. Following receipt of the final Calendar Year 2021 Medi-Cal capitation rates from the California Department of Health Care Services (DHCS) (which included an updated rate component for COVID-19-related adjustments), the Board authorized a second capitation rate increase for Medi-Cal health networks on January 7, 2021.

Discussion

In recognition of the unprecedented and dynamic nature of the pandemic, and the strain it has placed on providers, a supplemental payment increase for contracted CCN and COD-A Medi-Cal FFS providers, except those affiliated with Providence St. Joseph Heritage Healthcare, is recommended. CalOptima staff recommends that the Board approve a supplemental payment increase for certain medically necessary services provided retroactive to the period of January 1, 2021, through June 30, 2021. The increase is intended to support CalOptima's Medi-Cal FFS providers and strengthen access to care,

given potential utilization changes and COVID-19-related testing and treatment in the current environment. In some cases, groups and/or categories of services/providers not included here have separately received COVID-19-related increases based on direction from the Department of Health Care Services (e.g., long term care providers), prior CalOptima Board action (health networks), or staff recommendations for other actions on today's Board agenda (e.g., hospitals and community health centers). Attachment 1 provides additional details regarding exclusions from the Temporary, Short-Term Supplemental Payment increase.

Pending Board approval, the supplemental payment increase will be administered to eligible providers for identified services through the claims payment system. Staff will give notice to the providers covered by this recommended action of the 5% increase. Staff proposes making supplemental payment increases beginning in March 2021. Adjudicated and paid claims between January 1, 2021, and the processing date (a March date to be determined) will receive a 5% supplemental payment adjustment. Moving forward, the 5% supplemental payment will be made monthly, for paid claims identified subsequent to the prior monthly supplemental payment. Staff plans to identify and process the supplemental payments at the claim line level that, at a minimum, identifies the eligible date of service, service code and payment. CalOptima staff anticipates that supplemental payments will be issued to eligible providers monthly from prior month's payment by the end of each month. Supplemental payments on identified claims will be made so long as timely filing requirements have been met. Since supplemental payments are provided as an additional payment to already adjudicated and paid claims, timely payment requirements, such as interest, will not be applied. Staff will monitor the process to ensure that the supplemental payment adjustments are processed and paid appropriately. Additionally, current policies and procedures related to provider payment recoupment, grievance and appeals, and provider dispute resolution will be followed where applicable.

Fiscal Impact

The recommended action to authorize a temporary, short-term supplemental payment increase of 5% from current levels for contracted CCN and COD-A Medi-Cal FFS Primary Care, Specialist, Behavioral Health and Ancillary Providers, except those affiliated with Providence St. Joseph Heritage Healthcare, is an unbudgeted item.

The projected aggregate fiscal impact of the temporary, short-term supplemental payment increase to Medi-Cal FFS providers is approximately $5.1 million for the six-month period. Staff anticipates the net fiscal impact will be budget neutral, as decreased utilization of certain services within the Medi-Cal program in the current fiscal year will be sufficient to support the additional costs in unbudgeted FFS payments.

Rationale for Recommendation

The temporary, public health emergency-related supplemental payment for contracted CCN and COD-A Medi-Cal FFS providers is intended to ensure the viability of certain CalOptima's FFS Medi-Cal providers, strengthens access to member care and supports the safety net system serving CalOptima members during the pandemic.

Concurrence

Gary Crockett, Chief Counsel

Attachment

1. Services excluded from Temporary, Short-Term Supplemental Payment Increase

/s/ Richard Sanchez *02/24/2021*
Authorized Signature **Date**

Services excluded from Temporary, Short-Term Supplemental Payment Increase
▪ Pharmacy and Pharmacy Benefit Management Services, and other contracted Administrative Service providers for which CalOptima covers the cost of claims
▪ Non-pharmacy administered drugs
▪ Long Term Care facilities
▪ Durable Medical Equipment; Orthotics and Prosthetics and other medical devices
▪ Members in CalOptima's Program for All Inclusive Care for the Elderly (PACE), OneCare, and OneCare Connect
▪ Crossover Claims
▪ Other supplemental or directed payments, such as Proposition 56
▪ Claims paid by Letter of Agreement (LOA)

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken March 4, 2021
Regular Meeting of the CalOptima Board of Directors

Report Item

23. Consider Authorizing a Temporary, Short-Term Supplemental Payment Increase for Certain Contracted to Medi-Cal Providers Affiliated with Providence St. Joseph Heritage Healthcare for Mitigation of COVID-19-Related Expenses

Contacts

Ladan Khamseh, Chief Operations Officer, (714) 246-8866
Michelle Laughlin, Executive Director, Network Operations, (657) 900-1116

Recommended Actions

1. Authorize a temporary, short-term supplemental Medi-Cal payment increase of 5% from current levels to certain Providers affiliated with Providence St. Joseph Heritage Healthcare for certain medically necessary services provided retroactive to dates of service January 1, 2021, through June 30, 2021; and
2. Authorize the additional 5% unbudgeted expenditures to provide funding for the recommended supplemental payment increase.

Background

On January 31, 2020, the Secretary of Health and Human Services declared a public health emergency under Section 319 of the Public Health Service Act (42 U.S.C. 247d) in response to a novel coronavirus known as SARS-CoV-2 (coronavirus). On March 13, 2020, the President of the United States declared a national emergency based on the spread of this coronavirus. Subsequently, the Governor and the Orange County Health Officer have taken similar steps to slow the spread of the coronavirus and protect the public. In collaboration with federal, state and local agencies, CalOptima is taking action to continue efforts to support providers serving CalOptima members during the pandemic.

In response to the public health emergency, the Board authorized a Medi-Cal capitation rate increase to CalOptima's health networks on April 2, 2020. Following receipt of the final Calendar Year 2021 Medi-Cal capitation rates from the California Department of Health Care Services (DHCS) (which included an updated rate component for COVID-19-related adjustments), the Board authorized a second capitation rate increase for Medi-Cal health networks on January 7, 2021.

Discussion

In recognition of the unprecedented and dynamic nature of the pandemic, and the strain it has placed on providers, a supplemental payment increase for certain providers affiliated with Providence St. Joseph Heritage Healthcare is recommended. CalOptima staff recommends that the Board approve a supplemental payment increase for certain medically necessary services provided retroactive to the period of January 1, 2021, through June 30, 2021. The increase is intended to support certain providers affiliated with Providence St. Joseph Heritage Healthcare and strengthen access to care, given potential utilization changes and COVID-19-related testing and treatment in the current environment. In some cases, groups and/or categories of services/providers not included here have separately received COVID-19-related increases based on direction from the Department of Health Care Services (e.g., long term care providers), prior CalOptima Board action (health networks), or staff recommendations for

other actions on today's Board agenda (e.g., hospitals and community health centers). Attachment 1 provides additional details regarding exclusions from the Temporary, Short-Term Supplemental Payment increase.

Pending Board approval, the supplemental payment increase will be administered to certain providers affiliated with Providence St. Joseph Heritage Healthcare for identified services through the claims payment system. Staff will give notice to certain providers affiliated with Providence St. Joseph Heritage Healthcare of the 5% increase. Staff proposes making supplemental payment increases beginning in March 2021. Adjudicated and paid claims between January 1, 2021, and the processing date (a March date to be determined) will receive a 5% supplemental payment adjustment. Moving forward, the 5% supplemental payment will be made monthly, for paid claims identified subsequent to the prior monthly supplemental payment. Staff plans to identify and process the supplemental payments at the claim line level that, at a minimum, identifies the eligible date of service, service code and payment. CalOptima staff anticipates that supplemental payments will be issued to certain providers affiliated with Providence St. Joseph Heritage Healthcare monthly from prior month's payment by the end of each month. Supplemental payments on identified claims will be made so long as timely filing requirements have been met. Since supplemental payments are provided as an additional payment to already adjudicated and paid claims, timely payment requirements, such as interest, will not be applied. Staff will monitor the process to ensure that the supplemental payment adjustments are processed and paid appropriately. Additionally, current policies and procedures related to provider payment recoupment, grievance and appeals, and provider dispute resolution will be followed where applicable.

Fiscal Impact

The recommended action to authorize a temporary, short-term supplemental payment increase of 5% from current levels to certain providers affiliated with Providence St. Joseph Heritage Healthcare is an unbudgeted item.

The projected aggregated fiscal impact of the temporary, short-term supplemental payment increase to Medi-Cal fee-for-service providers is approximately $5.1 million for the six-month period. Staff anticipates the net fiscal impact will be budget neutral, as decreased utilization of certain services within the Medi-Cal program in the current fiscal year will be sufficient to support the additional costs in unbudgeted FFS payments.

Rationale for Recommendation

The temporary, public health emergency-related supplemental payment for St. Joseph Heritage Healthcare is intended to ensure the viability of certain CalOptima's FFS Medi-Cal providers, strengthen access to member care and support the safety net system serving CalOptima members during the pandemic.

Concurrence
Gary Crockett, Chief Counsel

Attachment
1. Services excluded from Temporary, Short-Term Supplemental Payment Increase

/s/ Richard Sanchez *02/24/2021*
Authorized Signature **Date**

Services excluded from Temporary, Short-Term Supplemental Payment Increase
▪ Pharmacy and Pharmacy Benefit Management Services, and other contracted Administrative Service providers for which CalOptima covers the cost of claims
▪ Non-pharmacy administered drugs
▪ Long Term Care facilities
▪ Durable Medical Equipment; Orthotics and Prosthetics and other medical devices
▪ Members in CalOptima's Program for All Inclusive Care for the Elderly (PACE), OneCare, and OneCare Connect
▪ Crossover Claims
▪ Other supplemental or directed payments, such as Proposition 56
▪ Claims paid by Letter of Agreement (LOA)

Services excluded from Temporary, Short-Term Supplemental Payment Increase
▪ Pharmacy and Pharmacy Benefit Management Services, and other contracted Administrative Service providers for which CalOptima covers the cost of claims
▪ Non-pharmacy administered drugs
▪ Long Term Care facilities
▪ Durable Medical Equipment; Orthotics and Prosthetics and other medical devices
▪ Members in CalOptima's Program for All Inclusive Care for the Elderly (PACE), OneCare, and OneCare Connect
▪ Crossover Claims
▪ Other supplemental or directed payments, such as Proposition 56
▪ Claims paid by Letter of Agreement (LOA)

Services excluded from Temporary, Short-Term Supplemental Payment Increase
▪ Pharmacy and Pharmacy Benefit Management Services, and other contracted Administrative Service providers for which CalOptima covers the cost of claims
▪ Non-pharmacy administered drugs
▪ Long Term Care facilities
▪ Durable Medical Equipment; Orthotics and Prosthetics and other medical devices
▪ Members in CalOptima's Program for All Inclusive Care for the Elderly (PACE), OneCare, and OneCare Connect
▪ Crossover Claims
▪ Other supplemental or directed payments, such as Proposition 56
▪ Claims paid by Letter of Agreement (LOA)

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken June 2, 2022
Regular Meeting of the CalOptima Board of Directors

Report Item

24. Authorize Extension of a Temporary, Short-Term Supplemental Payment Increase for Contracted CalOptima Community Network and CalOptima Direct-Administrative Medi-Cal Fee-for-Service Community Health Centers, for COVID-Related Expenses for Services Provided to CalOptima Community Network and CalOptima Direct-Administrative Medi-Cal Members

Contact

Yunkyung Kim, Chief Operating Officer (714) 246-8408

Recommended Actions

Authorize an extension of a temporary, short-term supplemental payment increase of 5% from Fiscal Year (FY) 2021-22 original budgeted funding levels, for compliant, contracted CalOptima Community Network (CCN) and CalOptima Direct-Administrative (COD-A) Medi-Cal Fee-for-Service (FFS) Community Health Centers, for certain medically necessary services provided to CCN and COD-A Medi-Cal members on dates of service July 1, 2022, through June 30, 2023.

Background & Discussion

Staff requests the CalOptima Board of Directors (Board) authorize an extension of a temporary, supplemental payment increase to FFS Community Health Centers for COVID-19related expenses between July 1, 2022, through June 30, 2023.

In response to COVID-19, the Board authorized three temporary, short-term supplemental payment increases for contracted CCN and COD-A Medi-Cal FFS community health centers for certain medically necessary services. The increases were implemented between January 1, 2021, to June 30, 2021; September 1, 2021 to December 31, 2021; and January 1, 2022 to June 30, 2022.

This supplemental payment increase under consideration is intended to continue supporting providers in anticipation of higher expense levels, promote and improve vaccination rates, address additional variants of the COVID-19 virus, cover increased expenses for testing and treatment, and ensure uninterrupted, medically necessary Medi-Cal covered services for CalOptima members.

To continue supporting providers with COVID-19-related expenses and members' access to care, staff recommends authorizing extension of the supplemental payment increase, excluding those services listed in Attachment 2, for dates of service July 1, 2022, through June 30, 2023.

Fiscal Impact

The recommended action is a budgeted item in the proposed CalOptima FY 2022-23 Operating Budget. The projected aggregate fiscal impact is approximately $600,000.

Rationale for Recommendation

Authorizing extension of the temporary, COVID-19-related supplemental payment increase for contracted CCN and COD-A Medi-Cal FFS community health centers will preserve the viability of

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CalOptima's provider network, strengthen members' access to care and support Orange County's safety net system serving CalOptima members.

Concurrence
Troy R. Szabo, Outside General Counsel, Kennaday Leavitt

Attachments
1. Board Action Dated February 3, 2022: Ratify Extension of a Temporary, Short-Term Supplemental Payment Increase for Contracted CalOptima Community Network and CalOptima Direct-Administrative Medi-Cal Fee-for-Service Community Health Centers, for COVID-Related Expenses for Services Provided to CalOptima Community Network and CalOptima Direct-Administrative Medi-Cal Members. This Board action includes the following:
    - Board Action Dated September 2, 2021: 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
    - Board Action Dated February 4, 2021: Consider Authorizing a Temporary, Short-Term Supplemental Payment Increase for Contracted Medi-Cal Community Network and CalOptima Direct-Administrative Fee-for-Service Community Health Centers, for mitigation of COVID-19-Related Expenses
2. Services Excluded from Temporary Increase

/s/ Michael Hunn — *05/27/2022*
Authorized Signature — **Date**

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken February 3, ~~2021~~ 2022
Regular Meeting of the CalOptima Board of Directors

Rev. 2/3/2022

Report Item

17. Ratify Extension of a Temporary, Short-Term Supplemental Payment Increase for Contracted CalOptima Community Network and CalOptima Direct-Administrative Medi-Cal Fee-for-Service Community Health Centers, for COVID-Related Expenses for Services Provided to CalOptima Community Network and CalOptima Direct-Administrative Medi-Cal Members

Contact

Yunkyung Kim, Chief Operating Officer (714) 246-8408

Recommended Actions

Ratify:

1. Extension of a temporary, short-term supplemental payment increase of 5% from Fiscal Year (FY) 2021-22 original budgeted funding levels, for compliant, contracted CalOptima Community Network (CCN) and CalOptima Direct-Administrative (COD-A) Medi-Cal Fee-for-Service (FFS) Community Health Centers, for certain medically necessary services provided to CalOptima CCN and COD-A Medi-Cal members on dates of service January 1, 2022, through June 30, 2022; and
2. Use of unbudgeted expenditures up to $240,000 from existing reserves to provide funding for the recommended supplemental payment increases.

Background & Discussion

Staff requests the CalOptima Board of Directors (Board) ratify both an extension of a temporary, supplemental payment increase to FFS Community Health Centers for COVID-related expenses between January 1, 2022, through June 30, 2022, as well as use of unbudgeted reserve funds to support the increase.

In response to COVID-19, the Board, at its February 4, 2021, meeting, authorized a temporary, short-term supplemental payment increase of 5% to contracted CCN and COD-A Medi-Cal FFS community health centers for certain medically necessary services provided between January 1, 2021, and June 30, 2021. At its September 2, 2021, meeting, the Board authorized resuming the increase through December 31, 2021.

The supplemental payment increase under consideration is intended to support providers, in anticipation of higher expense levels, promote and improve vaccination rates, address additional variants of the COVID-19 virus, cover increased expenses for testing and treatment, and ensure uninterrupted, medically necessary Medi-Cal covered services for CalOptima members.

To continue supporting providers with COVID-related expenses and members' access to care, staff recommends ratifying the supplemental payment increase, excluding those services listed in Attachment 3, for dates of service January 1, 2022, through June 30, 2022.

Fiscal Impact

The recommended action to ratify extension of a temporary, short term supplemental payment increase of 5% from FY 2021-22 original budgeted funding levels for the period of January 1, 2022, through

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June 30, 2022, for compliant, contracted CCN and COD-A Medi-Cal FFS Community Health Centers is an unbudgeted item. The projected aggregate fiscal impact is approximately $240,000 for the six-month period and will be funded from existing reserves.

Rationale for Recommendation

Ratifying extension of the temporary, COVID-related supplemental payment increase for contracted CCN and COD-A Medi-Cal Fee-for-Service community health centers will preserve the viability of CalOptima's provider network, strengthen members' access to care and support Orange County's safety net system serving CalOptima members.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. Board Action Dated February 4, 2021: Consider Authorizing a Temporary, Short-Term Supplemental Payment Increase for Contracted CalOptima Medi-Cal Community Network and CalOptima Direct-Administrative Medi-Cal Fee-for-Service Community Health Centers, for Mitigation of COVID-19-Related Expenses
2. Board Action Dated September 2, 2021: Consider Authorizing a Temporary, Short-Term Supplemental Payment Increase for Contracted Medi-Cal Fee-for-Service Community Health Centers due to COVID-19-Related Expenses for Services Provided to CalOptima Community Network and CalOptima Direct Medi-Cal Members
3. Services Excluded from Temporary Increase

/s/ Michael Hunn *01/27/2022*
Authorized Signature **Date**

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken February 4, 2021
Regular Meeting of the CalOptima Board of Directors

Report Item

21. Consider Authorizing a Temporary, Short-Term Supplemental Payment Increase for Contracted CalOptima Medi-Cal Community Network and CalOptima Direct-Administrative Medi-Cal Fee-for-Service Community Health Centers, for Mitigation of COVID-19-Related Expenses

Contact

Ladan Khamseh, Chief Operations Officer, (714) 246-8866
Michelle Laughlin, Executive Director, Network Operations, (657) 900-1116

Recommended Actions

1. Authorize a temporary, short-term supplemental payment increase of 5% from current levels, for compliant, contracted CalOptima Medi-Cal Community Network (CCN) and CalOptima Direct-Administrative (COD-A) Medi-Cal Fee-for-Service (FFS) Community Health Centers, for certain medically necessary services provided on dates of service January 1, 2021, through June 30, 2021; and

2. Authorize unbudgeted expenditures up to $210,000 to provide funding for the supplemental payment increase to Medi-Cal FFS Community Health Centers.

Background

On January 31, 2020, the Secretary of Health and Human Services declared a public health emergency under Section 319 of the Public Health Service Act (42 U.S.C. 247d) in response to a novel coronavirus known as SARS-CoV-2 (coronavirus). On March 13, 2020, the President of the United States declared a national emergency based on the spread of this coronavirus. Subsequently, the Governor and the Orange County Health Officer have taken similar steps to slow the spread of the coronavirus and protect the public. In collaboration with federal, state and local agencies, CalOptima is taking action to continue efforts to support providers serving CalOptima members during the pandemic.

In response to the public health emergency, the Board authorized a Medi-Cal capitation rate increase to CalOptima's health networks on April 2, 2020. Following receipt of the final Calendar Year 2021 Medi-Cal capitation rates from the California Department of Health Care Services (DHCS) (which included an updated rate component for COVID-19-related adjustments), the Board authorized a second capitation rate increase for Medi-Cal health networks on January 7, 2021.

Discussion

In recognition of the unprecedented and dynamic nature of the pandemic and the strain it has placed on providers, a supplemental payment increase for contracted CCN and COD-A Medi-Cal FFS Community Health Centers is recommended. CalOptima staff recommends that the Board approve a supplemental payment increase for services provided by CCN and COD-A Medi-Cal FFS Community Health Centers during the period of January 1, 2021 through June 30, 2021. The increase is intended to support CalOptima's FFS Medi-Cal providers and strengthen access to care, given potential utilization changes and COVID-19-related testing and treatment in the current environment.

This item applies solely to CalOptima's Community Health Centers—including Federally Qualified Health Centers (FQHC), FQHC look alike clinics, and community clinics—which are an important part of the safety net serving CalOptima members. They provide increased access to care for CalOptima's various member populations, including the homeless, by reducing barriers such as language, distance, and wait time. In addition to the variety of primary, preventive, and health education services they provide, Community Health Centers have a direct impact in preventing the spread of COVID-19 throughout the community by providing COVID-19 testing and treatment. Attachment 1 provides additional details regarding exclusions from the Temporary, Short-Term Supplemental Payment Increase.

Pending Board approval, the supplemental payment increase will be administered to eligible providers for identified services through the claims payment system. Staff will give notice to contracted CalOptima Community Network and CalOptima Direct-Administrative Medi-Cal Fee-for-Service Community Health Centers of the 5% increase following Board approval. Staff proposes making supplemental payment increases for dates of service beginning January 1, 2021 in February 2021. Adjudicated and paid claims for dates of service January 1, 2021, up until the supplemental payment processing date (a February date to be determined) will receive a 5% supplemental payment adjustment. Moving forward, the 5% supplemental payment will be made monthly, for paid claims identified subsequent to the prior monthly supplemental payment, on a rolling time schedule. Staff plans to identify and process the supplemental payment at the covered service claim line level that, at a minimum, identifies the eligible date of service, covered billing service code and payment amount. CalOptima staff anticipates that supplemental payments will be issued to eligible providers monthly from prior month's payment by the end of each month. Supplemental payments on identified eligible claims will be made so long as timely filing requirements have been met. Since supplemental payments are provided as an additional payment to adjudicated and paid claims, timely payment requirements, such as interest, will not be applied. However, staff will monitor the process to ensure that the supplemental payment adjustments are processed and paid appropriately. Additionally, current policies and procedures related to provider payment recoupment, grievance and appeals, and provider dispute resolution will be followed where applicable.

Fiscal Impact

The recommended action to authorize a temporary, short-term supplemental payment increase of 5% from current levels for contracted CCN and COD-A Medi-Cal FFS Community Health Centers is an unbudgeted item. The projected aggregate fiscal impact is approximately $210,000 for the six-month period. Staff anticipates the net fiscal impact will be budget neutral, as decreased utilization of certain services within the Medi-Cal program in the current fiscal year will be sufficient to support the additional costs in unbudgeted FFS payments.

Rationale for Recommendation

The temporary, public health emergency-related supplemental payment for contracted CCN and COD-A Medi-Cal FFS Community Health Centers is intended to ensure the viability of CalOptima's FFS Medi-

Cal clinic providers, strengthens access to member care and supports the safety net system serving CalOptima members during the pandemic.

Concurrence
Gary Crockett, Chief Counsel

Attachments
1. List of Exclusions for Temporary, Short-Term Supplemental Payment Increase

/s/ Richard Sanchez *01/27/2021*
Authorized Signature **Date**

List of Exclusions from Temporary, Short-Term Supplemental Payment Increase
▪ Pharmacy and Pharmacy Benefit Management Services, and other contracted Administrative Service providers for which CalOptima covers the cost of claims
▪ Non-pharmacy administered drugs
▪ Long Term Care services
▪ Durable Medical Equipment; Orthotics and Prosthetics and other medical devices
▪ Members in CalOptima's Program for All Inclusive Care for the Elderly (PACE), OneCare, and OneCare Connect
▪ Crossover Claims
▪ Other supplemental or directed payments, such as Proposition 56
▪ Claims paid by Letter of Agreement (LOA)

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken September 2, 2021
Regular Meeting of the CalOptima Board of Directors

Report Item

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

Contacts

Nancy Huang, Chief Financial Officer (657) 235-6935
Michelle Laughlin, Executive Director, Network Operations (657) 900-1116

Recommended Actions

1. Authorize 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. Authorize unbudgeted expenditures up to $150,000 from existing reserves to provide funding for the supplemental payment increase to Medi-Cal FFS Community Health Centers.

Background

On January 31, 2020, the Secretary of Health and Human Services declared a public health emergency (PHE) under section 319, of the Public Health Service Act (42 U.S.C. 247d) in response to a novel coronavirus known as SARS-CoV-2 (coronavirus). On March 13, 2020, the President of the United States declared a national emergency based on the spread of this coronavirus. Subsequently, the Governor and the Orange County Health Officer have similarly taken steps to slow the spread of the coronavirus and protect the public. As with federal, state, and local agencies, CalOptima is taking action to continue efforts to support providers serving CalOptima members during the pandemic.

At its February 4, 2021, meeting, the Board authorized a temporary, short-term supplemental payment increase of 5% from current levels to contracted CCN and COD Medi-Cal FFS community health centers for certain medically necessary services provided between January 1, 2021, and June 30, 2021.

Discussion

Management recognizes that the coronavirus pandemic continues to place significant stress on the healthcare providers and delivery system serving CalOptima members. In late June, the Centers for Disease Control and Prevention (CDC) issued new guidance and data related to the more contagious Delta variant. Orange County has experienced a surge of Delta variant cases leading to increased hospitalizations and strain on health care resources. In addition, the demand for coronavirus testing is expected to increase as children return to school in the fall. This will be especially true for certain age groups who are not currently eligible to receive the vaccine.

In mid-July, the California Department of Health Care Services (DHCS) released its Medi-Cal COVID-19 Vaccine Incentive Program. This program will use $350 million dollars statewide to

improve the vaccination rates among Medi-Cal beneficiaries. The focus populations include members who:

1. Are homebound and unable to travel to vaccination sites;
2. Are 50-64 years of age with multiple chronic diseases;
3. Self-identify as persons of color; and
4. With the return to school, are youth 12-25 years old.

The rate increase recommendation is intended to utilize and support providers in improving vaccination rates for CalOptima's members, consistent with DHCS's COVID-19 vaccination strategy. Pending additional guidance from DHCS, community health centers are expected to participate in the COVID-19 incentive program that CalOptima will develop. This additional funding will assist providers in addressing the latest surge in Delta variant cases and projected increase in demand for coronavirus testing, and to promote an increase in vaccinations within the Medi-Cal focus populations identified by DHCS.

In recognition of the demands the pandemic has placed on community health centers, providing the supplemental payment increase for the referenced period for medically necessary Medi-Cal services is recommended. The increase will help preserve the viability of CalOptima's Medi-Cal FFS community health centers and strengthen access to care in light of the higher utilization levels including COVID-19-related testing and treatment.

Staff recommends approving the temporary, supplemental 5% increase for providers, excluding those services listed in Attachment 2, and necessary unbudgeted expenditures to implement this increase for dates of service September 1, 2021 through December 31, 2021.

Fiscal Impact

The recommended action to authorize resuming a temporary, short term supplemental payment increase of 5% from current levels for the period of September 1, 2021 through December 31, 2021 for compliant, contracted Medi-Cal FFS Community Health Centers is an unbudgeted item. The projected aggregate fiscal impact is approximately $150,000 for the four-month period and will be funded from existing reserves.

As of this writing, DHCS has not released detailed guidance on their Medi-Cal COVID-19 Vaccine Incentive Program. Management anticipates that the use of reserves may be reduced depending on actual funding provided by DHCS for this purpose.

Rationale for Recommendation

The temporary, PHE-related supplemental payment for contracted CCN and COD-A Medi-Cal FFS Community Health Centers ensures the viability of CalOptima's FFS Medi-Cal providers, strengthens access to member care and supports Orange County's safety net system during the pandemic.

Concurrence
Gary Crockett, Chief Counsel

Attachments

1. Board Action Dated February 4, 2021: Consider Authorizing a Temporary, Short-Term Supplemental Payment Increase for Contracted CalOptima Medi-Cal Community Network and CalOptima Direct-Administrative Medi-Cal Fee-for-Service Community Health Centers, for Mitigation of COVID-19-Related Expenses
2. Services Excluded from Temporary Increase

/s/ Richard Sanchez *08/25/2021*
Authorized Signature **Date**

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken February 4, 2021
Regular Meeting of the CalOptima Board of Directors

Report Item

21. Consider Authorizing a Temporary, Short-Term Supplemental Payment Increase for Contracted CalOptima Medi-Cal Community Network and CalOptima Direct-Administrative Medi-Cal Fee-for-Service Community Health Centers, for Mitigation of COVID-19-Related Expenses

Contact

Ladan Khamseh, Chief Operations Officer, (714) 246-8866
Michelle Laughlin, Executive Director, Network Operations, (657) 900-1116

Recommended Actions

1. Authorize a temporary, short-term supplemental payment increase of 5% from current levels, for compliant, contracted CalOptima Medi-Cal Community Network (CCN) and CalOptima Direct-Administrative (COD-A) Medi-Cal Fee-for-Service (FFS) Community Health Centers, for certain medically necessary services provided on dates of service January 1, 2021, through June 30, 2021; and

2. Authorize unbudgeted expenditures up to $210,000 to provide funding for the supplemental payment increase to Medi-Cal FFS Community Health Centers.

Background

On January 31, 2020, the Secretary of Health and Human Services declared a public health emergency under Section 319 of the Public Health Service Act (42 U.S.C. 247d) in response to a novel coronavirus known as SARS-CoV-2 (coronavirus). On March 13, 2020, the President of the United States declared a national emergency based on the spread of this coronavirus. Subsequently, the Governor and the Orange County Health Officer have taken similar steps to slow the spread of the coronavirus and protect the public. In collaboration with federal, state and local agencies, CalOptima is taking action to continue efforts to support providers serving CalOptima members during the pandemic.

In response to the public health emergency, the Board authorized a Medi-Cal capitation rate increase to CalOptima's health networks on April 2, 2020. Following receipt of the final Calendar Year 2021 Medi-Cal capitation rates from the California Department of Health Care Services (DHCS) (which included an updated rate component for COVID-19-related adjustments), the Board authorized a second capitation rate increase for Medi-Cal health networks on January 7, 2021.

Discussion

In recognition of the unprecedented and dynamic nature of the pandemic and the strain it has placed on providers, a supplemental payment increase for contracted CCN and COD-A Medi-Cal FFS Community Health Centers is recommended. CalOptima staff recommends that the Board approve a supplemental payment increase for services provided by CCN and COD-A Medi-Cal FFS Community Health Centers during the period of January 1, 2021 through June 30, 2021. The increase is intended to support CalOptima's FFS Medi-Cal providers and strengthen access to care, given potential utilization changes and COVID-19-related testing and treatment in the current environment.

This item applies solely to CalOptima's Community Health Centers—including Federally Qualified Health Centers (FQHC), FQHC look alike clinics, and community clinics—which are an important part of the safety net serving CalOptima members. They provide increased access to care for CalOptima's various member populations, including the homeless, by reducing barriers such as language, distance, and wait time. In addition to the variety of primary, preventive, and health education services they provide, Community Health Centers have a direct impact in preventing the spread of COVID-19 throughout the community by providing COVID-19 testing and treatment. Attachment 1 provides additional details regarding exclusions from the Temporary, Short-Term Supplemental Payment Increase.

Pending Board approval, the supplemental payment increase will be administered to eligible providers for identified services through the claims payment system. Staff will give notice to contracted CalOptima Community Network and CalOptima Direct-Administrative Medi-Cal Fee-for-Service Community Health Centers of the 5% increase following Board approval. Staff proposes making supplemental payment increases for dates of service beginning January 1, 2021 in February 2021. Adjudicated and paid claims for dates of service January 1, 2021, up until the supplemental payment processing date (a February date to be determined) will receive a 5% supplemental payment adjustment. Moving forward, the 5% supplemental payment will be made monthly, for paid claims identified subsequent to the prior monthly supplemental payment, on a rolling time schedule. Staff plans to identify and process the supplemental payment at the covered service claim line level that, at a minimum, identifies the eligible date of service, covered billing service code and payment amount. CalOptima staff anticipates that supplemental payments will be issued to eligible providers monthly from prior month's payment by the end of each month. Supplemental payments on identified eligible claims will be made so long as timely filing requirements have been met. Since supplemental payments are provided as an additional payment to adjudicated and paid claims, timely payment requirements, such as interest, will not be applied. However, staff will monitor the process to ensure that the supplemental payment adjustments are processed and paid appropriately. Additionally, current policies and procedures related to provider payment recoupment, grievance and appeals, and provider dispute resolution will be followed where applicable.

Fiscal Impact

The recommended action to authorize a temporary, short-term supplemental payment increase of 5% from current levels for contracted CCN and COD-A Medi-Cal FFS Community Health Centers is an unbudgeted item. The projected aggregate fiscal impact is approximately $210,000 for the six-month period. Staff anticipates the net fiscal impact will be budget neutral, as decreased utilization of certain services within the Medi-Cal program in the current fiscal year will be sufficient to support the additional costs in unbudgeted FFS payments.

Rationale for Recommendation

The temporary, public health emergency-related supplemental payment for contracted CCN and COD-A Medi-Cal FFS Community Health Centers is intended to ensure the viability of CalOptima's FFS Medi-

Cal clinic providers, strengthens access to member care and supports the safety net system serving CalOptima members during the pandemic.

Concurrence
Gary Crockett, Chief Counsel

Attachments
1. List of Exclusions for Temporary, Short-Term Supplemental Payment Increase

/s/ Richard Sanchez *01/27/2021*
Authorized Signature **Date**

List of Exclusions from Temporary, Short-Term Supplemental Payment Increase
▪ Pharmacy and Pharmacy Benefit Management Services, and other contracted Administrative Service providers for which CalOptima covers the cost of claims
▪ Non-pharmacy administered drugs
▪ Long Term Care services
▪ Durable Medical Equipment; Orthotics and Prosthetics and other medical devices
▪ Members in CalOptima's Program for All Inclusive Care for the Elderly (PACE), OneCare, and OneCare Connect
▪ Crossover Claims
▪ Other supplemental or directed payments, such as Proposition 56
▪ Claims paid by Letter of Agreement (LOA)

Services excluded from Temporary, Short-Term Supplemental Payment Increase
▪ Pharmacy and Pharmacy Benefit Management Services, and other contracted Administrative Service providers for which CalOptima covers the cost of claims
▪ Non-pharmacy administered drugs
▪ Long Term Care facilities
▪ Durable Medical Equipment; Orthotics and Prosthetics and other medical devices
▪ Members in CalOptima's Program for All Inclusive Care for the Elderly (PACE), OneCare, and OneCare Connect
▪ Crossover Claims
▪ Other supplemental or directed payments, such as Proposition 56
▪ Claims paid by Letter of Agreement (LOA)

Services excluded from Temporary, Short-Term Supplemental Payment Increase
▪ Pharmacy and Pharmacy Benefit Management Services, and other contracted Administrative Service providers for which CalOptima covers the cost of claims
▪ Non-pharmacy administered drugs
▪ Long Term Care facilities
▪ Durable Medical Equipment; Orthotics and Prosthetics and other medical devices
▪ Members in CalOptima's Program for All Inclusive Care for the Elderly (PACE), OneCare, and OneCare Connect
▪ Crossover Claims
▪ Other supplemental or directed payments, such as Proposition 56
▪ Claims paid by Letter of Agreement (LOA)

Services excluded from Temporary, Short-Term Supplemental Payment Increase
▪ Pharmacy and Pharmacy Benefit Management Services, and other contracted Administrative Service providers for which CalOptima covers the cost of claims
▪ Non-pharmacy administered drugs
▪ Long Term Care facilities
▪ Durable Medical Equipment; Orthotics and Prosthetics and other medical devices
▪ Members in CalOptima's Program for All Inclusive Care for the Elderly (PACE), OneCare, and OneCare Connect
▪ Crossover Claims
▪ Other supplemental or directed payments, such as Proposition 56
▪ Claims paid by Letter of Agreement (LOA)

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken June 2, 2022
Regular Meeting of the CalOptima Board of Directors

Report Item

25. Authorize Extension of a Supplemental Capitation Rate Increase for all Contracted Medi-Cal Health Networks, except ARTA Western California Inc., Monarch Health Plan Inc., Talbert Medical Group P.C., and Kaiser Foundation Health Plan Inc., for COVID-Related Expenses for Services Provided to CalOptima Medi-Cal Members and Authorize CEO to Execute Necessary Amendments

Contact

Yunkyung Kim, Chief Operating Officer 714-246-8408

Recommended Actions

1. Authorize an extension of capitation rate increases for all contracted Physician Hospital Consortia (PHC), Shared Risk Group (SRG), and Health Maintenance Organization (HMO) Medi-Cal health networks, except ARTA Western California Inc. (ARTA), Monarch Health Plan Inc. (Monarch), Talbert Medical Group P.C. (Talbert), and Kaiser Foundation Health Plan Inc. (Kaiser) on Child, Adult and Seniors and Persons with Disabilities (SPD) Categories of Aid (COA) by 7.5% from Fiscal Year (FY) 2021-22 original budgeted base rates for the period of July 1, 2022, through June 30, 2023; and

2. Authorize the Chief Executive Officer (CEO) to execute amendments to Medi-Cal PHC, SRG, and HMO health network contracts except ARTA, Monarch, Talbert, and Kaiser, to implement health network capitation rate adjustments.

Background and Discussion

Staff requests that the CalOptima Board of Directors (Board) authorize extension of capitation rate increase for all Medi-Cal health networks, except ARTA, Monarch, Talbert, and Kaiser, for COVID-related expenses between July 1, 2022 and June 30, 2023. In response to COVID-19, the Board has authorized four temporary, short-term supplemental increases for contracted Medi-Cal health networks for certain medically necessary services provided to CalOptima members. The increases were implemented on December 20, 2021, September 2, 2021, January 7, 2021, and April 2, 2020

Management recognizes that continued support is necessary to help providers promote and improve vaccination rates, address additional variants of the COVID-19 virus, cover increased expenses for testing and treatment, and ensure uninterrupted, medically necessary Medi-Cal covered services for CalOptima members. Staff recommends authorizing extension of the capitation rate increase from July 1, 2022 through June 30, 2023, and amending all Medi-Cal health network contracts except ARTA, Monarch, Talbert, and Kaiser, to reflect this increase.

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Fiscal Impact

The recommended action is a budgeted item in the proposed CalOptima FY 2022-23 Operating Budget. The projected aggregate fiscal impact for all health networks is approximately $30 million.

Rationale for Recommendation

Authorizing the capitation rate increase for all Medi-Cal health networks except ARTA, Monarch, Talbert, and Kaiser, will ensure the viability of CalOptima's provider network, strengthen access to member care and support Orange County's safety net system serving CalOptima members.

Concurrence

Troy R. Szabo, Outside General Counsel, Kennaday Leavitt

Attachments

1. Entities Covered by this Recommended Board Action
2. Board Action dated December 20, 2021: Consider Authorizing Extension of a Temporary, Short-term, Supplemental Capitation Rate Increase for all Contracted Medi-Cal Health Networks Except ARTA Western California Inc., Monarch Health Plan Inc., and Talbert Medical Group P.C for COVID-Related Expenses for Services Provided to CalOptima Medi-Cal Members. This Board action includes the following:
    - Board Action dated September 2, 2021: Authorize Medi-Cal Health Network Capitation Rate Increases for the Period of September 1, 2021 through December 31, 2021, due to COVID-Related Expenses
    - Board Action dated January 7, 2021: Authorize Health Network Medi-Cal Rate Increases for the Period of January 1, 2021, through June 30, 2021, due to COVID-Related Expenses
    - Board Action dated April 2, 2020: Consider Actions Related to Coronavirus (COVID-19) Pandemic
3. Proposed Medi-Cal Health Network Amendment

/s/ Michael Hunn — *05/27/2022*

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
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
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
United Care Medical Group, Inc.	600 City Parkway West	Orange	CA	92868

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken December 20, 2021
Special Meeting of the CalOptima Board of Directors

Report Item

48. Consider Authorizing Extension of a Temporary, Short-Term, Supplemental Capitation Rate Increase for all Contracted Medi-Cal Health Networks Except ARTA Western California Inc., Monarch Health Plan Inc., and Talbert Medical Group P.C. for COVID-Related Expenses for Services Provided to CalOptima Medi-Cal Members

Contacts

Yunkyung Kim, Chief Operating Officer, (714) 246-8408
Michelle Laughlin, Executive Director, Network Operations, (657) 900-1116

Recommended Actions

Recommend authorizing the following actions for all Medi-Cal health networks except ARTA Western California Inc.(ARTA), Monarch Health Plan Inc. (Monarch), and Talbert Medical Group P.C. (Talbert):

1. Extending capitation rate increases for all contracted Physician Hospital Consortia (PHC), Shared Risk Group (SRG), and Health Maintenance Organization (HMO) Medi-Cal health networks except ARTA, Monarch, and Talbert on Child, Adult and Seniors and Persons with Disabilities (SPD) Categories of Aid (COA) by 7.5% from Fiscal Year (FY) 2021-22 original budgeted base rates for the period of January 1, 2022, through June 30, 2022;
2. Use of unbudgeted expenditures in an aggregate amount for all health networks up to $16.2 million from existing reserves to provide funding for Health Network capitation rate adjustments; and
3. Authorize the Chief Executive Officer (CEO), with the assistance of Legal Counsel, to amend all Medi-Cal PHC, SRG, and HMO Health Network contracts except ARTA, Monarch, and Talbert, to implement the health network capitation rate adjustments

Background

On January 31, 2020, the U.S. Secretary of Health and Human Services declared a public health emergency (PHE) under Section 319, of the Public Health Service Act (42 U.S.C. 247d) in response to a novel coronavirus known as SARS-CoV-2 (coronavirus). On March 13, 2020, the President of the United States declared a national emergency based on the spread of this coronavirus. Subsequently, the Governor of California and the Orange County Health Officer have similarly taken steps to slow the spread of the coronavirus and protect the public. As with federal, state, and local agencies, CalOptima is continuing efforts to support providers serving CalOptima members during the pandemic.

At its April 2, 2020, meeting, the Board authorized a temporary, short-term supplemental 5% health network Medi-Cal capitation rate increase from reserves for contracted PHCs, SRGs and HMOs for the period of April 1, 2020, through June 30, 2020, to support CalOptima's provider networks and ensure member access proactively at the beginning of the pandemic.

At its January 7, 2021, special meeting, the Board authorized another 5% Health Network Medi-Cal capitation rate increase for contracted PHCs, SRGs and HMOs, except Kaiser, on Child, Adult and SPD COAs for the period of January 1, 2021, through June 30, 2021.

At its September 2, 2021, meeting, the Board authorized a Health Network Medi-Cal capitation rate increase of 7.5% from current levels, (i.e., FY 2021-22 original budgeted base rates) for the period of September 1, 2021, through December 31, 2021.

Discussion

Management recognizes that continued support is necessary to help providers promote and improve vaccination rates, address additional variants of the COVID-19 virus, cover increased expenses for testing and treatment, and ensure uninterrupted, medically necessary Medi-Cal covered services for CalOptima members. Aligned with increased funding from the Department of Health Care Services (DHCS) for such expenses, staff recommends continuing enhanced funding to CalOptima providers. This action will help preserve the viability of CalOptima's Medi-Cal provider network and strengthen members' access to care in anticipation of higher expense levels post-pandemic.

To support our contracted health networks, Staff requests authority to:

1. Extend a 7.5% increase from FY 2021-22 original budgeted base rates to Medi-Cal capitation rates, and shared risk pool funding on Child, Adult and SPD COAs, for all Medi-Cal health networks except ARTA, Monarch, and Talbert for the period of January 1, 2022, through June 30, 2022. The projected aggregate fiscal impact is approximately $16.2 million for the six-month period and will be funded from existing reserves.

2. Amend all Medi-Cal health network contracts except ARTA, Monarch, and Talbert to reflect this increase for the period stated above.

Fiscal Impact

The total funds for the Health Network Medi-Cal capitation rates for contracted PHCs, SRGs and HMOs will not exceed 7.5% of total medical capitation expenditures, on Child, Adult and SPD COAs for the period of January 1, 2022, through June 30, 2022, in the CalOptima FY 2021-22 Operating Budget. The projected aggregate fiscal impact for all health networks is approximately $16.2 million for the six-month period and will be funded from existing reserves.

Rationale for Recommendation

Authorizing the Health Network Medi-Cal capitation rate increases for all Medi-Cal health networks except ARTA, Monarch, and Talbert will ensure the viability of CalOptima's provider network, strengthen access to member care and support Orange County's safety net system serving CalOptima members.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. Entities Covered by this Recommended Action
2. Board Action Dated September 2, 2021: Authorize Medi-Cal Health Network Capitation Rate Increases for the Period of September 1, 2021, through December 31, 2021, due to COVID-Related Expenses
3. Board Action Dated January 7, 2021: Authorize Health Network Medi-Cal Capitation Rate Increases for the Period of January 1, 2021, through June 30, 2021, due to COVID-Related Expenses
4. Board Action Dated April 2, 2020: Consider Actions Related to Coronavirus (COVID-19) Pandemic
5. Proposed Medi-Cal Health Network Amendment

/s/ Michael Hunn *12/15/2021*
Authorized Signature **Date**

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
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
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
United Care Medical Group, Inc.	600 City Parkway West	Orange	CA	92868

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken September 2, 2021
Regular Meeting of the CalOptima Board of Directors

Report Item

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

Contacts

Nancy Huang, Chief Financial Officer, (657) 235-6935
Michelle Laughlin, Executive Director, Network Operations, (657) 900-1116

Recommended Actions

1. Authorize 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. Authorize unbudgeted expenditures up to $10.4 million from existing reserves to provide funding for Health Network capitation rate adjustments; and
3. Authorize 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.

Background

On January 31, 2020, the Secretary of Health and Human Services declared a public health emergency (PHE) under section 319, of the Public Health Service Act (42 U.S.C. 247d) in response to a novel coronavirus known as SARS-CoV-2 (coronavirus). On March 13, 2020, the President of the United States declared a national emergency based on the spread of this coronavirus. Subsequently, the Governor and the Orange County Health Officer have similarly taken steps to slow the spread of the coronavirus and protect the public. As with federal, state, and local agencies, CalOptima is taking action to continue efforts to support providers serving CalOptima members during the pandemic.

At its April 2, 2020, meeting, the Board authorized a 5% health network Medi-Cal capitation rate increase from reserves for contracted PHCs, SRGs and HMOs for the period from April 1, 2020, through June 30, 2020, to support CalOptima's provider networks and ensure member access proactively at the beginning of the pandemic.

At its January 7, 2021, special meeting, the Board authorized another 5% Health Network Medi-Cal capitation rate increase for contracted PHCs, SRGs and HMOs, except Kaiser, on Child, Adult and SPD COAs for the period from January 1, 2021, through June 30, 2021.

Discussion

Management recognizes that the coronavirus pandemic continues to place significant stress on the healthcare providers and delivery system serving CalOptima members. In late June, the Centers for Disease Control and Prevention (CDC) issued new guidance and data related to the more contagious Delta variant. Orange County has experienced a surge of Delta variant cases leading to increased hospitalizations and strain on health care resources. In addition, the demand for coronavirus testing is

expected to increase as children return to school in the fall. This will be especially true for certain age groups who are not currently eligible to receive the vaccine.

In mid-July, the California Department of Health Care Services (DHCS) released its Medi-Cal COVID-19 Vaccine Incentive Program. This program will use $350 million dollars statewide to improve the vaccination rates among Medi-Cal beneficiaries. The focus populations include members who:

1. Are homebound and unable to travel to vaccination sites;
2. Are 50-64 years of age with multiple chronic diseases;
3. Self-identify as persons of color; and
4. With the return to school, are youth 12-25 years old.

The rate increase recommendation is intended to utilize and support health networks to improve vaccination rates for CalOptima's delegated members and create a vaccine strategy consistent with DHCS's COVID-19 Vaccine Incentive Program and CalOptima's Vaccine Response Plan. The health network's vaccine strategy will include working with primary care providers (PCPs) to conduct direct outreach to unvaccinated members assigned to the PCP offices and may include member outreach, implementation of best practices, health education strategies for members who are hesitant, development of partnerships with community organizations, and increased accessibility of vaccinations for hard-to-reach members (e.g., pop-up clinics, mobile units, vaccinations for homebound members). A health network will be responsible for meeting pre-identified outcome measures to demonstrate improvements in vaccination rates among DHCS-identified populations of focus. Each health network will collaborate with CalOptima's Quality Improvement Department to ensure a streamlined approach for CalOptima members.

In recognition of the demands the pandemic has placed on health networks, providing the supplemental payment increase for the referenced period for medically necessary Medi-Cal services is recommended. The increase will help preserve the viability of CalOptima's health networks and strengthen access to care considering the higher utilization levels including COVID-19-related testing and treatment.

In order to support our contracted health networks, Staff requests authority to:

1. Provide a 7.5% increase from current levels to contracted PHC, SRG and HMO Medi-Cal capitation rates (except for Kaiser), and shared risk pool funding for Child, Adult and SPD COAs, for the period from September 1, 2021, through December 31, 2021. The projected aggregate fiscal impact is approximately $10.4 million for the four-month period and will be funded from existing reserves.

2. Amend the Medi-Cal PHC, SRG, and HMO Health Network contracts, except Kaiser, to reflect this increase for the period stated above.

This additional funding will assist Health Networks to address the latest surge in Delta variant cases and projected increase in demand for coronavirus testing, and to promote an increase in vaccinations within the Medi-Cal focus populations identified by DHCS.

Fiscal Impact

The total funds for the Health Network Medi-Cal capitation rates for contracted PHCs, SRGs and HMOs will not exceed 7.5% of total medical capitation expenditures, on Child, Adult and SPD COAs for the period of September 1, 2021, through December 31, 2021, in the CalOptima Fiscal Year (FY) 2021-22 Operating Budget. The projected aggregate fiscal impact is approximately $10.4 million for the four-month period and will be funded from existing reserves.

As of this writing, DHCS has not released detailed guidance on their Medi-Cal COVID-19 Vaccine Incentive Program. Management anticipates that the use of reserves may be reduced depending on actual funding provided by DHCS for this purpose.

Rationale for Recommendation

Resuming the supplemental capitation rate increase for Medi-Cal PHC, SRG, and HMO Health Networks, except Kaiser, during the coronavirus pandemic will ensure providers remain viable and accessible to our members, as well as providing increased financial security for the Orange County safety net system.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. Entities Covered by this Recommended Action
2. Board Action Dated January 7, 2021: Authorize Health Network Medi-Cal Capitation Rate Increases for the Period of January 1, 2021, through June 30, 2021, due to COVID-Related Expenses
3. Board Action Dated April 2, 2020: Consider Actions Related to Coronavirus (COVID-19) Pandemic
4. Proposed Contract Amendment with Health Networks

/s/ Richard Sanchez — *08/26/2021*

Authorized Signature — **Date**

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
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

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken January 7, 2021
Special Meeting of the CalOptima Board of Directors

Report Item

7. Authorize Health Network Medi-Cal Capitation Rate Increases for the Period of January 1, 2021, through June 30, 2021, due to COVID-Related Expenses

Contacts

Richard Sanchez, Chief Executive Officer, (657) 900-1481
Nancy Huang, Chief Financial Officer, (657) 235-6935

Recommended Actions

1. Authorize 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 5.0% from current levels for the period of January 1, 2021 through June 30, 2021;
2. Authorize unbudgeted expenditures up to $9 million to provide funding for Health Network capitation rate adjustments; and
3. Authorize the Chief Executive Officer, 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.

Background

On January 31, 2020, the Secretary of Health and Human Services declared a public health emergency under section 319, of the Public Health Service Act (42 U.S.C. 247d) in response to a novel coronavirus known as SARS-CoV-2 (coronavirus). On March 13, 2020, the President of the United States declared a national emergency based on the spread of this coronavirus. Subsequently, the Governor and the Orange County Health Officer have similarly taken steps to slow the spread of the coronavirus and protect the public. As with federal, state, and local agencies, CalOptima is taking action to continue efforts to support providers serving CalOptima members during the pandemic.

At its April 2, 2020, meeting, the Board authorized a 5% health network Medi-Cal capitation rate increase from reserve for contracted PHCs, SRGs and HMOs for the period of April 1, 2020, through June 30, 2020 to support CalOptima's provider networks and ensure member access proactively in the beginning of pandemic.

On December 23, 2020, CalOptima received final Calendar Year 2021 Medi-Cal capitation rates from the California Department of Health Care Services (DHCS). The final rates included an update rate component for COVID-related adjustments.

Discussion

Management recognizes that the coronavirus pandemic has placed significant stress on healthcare providers and on the delivery system serving CalOptima members. Consistent with DHCS's rate adjustment methodology, staff has included COVID-related testing and treatment costs, as well as potential changes in utilization in the evaluation. As such, in order to support the viability of our contracted health networks, Management requests authority to:

1. Provide a 5.0% increase from current levels to contracted PHC, SRG and HMO Medi-Cal capitation rates, and shared risk pool funding on Child, Adult and SPD COAs, for the period of January 1, 2021, through June 30, 2021, except Kaiser. The estimated aggregate monthly fiscal impact is approximately $1.5 million.

2. Amend the Medi-Cal PHC, SRG, and HMO Health Network contracts, except Kaiser, to reflect this increase for the period stated above.

Fiscal Impact

The total funds for the Health Network Medi-Cal capitation rates for contracted PHCs, SRGs and HMOs will not exceed 5.0% of total medical capitation expenditures, on Child, Adult and SPD COAs, in the CalOptima Fiscal Year (FY) 2020-21 Operating Budget. The projected aggregate monthly fiscal impact is approximately $1.5 million or up to $9 million for the period of January 1, 2021, through June 30, 2021. It will be net budget neutral since additional funding from DHCS is anticipated to be sufficient to cover the unbudgeted Medi-Cal capitation rate increase.

Rationale for Recommendation

Providing additional provider payments during the coronavirus pandemic will ensure providers remain viable and accessible to our members, as well as increased financial security for the Orange County safety net system.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. Entities Covered by this Recommended Action
2. Board Action Dated April 2, 2020: Consider Actions Related to Coronavirus (COVID-19) Pandemic

/s/ Richard Sanchez — *12/31/2020*
Authorized Signature — **Date**

ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
Heritage Provider Network, Inc.	8510 Balboa Blvd., Ste. 285	Northridge	CA	91325
Monarch Health Plan, Inc.	11 Technology Dr.	Irvine	CA	92618
Prospect Health Plan, Inc.	600 City Parkway West, Ste. 800	Orange	CA	92868
CHOC Physicians Network and Children's Hospital of Orange County	1120 West La Veta Ave., Ste. 450	Orange	CA	92868
Family Choice Medical Group, Inc.	7631 Wyoming St., Ste. 202	Westminster	CA	92683
Fountain Valley Regional Hospital and Medical Center	17100 Euclid St.	Fountain Valley	CA	92708
AMVI Care Health Network	600 City Parkway West, Ste. 800	Orange	CA	92868
Orange County Physicians IPA Medical Group, Inc dba Noble Community Medical Associates, Inc.	10855 Business Center Dr., Ste. C	Cypress	CA	90630
Talbert Medical Group, P.C.	2175 Park Place	El Segundo	CA	90245
ARTA Western California, Inc.	2175 Park Place	El Segundo	CA	90245
United Care Medical Group, Inc.	600 City Parkway West	Orange	CA	92868
AltaMed Health Services Corporation	2040 Camfield Ave.	Los Angeles	CA	90040

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken April 2, 2020
Regular Meeting of the CalOptima Board of Directors

Report Item

4. Consider Actions Related to Coronavirus (COVID-19) Pandemic

Contact

Nancy Huang, Chief Financial Officer (714) 246-8400
Michelle Laughlin, Executive Director Network Operations (714) 246-8400

Recommended Actions

1. Authorize Health Network Medi-Cal capitation rate increases for contracted Physician Hospital Consortia (PHC), Shared Risk Group (SRG), and Health Maintenance Organizations (HMO) by 5% from current levels for the period of April 1, 2020, through June 30, 2020;

2. Authorize waiver of the minimum stay requirement and expand types of services eligible for per diem payments for contracted Community-Based Adult Services (CBAS) providers for Medi-Cal and OneCare Connect;

3. Authorize unbudgeted expenditures from existing reserves of up to $14 million to provide funding for rates adjustments for Health Network capitation rates;

~~4. Authorize interim Medi-Cal rate for coronavirus testing for dates of service on or after February 4, 2020;~~ Amended 4/2/20

5. Authorize the Chief Executive Officer (CEO), with the assistance of Legal Counsel, to:

    a. Amend the Medi-Cal PHC, SRG, and HMO Health Network contracts to implement the 5% capitation rate increase; and
    b. Amend Medi-Cal and OneCare Connect contracts with CBAS providers effective March 13, 2020 to provide flexibility for services, in accordance with the Department of Health Care Services' (DHCS) section 1135 Waiver application.

Background

On January 31, 2020, the Secretary of Health and Human Services declared a public health emergency under section 319, of the Public Health Service Act (42 U.S.C. 247d) in response to a novel coronavirus known as SARS-CoV-2 (coronavirus). On March 13, 2020, the President of the United States declared a national emergency based on the spread of this coronavirus. Along with federal, state, and local agencies, CalOptima is taking action to continue efforts to protect the health and safety of our providers and members.

As an unprecedented safety measure, the state has issued self-quarantine and social distancing requirements for an unknown period of time. These requirements have and continue to affect CalOptima's provider networks as the coronavirus pandemic develops. One immediate downstream effect of these measures has been CBAS closures as a result of a reduction of in-person utilization. Left

unaddressed, this can rapidly jeopardize the viability of CalOptima's CBAS provider network. Moreover, it underscores the need for CalOptima to take necessary measures to ensure there is limited disruption of care and access to services for our members, which includes vulnerable individuals.

Discussion

CalOptima management recognizes that healthcare service delivery to our members has undergone significant changes during the coronavirus pandemic. Management recommends the following actions in order to provide immediate aid and service authorization flexibilities to CalOptima's provider network in order to ensure that members received access to covered, medically necessary health care services:

Medi-Cal Rate Enhancement for Health Networks

To provide immediate aid and support and maintain the viability of the health networks, Management proposes to:

1. Provide a 5% increase from current levels to contracted PHC, SRG and HMO Medi-Cal capitation rates for the period of April 1, 2020, through June 30, 2020. The estimated aggregate monthly fiscal impact is approximately $4.4 million.

2. Amend the Medi-Cal Health Network contracts to reflect this increase for the period stated above.

Special Reimbursement to CBAS providers

Staff anticipates face-to-face visits at CBAS centers to continue decreasing due to the Governor's stay at home executive order issued on March 19, 2020, and the County of Orange's social distancing requirements. CalOptima currently holds contracts with 31 CBAS centers, serving approximately 2,580 members. Preventing this is critical at this time, as CBAS centers serve CalOptima's most vulnerable senior members On March 19, 2020, the California Department of Health Care Services (DHCS) submitted a request for additional Section 1135 Waiver flexibilities related to coronavirus. This request included additional flexibilities related to the CBAS benefit and individual plan of care. In order to continue uninterrupted access to CBAS services, effective March 13, 2020, Management proposes to:

1. Waive the 1115 waiver requirement of a minimum of a four-hour stay at the center. This change will enable CalOptima members to receive appropriate services at home and remove barriers to access.

2. Expand the types of services eligible for per diem payments. Pursuant to DHCS' 1135 Waiver request, CalOptima will provide per diem payments to CBAS providers who provide:
   - Telephonic or live video interactions in lieu of face-to-face social/therapeutic visits and/or assessments;
   - Arrange for home delivered meals in absence of meals provided at the CBAS center; and/or
   - Provide physical therapy or occupational therapy in the home

3. Amend CBAS contracts to reflect the waiver of the minimum four-hour stay requirement and expansion of services pursuant to DHCS 1135 Waiver request.

~~Interim Medi-Cal Rate for Coronavirus Testing~~

~~The Centers for Medicare & Medicaid Services (CMS) established, for the Medicare program, procedure codes and provider reimbursement rates for coronavirus testing conducted on or after February 4, 2020. DHCS adopted these same procedure codes for the Medi-Cal program effective February 4, 2020. As of this writing, DHCS has not established Medi-Cal reimbursement rates for coronavirus testing.~~ Amended 4/2/20

~~Management proposes to adopt the Medicare provider reimbursement rates on an interim basis for CalOptima's Medi-Cal program for dates of service on or after February 4, 2020. Once DHCS establishes Medi-Cal reimbursement rates for coronavirus testing, CalOptima will make retroactive adjustments to Medi-Cal claims, as appropriate.~~ Amended 4/2/20

Fiscal Impact

The total funds for the Health Network Medi-Cal capitation rates for contracted PHCs, SRGs and HMOs will not exceed 5% of total medical capitation expenditures, in aggregate, in the CalOptima Fiscal Year (FY) 2019-20 Operating Budget. Staff projects the monthly incremental funding at approximately $4.4 million. An allocation of up to $14 million from existing reserves will fund this action.

The CalOptima FY 2019-20 Operating Budget includes funding for Professional medical expenditures for contracted CBAS providers. Currently, the net fiscal impact for the recommended action is unknown. However, assuming current utilization levels will continue, Staff anticipates the recommended action will not have an additional fiscal impact to the operating budget.

~~The fiscal impact for the recommended action to authorize an interim Medi-Cal rate for coronavirus testing is unknown at this time, since both utilization and costs estimates are difficult to quantify. However, Staff anticipates future funding received from DHCS for this purpose will fully offset expenses incurred by CalOptima.~~ Amended 4/2/20

Rationale for Recommendation

Providing additional provider payments during the coronavirus pandemic will ensure providers remain viable and accessible to our members, as well as increased financial security for the Orange County safety net system.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. DHCS Request for Additional Section 1135 Waiver Flexibilities Related to Novel Coronavirus Disease (COVID-19) National Emergency/Public Health Emergency dated March 19, 2020

/s/ Michael Schrader *03/26/2020*

Authorized Signature **Date**

State of California—Health and Human Services Agency
Department of Health Care Services

BRADLEY P. GILBERT, MD, MPP
DIRECTOR

GAVIN NEWSOM
GOVERNOR

March 19, 2020

Jackie Glaze
CMS Acting Director
Medicaid & CHIP Operations Group Center for Medicaid & CHIP
Services 7500 Security Boulevard
Baltimore, MD 21244
Jackie.Glaze@cms.hhs.gov

REQUEST FOR ADDITIONAL SECTION 1135 WAIVER FLEXIBILITIES RELATED TO NOVEL CORONAVIRUS DISEASE (COVID-19) NATIONAL EMERGENCY/PUBLIC HEALTH EMERGENCY

Dear Ms. Glaze:

The Department of Health Care Services (DHCS) writes to request approval for the below-detailed additional flexibilities under Section 1135 of the Social Security Act (42 U.S.C. § 1320b-5) as related to the Novel Coronavirus Disease (COVID-19). These flexibilities are in addition to the request submitted from DHCS on March 16, 2020. As you know, the COVID-19 outbreak was declared a national emergency on March 13, 2020, and was previously declared a nationwide public health emergency on January 31, 2020 (retroactive to January 27, 2020).

The below list represents California's additional requested flexibilities under the Section 1135 authority in connection with the COVID-19 outbreak and emergency based on further exploration of need. Because circumstances surrounding the COVID-19 emergency remain quite fluid, DHCS may subsequently request approval for additional flexibilities, which we can commit to doing promptly as soon as the need is discovered. Consistent with Section 1 of the President's March 13, 2020, national emergency declaration, DHCS requests a retroactive effective date of January 27, 2020, for the requested Section 1135 flexibilities to coincide with the effective start date of the Public Health Emergency, unless otherwise specified. In the event a requested flexibility below is not approvable under the Section 1135 authority, DHCS requests CMS technical assistance to identify any other authority (e.g. under the State Plan or Section 1115) for which approval may be available. Per our discussion with CMS on March 19, 2020, DHCS will request the flexibilities associated with Inmate and Institutions for Mental Disease (IMD) funding exclusions in the Section 1115 context (according to the forthcoming CMS instructions/Section 1115 template).

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In addition, DHCS requests confirmation that any approved flexibility granted with respect to fee-for-service Medi-Cal benefits and providers would apply equally, to the extent applicable, to our various federally approved delivery systems, such as Medi-Cal managed care plans (MCPs), county organized health systems, county mental health plans, and Drug Medi-Cal organized delivery systems (DMC-ODS) and to the State's standalone Children's Health Insurance Program.

1. **Service authorization and utilization controls**, including but not necessarily limited to:

- Waiver of Attachment 3.1 – A.1, page 2 of the State Plan, exclusion of adult receipt of acetaminophen-containing and cough/cold products.

- For individuals with developmental disabilities receiving services under the State Plan 1915(i) authority, the state requests retainer payments. Retainer payments are available only for absences (maximum 30 consecutive days) in excess of the average number of absences experienced by the provider during the 12 month period prior to 2020.

- For Community-Based Adult Services (CBAS) – CBAS Benefit and Individual Plan of Care (IPC), the state requests:
    - Flexibility to reduce day center activities/gatherings and limit exposure to vulnerable populations.
    - Flexibility to utilize telephonic or live video interactions in lieu of face-to-face social/therapeutic visits.
    - Flexibility to utilize telephonic or live video interactions in lieu of face-to-face assessments.
    - Flexibility to allow following services to be provided at a beneficiary's home:
        - Physical Therapy
        - Occupational Therapy
    - Flexibility to provide or arrange for home delivered meals in absence of meals provided at the CBAS Center.
    - Flexibility for DHCS and MCPs to provide per diem payments to CBAS providers who provide telephonic or live video interactions in lieu of face-to-face social/therapeutic visits and/or assessments, arrange for home delivered meals in absence of meals provided at the CBAS Center, and/or provide physical therapy or occupational therapy in the home.

2. **Eligibility Flexibilities**, including but not necessarily limited to:

    - Flexibility in the hospital presumptive eligibility (HPE) program to cover more than one HPE period in a given 12-month timeframe. To the extent a beneficiary seeks care for coronavirus but has already used an HPE period in the last 12 months, or tests negative and then seeks care for a suspected episode later in the same 12-month period, HPE can provide a fast, low-barrier way to provide immediate, temporary coverage during the emergency period.

3. **Telehealth/Telephonic/Virtual Visits**, including but not necessarily limited to:

    - Waiver of 42 C.F.R. §438.6(c)(1), as necessary, to permit the State to direct MCO and PIHP payments to network providers, where telehealth/telephonic service is medically appropriate and feasible, at the same rate the MCO or PIHP would pay if the service was provided in person, unless the MCO/PIHP and the provider otherwise agree to a different rate for the telehealth modality.

    - Similar to flexibility granted at the federal level, DHCS requests authority for the State not to impose penalties for noncompliance with the regulatory requirements under the Health Insurance Portability and Accountability Act (HIPAA) against covered health care providers in connection with the good faith provision of telehealth during the COVID-19 emergency.

4. **Administrative Activities**, regarding deadlines and timetables for performance of required activities, DHCS requests extension of time for activities conducted by the state, MCPs, and/or county mental health and substance use disorder prepaid inpatient health plans (PIHPs), as applicable, due to social distancing to reduce the spread of COVID-19 and to allow the state, MCP, and/or PIHP resources to prioritize COVID-19 response efforts including:

    - Waiver of the two-year claiming submission limit (42 USC §1320b-2; 45 CFR §95.1, et seq.) for federal financial participation or claiming adjustments with respect to medical assistance and administrative expenditures.

    - Waiver of the requirement in 42 CFR §447.45(d)(1), that DHCS require providers to submit all claims no later than 12 months from the date of service. DHCS is requesting authority to extend the 12-month timeframe for services provided with dates of service during this emergency.

    - Modification of the federal deadlines for submission of cost reports for Medicare and Medicaid (currently due Nov. 2020) by at least 6 months, with no late penalties, so that providers have time to file the appropriate documents. Many provider and hospital staff have been told to work remotely or have been reassigned to

emergency response activities, which will cause delays in meeting reporting timelines.

- Waiver of the timeframe required for financial oversight and medical compliance audits for PIHPs and State Plan Drug Medi-Cal counties. DHCS requests this waiver to allow flexibility regarding deploying staff resources to manage the emergency.

5. **Payment Rates**, including but not necessarily limited to:

- Waiver of the county interim rate setting methodology described beginning on page 10 of the Certified Public Expenditure (CPE) protocol approved through the 1915(b) waiver. The CPE protocol requires DHCS to calculate county interim rates using prior year cost reports trended forward using the Home Health Agency Market Basket Index or a CMS approved cost of living index. As utilization drops and costs increase during this emergency, DHCS is requesting authority to use alternative methodologies, at DHCS's discretion, to temporarily increase county interim rates.

- Waiver of the interim rate setting methodology described on page 5 and 6 of the Drug Medi-Cal Organized Delivery System (DMC ODS) Certified Public Expenditure protocol approved through the 1115 demonstration. The CPE protocol requires DHCS to reimburse DMC ODS counties on an interim basis pursuant to county developed and DHCS approved interim rates for each service, which are expected to be based upon the most recently calculated or estimated county costs for the specific service. DHCS is requesting authority, if counties reimburse DMC providers up to actual cost, to reimburse counties the federal and state share of their certified public expenditures for services rendered during this emergency.

- Waiver of the Statewide Maximum Allowance (SMA) rate limitation on interim reimbursement and final settlement for Drug Medi-Cal (DMC) services provided in state plan counties. California's State Plan describes the reimbursement methodology for DMC services in Attachment 4.19-B, pages 38-41b (SPA 09-022 and SPA 15-013), which limits interim payments to DMC providers to the lower of the SMA or the USDR (Section E.1, page 41). Furthermore, the Medicaid State Plan also limits final reimbursement to lower of actual cost, usual and customary charges, or the SMA for DMC providers. DHCS is requesting authority to waive the SMA and usual and customary charge limitations on interim and final reimbursement for DMC state plan services.

6. **Clarification of Previous Requests**:

- Item 2 in the March 16, 2020 1135 Waiver requested to waive various federal and State Plan requirements pertaining to service authorization and utilization controls

imposed on covered benefits. DHCS seeks to clarify that the requested waivers would extend to any limitations for elective procedures and informed consent (including, but not necessarily limited, to 42 C.F.R. § 441.253) to enable provider to postpone elective procedures to prioritize COVID-19 response activities. DHCS suggests extending the current 180-day limit for beneficiary informed consent to 360 days.

- Item 5 in the March 16, 2020 1135 Waiver requested to waive restrictions existing restrictions on individual counseling sessions under the Drug Medi-Cal state plan. DHCS wants to clarify that we are requesting to waive Supplement 3 to Attachment 3.1-B, to allow individual visits in lieu of group visits, and that these visits may be conducted by telephone, telehealth, and/or in-person. Waive the current restriction on individual visits (only allowed for intake, crisis intervention, collateral services, and treatment and discharge planning). Allow individual visits to be used for counseling focused on short-term personal, family, job/school and other problems and their relationship to substance use. This waiver is needed so the services previously provided in groups can be done in individual sessions during the emergency, to prevent COVID-19 exposure.

- Item 6 in the March 16, 2020 1135 Waiver requested to waive State Plan Attachment 4.19-D, including any applicable Supplements, which establishes the payment methodology for Intermediate Care Facilities for the Developmentally Disabled (ICF-DD) and skilled nursing facilities (SNFs). The state wanted to clarify that the waiver being requested would apply to all SNF and ICF-DD facility types and the reimbursement flexibilities would not be limited solely to the costs associated with suspension of Day Programs. SNFs and ICF-DDs are experiencing increased cost pressures in a variety of areas as a result of the COVID-19 response and the state is seeking flexibility to allow consideration of all costs being incurred by facilities to ensure the health and safety of residents.

7. Flexibilities to be Requested under Section 1115 Authority (according to forthcoming CMS guidance):

- Waiver of the inmate exclusion (42 U.S.C. §1396d(a)(30)(A)) to allow for Medi-Cal claiming for services provided ***in*** jails and prisons for the testing, diagnosis and treatment of COVID-19 or services to ensure other care is provided in a safe way without transporting individuals to acute care facilities.

- Waiver of the 16-bed limitation/prohibition on receipt of federal financial participation for patients residing in Institutions for Mental Disease (IMD) pursuant to 42 U.S.C. §1396d(a)(30)(B). DHCS believes waiver of the IMD exclusion is necessary to temporarily increase bed capacity for affected beneficiaries and to allow facilities to claim for services provided for these

additional beds. Evaluation of less restritictive settings would be completed prior to placement.

During such difficult times for California and the nation, DHCS greatly appreciates the prompt attention exhibited by CMS to these matters and we look forward to the continued partnership.

Sincerely,
Original Signed By:

Jacey Cooper
Chief Deputy Director
Health Care Programs
State Medicaid Director

cc: Bradley P. Gilbert, MD, MPP
Director
Department of Health Care Services

Erika Sperbeck
Chief Deputy Director
Policy & Program Support
Department of Health Care

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken April 2, 2020
Regular Meeting of the CalOptima Board of Directors

Report Item
4. Consider Actions Related to Coronavirus (COVID-19) Pandemic

Contact
Nancy Huang, Chief Financial Officer (714) 246-8400
Michelle Laughlin, Executive Director Network Operations (714) 246-8400

Recommended Actions
1. Authorize Health Network Medi-Cal capitation rate increases for contracted Physician Hospital Consortia (PHC), Shared Risk Group (SRG), and Health Maintenance Organizations (HMO) by 5% from current levels for the period of April 1, 2020, through June 30, 2020;

2. Authorize waiver of the minimum stay requirement and expand types of services eligible for per diem payments for contracted Community-Based Adult Services (CBAS) providers for Medi-Cal and OneCare Connect;

3. Authorize unbudgeted expenditures from existing reserves of up to $14 million to provide funding for rates adjustments for Health Network capitation rates;

~~4. Authorize interim Medi-Cal rate for coronavirus testing for dates of service on or after February 4, 2020;~~ Amended 4/2/20

5. Authorize the Chief Executive Officer (CEO), with the assistance of Legal Counsel, to:

    a. Amend the Medi-Cal PHC, SRG, and HMO Health Network contracts to implement the 5% capitation rate increase; and
    b. Amend Medi-Cal and OneCare Connect contracts with CBAS providers effective March 13, 2020 to provide flexibility for services, in accordance with the Department of Health Care Services' (DHCS) section 1135 Waiver application.

Background
On January 31, 2020, the Secretary of Health and Human Services declared a public health emergency under section 319, of the Public Health Service Act (42 U.S.C. 247d) in response to a novel coronavirus known as SARS-CoV-2 (coronavirus). On March 13, 2020, the President of the United States declared a national emergency based on the spread of this coronavirus. Along with federal, state, and local agencies, CalOptima is taking action to continue efforts to protect the health and safety of our providers and members.

As an unprecedented safety measure, the state has issued self-quarantine and social distancing requirements for an unknown period of time. These requirements have and continue to affect CalOptima's provider networks as the coronavirus pandemic develops. One immediate downstream effect of these measures has been CBAS closures as a result of a reduction of in-person utilization. Left

unaddressed, this can rapidly jeopardize the viability of CalOptima's CBAS provider network. Moreover, it underscores the need for CalOptima to take necessary measures to ensure there is limited disruption of care and access to services for our members, which includes vulnerable individuals.

Discussion

CalOptima management recognizes that healthcare service delivery to our members has undergone significant changes during the coronavirus pandemic. Management recommends the following actions in order to provide immediate aid and service authorization flexibilities to CalOptima's provider network in order to ensure that members received access to covered, medically necessary health care services:

Medi-Cal Rate Enhancement for Health Networks

To provide immediate aid and support and maintain the viability of the health networks, Management proposes to:

1. Provide a 5% increase from current levels to contracted PHC, SRG and HMO Medi-Cal capitation rates for the period of April 1, 2020, through June 30, 2020. The estimated aggregate monthly fiscal impact is approximately $4.4 million.

2. Amend the Medi-Cal Health Network contracts to reflect this increase for the period stated above.

Special Reimbursement to CBAS providers

Staff anticipates face-to-face visits at CBAS centers to continue decreasing due to the Governor's stay at home executive order issued on March 19, 2020, and the County of Orange's social distancing requirements. CalOptima currently holds contracts with 31 CBAS centers, serving approximately 2,580 members. Preventing this is critical at this time, as CBAS centers serve CalOptima's most vulnerable senior members On March 19, 2020, the California Department of Health Care Services (DHCS) submitted a request for additional Section 1135 Waiver flexibilities related to coronavirus. This request included additional flexibilities related to the CBAS benefit and individual plan of care. In order to continue uninterrupted access to CBAS services, effective March 13, 2020, Management proposes to:

1. Waive the 1115 waiver requirement of a minimum of a four-hour stay at the center. This change will enable CalOptima members to receive appropriate services at home and remove barriers to access.

2. Expand the types of services eligible for per diem payments. Pursuant to DHCS' 1135 Waiver request, CalOptima will provide per diem payments to CBAS providers who provide:
   - Telephonic or live video interactions in lieu of face-to-face social/therapeutic visits and/or assessments;
   - Arrange for home delivered meals in absence of meals provided at the CBAS center; and/or
   - Provide physical therapy or occupational therapy in the home

3. Amend CBAS contracts to reflect the waiver of the minimum four-hour stay requirement and expansion of services pursuant to DHCS 1135 Waiver request.

~~Interim Medi-Cal Rate for Coronavirus Testing~~

~~The Centers for Medicare & Medicaid Services (CMS) established, for the Medicare program, procedure codes and provider reimbursement rates for coronavirus testing conducted on or after February 4, 2020. DHCS adopted these same procedure codes for the Medi-Cal program effective February 4, 2020. As of this writing, DHCS has not established Medi-Cal reimbursement rates for coronavirus testing.~~ Amended 4/2/20

~~Management proposes to adopt the Medicare provider reimbursement rates on an interim basis for CalOptima's Medi-Cal program for dates of service on or after February 4, 2020. Once DHCS establishes Medi-Cal reimbursement rates for coronavirus testing, CalOptima will make retroactive adjustments to Medi-Cal claims, as appropriate.~~ Amended 4/2/20

Fiscal Impact

The total funds for the Health Network Medi-Cal capitation rates for contracted PHCs, SRGs and HMOs will not exceed 5% of total medical capitation expenditures, in aggregate, in the CalOptima Fiscal Year (FY) 2019-20 Operating Budget. Staff projects the monthly incremental funding at approximately $4.4 million. An allocation of up to $14 million from existing reserves will fund this action.

The CalOptima FY 2019-20 Operating Budget includes funding for Professional medical expenditures for contracted CBAS providers. Currently, the net fiscal impact for the recommended action is unknown. However, assuming current utilization levels will continue, Staff anticipates the recommended action will not have an additional fiscal impact to the operating budget.

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Rationale for Recommendation

Providing additional provider payments during the coronavirus pandemic will ensure providers remain viable and accessible to our members, as well as increased financial security for the Orange County safety net system.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. DHCS Request for Additional Section 1135 Waiver Flexibilities Related to Novel Coronavirus Disease (COVID-19) National Emergency/Public Health Emergency dated March 19, 2020

/s/ Michael Schrader *03/26/2020*

Authorized Signature **Date**

State of California—Health and Human Services Agency
Department of Health Care Services

BRADLEY P. GILBERT, MD, MPP
DIRECTOR

GAVIN NEWSOM
GOVERNOR

March 19, 2020

Jackie Glaze
CMS Acting Director
Medicaid & CHIP Operations Group Center for Medicaid & CHIP
Services 7500 Security Boulevard
Baltimore, MD 21244
Jackie.Glaze@cms.hhs.gov

REQUEST FOR ADDITIONAL SECTION 1135 WAIVER FLEXIBILITIES RELATED TO NOVEL CORONAVIRUS DISEASE (COVID-19) NATIONAL EMERGENCY/PUBLIC HEALTH EMERGENCY

Dear Ms. Glaze:

The Department of Health Care Services (DHCS) writes to request approval for the below-detailed additional flexibilities under Section 1135 of the Social Security Act (42 U.S.C. § 1320b-5) as related to the Novel Coronavirus Disease (COVID-19). These flexibilities are in addition to the request submitted from DHCS on March 16, 2020. As you know, the COVID-19 outbreak was declared a national emergency on March 13, 2020, and was previously declared a nationwide public health emergency on January 31, 2020 (retroactive to January 27, 2020).

The below list represents California's additional requested flexibilities under the Section 1135 authority in connection with the COVID-19 outbreak and emergency based on further exploration of need. Because circumstances surrounding the COVID-19 emergency remain quite fluid, DHCS may subsequently request approval for additional flexibilities, which we can commit to doing promptly as soon as the need is discovered. Consistent with Section 1 of the President's March 13, 2020, national emergency declaration, DHCS requests a retroactive effective date of January 27, 2020, for the requested Section 1135 flexibilities to coincide with the effective start date of the Public Health Emergency, unless otherwise specified. In the event a requested flexibility below is not approvable under the Section 1135 authority, DHCS requests CMS technical assistance to identify any other authority (e.g. under the State Plan or Section 1115) for which approval may be available. Per our discussion with CMS on March 19, 2020, DHCS will request the flexibilities associated with Inmate and Institutions for Mental Disease (IMD) funding exclusions in the Section 1115 context (according to the forthcoming CMS instructions/Section 1115 template).

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6. **Clarification of Previous Requests**:

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imposed on covered benefits. DHCS seeks to clarify that the requested waivers would extend to any limitations for elective procedures and informed consent (including, but not necessarily limited, to 42 C.F.R. § 441.253) to enable provider to postpone elective procedures to prioritize COVID-19 response activities. DHCS suggests extending the current 180-day limit for beneficiary informed consent to 360 days.

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During such difficult times for California and the nation, DHCS greatly appreciates the prompt attention exhibited by CMS to these matters and we look forward to the continued partnership.

Sincerely,
Original Signed By:

Jacey Cooper
Chief Deputy Director
Health Care Programs
State Medicaid Director

cc: Bradley P. Gilbert, MD, MPP
Director
Department of Health Care Services

Erika Sperbeck
Chief Deputy Director
Policy & Program Support
Department of Health Care

AMENDMENT IX TO
CONTRACT FOR HEALTH CARE SERVICES

THIS AMENDMENT IX TO THE CONTRACT FOR HEALTH CARE SERVICES ("Amendment") is effective as of _____ by and between Orange County Health Authority, a Public Agency, dba CalOptima ("CalOptima"), and, _____("HMO"), with respect to the following facts:

RECITALS

A. CalOptima and HMO have entered into a Contract for Health Care Services ("Contract"), by which Physician has agreed to provide or arrange for the provision of Covered Services to Members.

B. On January 31, 2020, the Secretary of Health and Human Services declared a public health emergency under section 319 of the Public Health Service ACT (42 U.S.C. 247d) in response to a novel coronavirus known as SARS-CoV-2 (COVID-19), the COVID-19 Public Health Emergency ("COVID-19 PHE").

C. CalOptima and HMO have entered into amendments for the periods of April 1, 2020, through June 30, 2020, and January 1, 2021, through June 30, 2021 that have included the Medi-Cal capitation base rate enhancement approved by the CalOptima Board of Directors for immediate aid due to the COVID-19 PHE.

D. CalOptima and HMO desire to amend the Contract to include the Medi-Cal capitation base rate enhancement approved by the CalOptima Board of Directors for immediate aid due to the COVID-19 PHE.

NOW, THEREFORE, the parties agree as follows:

1. Attachment E-9, "MEDI-CAL RATE ENHANCEMENT" shall be added to the Contract and is attached hereto.

2. CONTRACT REMAINS IN FULL FORCE AND EFFECT – Except as specifically amended by this Amendment, all other conditions contained in the Contract shall continue in full force and effect. This Amendment is subject to approval by the Government Agencies and by the CalOptima Board of Directors.

IN WITNESS WHEREOF, CalOptima and _____ have executed this Amendment:

FOR HMO:	FOR CALOPTIMA:
_____	_____
SIGNATURE	SIGNATURE
_____	Ladan Khamseh
PRINT NAME	PRINT NAME
_____	Chief Operating Officer
TITLE	TITLE

DATE

DATE

ATTACHMENT E-9

MEDI-CAL RATE ENHANCEMENT

For the period from September 1, 2021, through December 31, 2021, the base physician and base hospital capitation rates set forth in Attachment E-Amendment VI for the Child/Adult and SPD aid code categories shall be increased by _%. This rate enhancement shall not apply to the capitation rates for ESRD and AIDS aid code categories, the Whole Child Model base capitation rates in Attachment E - Amendment VI, Adult Expansion Member capitation rates in Attachment E-1 Amendment V, or the Health Homes Program supplemental capitation payments in Attachment E-5 - Amendment VI.

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken January 7, 2021
Special Meeting of the CalOptima Board of Directors

Report Item

7. Authorize Health Network Medi-Cal Capitation Rate Increases for the Period of January 1, 2021, through June 30, 2021, due to COVID-Related Expenses

Contacts

Richard Sanchez, Chief Executive Officer, (657) 900-1481
Nancy Huang, Chief Financial Officer, (657) 235-6935

Recommended Actions

1. Authorize 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 5.0% from current levels for the period of January 1, 2021 through June 30, 2021;
2. Authorize unbudgeted expenditures up to $9 million to provide funding for Health Network capitation rate adjustments; and
3. Authorize the Chief Executive Officer, 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.

Background

On January 31, 2020, the Secretary of Health and Human Services declared a public health emergency under section 319, of the Public Health Service Act (42 U.S.C. 247d) in response to a novel coronavirus known as SARS-CoV-2 (coronavirus). On March 13, 2020, the President of the United States declared a national emergency based on the spread of this coronavirus. Subsequently, the Governor and the Orange County Health Officer have similarly taken steps to slow the spread of the coronavirus and protect the public. As with federal, state, and local agencies, CalOptima is taking action to continue efforts to support providers serving CalOptima members during the pandemic.

At its April 2, 2020, meeting, the Board authorized a 5% health network Medi-Cal capitation rate increase from reserve for contracted PHCs, SRGs and HMOs for the period of April 1, 2020, through June 30, 2020 to support CalOptima's provider networks and ensure member access proactively in the beginning of pandemic.

On December 23, 2020, CalOptima received final Calendar Year 2021 Medi-Cal capitation rates from the California Department of Health Care Services (DHCS). The final rates included an update rate component for COVID-related adjustments.

Discussion

Management recognizes that the coronavirus pandemic has placed significant stress on healthcare providers and on the delivery system serving CalOptima members. Consistent with DHCS's rate adjustment methodology, staff has included COVID-related testing and treatment costs, as well as potential changes in utilization in the evaluation. As such, in order to support the viability of our contracted health networks, Management requests authority to:

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1. Provide a 5.0% increase from current levels to contracted PHC, SRG and HMO Medi-Cal capitation rates, and shared risk pool funding on Child, Adult and SPD COAs, for the period of January 1, 2021, through June 30, 2021, except Kaiser. The estimated aggregate monthly fiscal impact is approximately $1.5 million.

2. Amend the Medi-Cal PHC, SRG, and HMO Health Network contracts, except Kaiser, to reflect this increase for the period stated above.

Fiscal Impact
The total funds for the Health Network Medi-Cal capitation rates for contracted PHCs, SRGs and HMOs will not exceed 5.0% of total medical capitation expenditures, on Child, Adult and SPD COAs, in the CalOptima Fiscal Year (FY) 2020-21 Operating Budget. The projected aggregate monthly fiscal impact is approximately $1.5 million or up to $9 million for the period of January 1, 2021, through June 30, 2021. It will be net budget neutral since additional funding from DHCS is anticipated to be sufficient to cover the unbudgeted Medi-Cal capitation rate increase.

Rationale for Recommendation
Providing additional provider payments during the coronavirus pandemic will ensure providers remain viable and accessible to our members, as well as increased financial security for the Orange County safety net system.

Concurrence
Gary Crockett, Chief Counsel

Attachments
1. Entities Covered by this Recommended Action
2. Board Action Dated April 2, 2020: Consider Actions Related to Coronavirus (COVID-19) Pandemic

/s/ Richard Sanchez — *12/31/2020*
Authorized Signature — **Date**

ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
Heritage Provider Network, Inc.	8510 Balboa Blvd., Ste. 285	Northridge	CA	91325
Monarch Health Plan, Inc.	11 Technology Dr.	Irvine	CA	92618
Prospect Health Plan, Inc.	600 City Parkway West, Ste. 800	Orange	CA	92868
CHOC Physicians Network and Children's Hospital of Orange County	1120 West La Veta Ave., Ste. 450	Orange	CA	92868
Family Choice Medical Group, Inc.	7631 Wyoming St., Ste. 202	Westminster	CA	92683
Fountain Valley Regional Hospital and Medical Center	17100 Euclid St.	Fountain Valley	CA	92708
AMVI Care Health Network	600 City Parkway West, Ste. 800	Orange	CA	92868
Orange County Physicians IPA Medical Group, Inc dba Noble Community Medical Associates, Inc.	10855 Business Center Dr., Ste. C	Cypress	CA	90630
Talbert Medical Group, P.C.	2175 Park Place	El Segundo	CA	90245
ARTA Western California, Inc.	2175 Park Place	El Segundo	CA	90245
United Care Medical Group, Inc.	600 City Parkway West	Orange	CA	92868
AltaMed Health Services Corporation	2040 Camfield Ave.	Los Angeles	CA	90040

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken April 2, 2020
Regular Meeting of the CalOptima Board of Directors

Report Item

4. Consider Actions Related to Coronavirus (COVID-19) Pandemic

Contact

Nancy Huang, Chief Financial Officer (714) 246-8400
Michelle Laughlin, Executive Director Network Operations (714) 246-8400

Recommended Actions

1. Authorize Health Network Medi-Cal capitation rate increases for contracted Physician Hospital Consortia (PHC), Shared Risk Group (SRG), and Health Maintenance Organizations (HMO) by 5% from current levels for the period of April 1, 2020, through June 30, 2020;

2. Authorize waiver of the minimum stay requirement and expand types of services eligible for per diem payments for contracted Community-Based Adult Services (CBAS) providers for Medi-Cal and OneCare Connect;

3. Authorize unbudgeted expenditures from existing reserves of up to $14 million to provide funding for rates adjustments for Health Network capitation rates;

~~4. Authorize interim Medi-Cal rate for coronavirus testing for dates of service on or after February 4, 2020;~~ Amended 4/2/20

5. Authorize the Chief Executive Officer (CEO), with the assistance of Legal Counsel, to:

    a. Amend the Medi-Cal PHC, SRG, and HMO Health Network contracts to implement the 5% capitation rate increase; and
    b. Amend Medi-Cal and OneCare Connect contracts with CBAS providers effective March 13, 2020 to provide flexibility for services, in accordance with the Department of Health Care Services' (DHCS) section 1135 Waiver application.

Background

On January 31, 2020, the Secretary of Health and Human Services declared a public health emergency under section 319, of the Public Health Service Act (42 U.S.C. 247d) in response to a novel coronavirus known as SARS-CoV-2 (coronavirus). On March 13, 2020, the President of the United States declared a national emergency based on the spread of this coronavirus. Along with federal, state, and local agencies, CalOptima is taking action to continue efforts to protect the health and safety of our providers and members.

As an unprecedented safety measure, the state has issued self-quarantine and social distancing requirements for an unknown period of time. These requirements have and continue to affect CalOptima's provider networks as the coronavirus pandemic develops. One immediate downstream effect of these measures has been CBAS closures as a result of a reduction of in-person utilization. Left

unaddressed, this can rapidly jeopardize the viability of CalOptima's CBAS provider network. Moreover, it underscores the need for CalOptima to take necessary measures to ensure there is limited disruption of care and access to services for our members, which includes vulnerable individuals.

Discussion

CalOptima management recognizes that healthcare service delivery to our members has undergone significant changes during the coronavirus pandemic. Management recommends the following actions in order to provide immediate aid and service authorization flexibilities to CalOptima's provider network in order to ensure that members received access to covered, medically necessary health care services:

Medi-Cal Rate Enhancement for Health Networks

To provide immediate aid and support and maintain the viability of the health networks, Management proposes to:

1. Provide a 5% increase from current levels to contracted PHC, SRG and HMO Medi-Cal capitation rates for the period of April 1, 2020, through June 30, 2020. The estimated aggregate monthly fiscal impact is approximately $4.4 million.

2. Amend the Medi-Cal Health Network contracts to reflect this increase for the period stated above.

Special Reimbursement to CBAS providers

Staff anticipates face-to-face visits at CBAS centers to continue decreasing due to the Governor's stay at home executive order issued on March 19, 2020, and the County of Orange's social distancing requirements. CalOptima currently holds contracts with 31 CBAS centers, serving approximately 2,580 members. Preventing this is critical at this time, as CBAS centers serve CalOptima's most vulnerable senior members On March 19, 2020, the California Department of Health Care Services (DHCS) submitted a request for additional Section 1135 Waiver flexibilities related to coronavirus. This request included additional flexibilities related to the CBAS benefit and individual plan of care. In order to continue uninterrupted access to CBAS services, effective March 13, 2020, Management proposes to:

1. Waive the 1115 waiver requirement of a minimum of a four-hour stay at the center. This change will enable CalOptima members to receive appropriate services at home and remove barriers to access.

2. Expand the types of services eligible for per diem payments. Pursuant to DHCS' 1135 Waiver request, CalOptima will provide per diem payments to CBAS providers who provide:
   - Telephonic or live video interactions in lieu of face-to-face social/therapeutic visits and/or assessments;
   - Arrange for home delivered meals in absence of meals provided at the CBAS center; and/or
   - Provide physical therapy or occupational therapy in the home

3. Amend CBAS contracts to reflect the waiver of the minimum four-hour stay requirement and expansion of services pursuant to DHCS 1135 Waiver request.

~~Interim Medi-Cal Rate for Coronavirus Testing~~

~~The Centers for Medicare & Medicaid Services (CMS) established, for the Medicare program, procedure codes and provider reimbursement rates for coronavirus testing conducted on or after February 4, 2020. DHCS adopted these same procedure codes for the Medi-Cal program effective February 4, 2020. As of this writing, DHCS has not established Medi-Cal reimbursement rates for coronavirus testing.~~ Amended 4/2/20

~~Management proposes to adopt the Medicare provider reimbursement rates on an interim basis for CalOptima's Medi-Cal program for dates of service on or after February 4, 2020. Once DHCS establishes Medi-Cal reimbursement rates for coronavirus testing, CalOptima will make retroactive adjustments to Medi-Cal claims, as appropriate.~~ Amended 4/2/20

Fiscal Impact

The total funds for the Health Network Medi-Cal capitation rates for contracted PHCs, SRGs and HMOs will not exceed 5% of total medical capitation expenditures, in aggregate, in the CalOptima Fiscal Year (FY) 2019-20 Operating Budget. Staff projects the monthly incremental funding at approximately $4.4 million. An allocation of up to $14 million from existing reserves will fund this action.

The CalOptima FY 2019-20 Operating Budget includes funding for Professional medical expenditures for contracted CBAS providers. Currently, the net fiscal impact for the recommended action is unknown. However, assuming current utilization levels will continue, Staff anticipates the recommended action will not have an additional fiscal impact to the operating budget.

~~The fiscal impact for the recommended action to authorize an interim Medi-Cal rate for coronavirus testing is unknown at this time, since both utilization and costs estimates are difficult to quantify. However, Staff anticipates future funding received from DHCS for this purpose will fully offset expenses incurred by CalOptima.~~ Amended 4/2/20

Rationale for Recommendation

Providing additional provider payments during the coronavirus pandemic will ensure providers remain viable and accessible to our members, as well as increased financial security for the Orange County safety net system.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. DHCS Request for Additional Section 1135 Waiver Flexibilities Related to Novel Coronavirus Disease (COVID-19) National Emergency/Public Health Emergency dated March 19, 2020

/s/ Michael Schrader — **Authorized Signature**

03/26/2020 — **Date**

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State of California—Health and Human Services Agency
Department of Health Care Services

BRADLEY P. GILBERT, MD, MPP
DIRECTOR

GAVIN NEWSOM
GOVERNOR

March 19, 2020

Jackie Glaze
CMS Acting Director
Medicaid & CHIP Operations Group Center for Medicaid & CHIP
Services 7500 Security Boulevard
Baltimore, MD 21244
Jackie.Glaze@cms.hhs.gov

REQUEST FOR ADDITIONAL SECTION 1135 WAIVER FLEXIBILITIES RELATED TO NOVEL CORONAVIRUS DISEASE (COVID-19) NATIONAL EMERGENCY/PUBLIC HEALTH EMERGENCY

Dear Ms. Glaze:

The Department of Health Care Services (DHCS) writes to request approval for the below-detailed additional flexibilities under Section 1135 of the Social Security Act (42 U.S.C. § 1320b-5) as related to the Novel Coronavirus Disease (COVID-19). These flexibilities are in addition to the request submitted from DHCS on March 16, 2020. As you know, the COVID-19 outbreak was declared a national emergency on March 13, 2020, and was previously declared a nationwide public health emergency on January 31, 2020 (retroactive to January 27, 2020).

The below list represents California's additional requested flexibilities under the Section 1135 authority in connection with the COVID-19 outbreak and emergency based on further exploration of need. Because circumstances surrounding the COVID-19 emergency remain quite fluid, DHCS may subsequently request approval for additional flexibilities, which we can commit to doing promptly as soon as the need is discovered. Consistent with Section 1 of the President's March 13, 2020, national emergency declaration, DHCS requests a retroactive effective date of January 27, 2020, for the requested Section 1135 flexibilities to coincide with the effective start date of the Public Health Emergency, unless otherwise specified. In the event a requested flexibility below is not approvable under the Section 1135 authority, DHCS requests CMS technical assistance to identify any other authority (e.g. under the State Plan or Section 1115) for which approval may be available. Per our discussion with CMS on March 19, 2020, DHCS will request the flexibilities associated with Inmate and Institutions for Mental Disease (IMD) funding exclusions in the Section 1115 context (according to the forthcoming CMS instructions/Section 1115 template).

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In addition, DHCS requests confirmation that any approved flexibility granted with respect to fee-for-service Medi-Cal benefits and providers would apply equally, to the extent applicable, to our various federally approved delivery systems, such as Medi-Cal managed care plans (MCPs), county organized health systems, county mental health plans, and Drug Medi-Cal organized delivery systems (DMC-ODS) and to the State's standalone Children's Health Insurance Program.

1. **Service authorization and utilization controls**, including but not necessarily limited to:

- Waiver of Attachment 3.1 – A.1, page 2 of the State Plan, exclusion of adult receipt of acetaminophen-containing and cough/cold products.

- For individuals with developmental disabilities receiving services under the State Plan 1915(i) authority, the state requests retainer payments. Retainer payments are available only for absences (maximum 30 consecutive days) in excess of the average number of absences experienced by the provider during the 12 month period prior to 2020.

- For Community-Based Adult Services (CBAS) – CBAS Benefit and Individual Plan of Care (IPC), the state requests:
    - Flexibility to reduce day center activities/gatherings and limit exposure to vulnerable populations.
    - Flexibility to utilize telephonic or live video interactions in lieu of face-to-face social/therapeutic visits.
    - Flexibility to utilize telephonic or live video interactions in lieu of face-to-face assessments.
    - Flexibility to allow following services to be provided at a beneficiary's home:
        - Physical Therapy
        - Occupational Therapy
    - Flexibility to provide or arrange for home delivered meals in absence of meals provided at the CBAS Center.
    - Flexibility for DHCS and MCPs to provide per diem payments to CBAS providers who provide telephonic or live video interactions in lieu of face-to-face social/therapeutic visits and/or assessments, arrange for home delivered meals in absence of meals provided at the CBAS Center, and/or provide physical therapy or occupational therapy in the home.

2. **Eligibility Flexibilities**, including but not necessarily limited to:

    - Flexibility in the hospital presumptive eligibility (HPE) program to cover more than one HPE period in a given 12-month timeframe. To the extent a beneficiary seeks care for coronavirus but has already used an HPE period in the last 12 months, or tests negative and then seeks care for a suspected episode later in the same 12-month period, HPE can provide a fast, low-barrier way to provide immediate, temporary coverage during the emergency period.

3. **Telehealth/Telephonic/Virtual Visits**, including but not necessarily limited to:

    - Waiver of 42 C.F.R. §438.6(c)(1), as necessary, to permit the State to direct MCO and PIHP payments to network providers, where telehealth/telephonic service is medically appropriate and feasible, at the same rate the MCO or PIHP would pay if the service was provided in person, unless the MCO/PIHP and the provider otherwise agree to a different rate for the telehealth modality.

    - Similar to flexibility granted at the federal level, DHCS requests authority for the State not to impose penalties for noncompliance with the regulatory requirements under the Health Insurance Portability and Accountability Act (HIPAA) against covered health care providers in connection with the good faith provision of telehealth during the COVID-19 emergency.

4. **Administrative Activities**, regarding deadlines and timetables for performance of required activities, DHCS requests extension of time for activities conducted by the state, MCPs, and/or county mental health and substance use disorder prepaid inpatient health plans (PIHPs), as applicable, due to social distancing to reduce the spread of COVID-19 and to allow the state, MCP, and/or PIHP resources to prioritize COVID-19 response efforts including:

    - Waiver of the two-year claiming submission limit (42 USC §1320b-2; 45 CFR §95.1, et seq.) for federal financial participation or claiming adjustments with respect to medical assistance and administrative expenditures.

    - Waiver of the requirement in 42 CFR §447.45(d)(1), that DHCS require providers to submit all claims no later than 12 months from the date of service. DHCS is requesting authority to extend the 12-month timeframe for services provided with dates of service during this emergency.

    - Modification of the federal deadlines for submission of cost reports for Medicare and Medicaid (currently due Nov. 2020) by at least 6 months, with no late penalties, so that providers have time to file the appropriate documents. Many provider and hospital staff have been told to work remotely or have been reassigned to

emergency response activities, which will cause delays in meeting reporting timelines.

- Waiver of the timeframe required for financial oversight and medical compliance audits for PIHPs and State Plan Drug Medi-Cal counties. DHCS requests this waiver to allow flexibility regarding deploying staff resources to manage the emergency.

5. **Payment Rates**, including but not necessarily limited to:

- Waiver of the county interim rate setting methodology described beginning on page 10 of the Certified Public Expenditure (CPE) protocol approved through the 1915(b) waiver. The CPE protocol requires DHCS to calculate county interim rates using prior year cost reports trended forward using the Home Health Agency Market Basket Index or a CMS approved cost of living index. As utilization drops and costs increase during this emergency, DHCS is requesting authority to use alternative methodologies, at DHCS's discretion, to temporarily increase county interim rates.

- Waiver of the interim rate setting methodology described on page 5 and 6 of the Drug Medi-Cal Organized Delivery System (DMC ODS) Certified Public Expenditure protocol approved through the 1115 demonstration. The CPE protocol requires DHCS to reimburse DMC ODS counties on an interim basis pursuant to county developed and DHCS approved interim rates for each service, which are expected to be based upon the most recently calculated or estimated county costs for the specific service. DHCS is requesting authority, if counties reimburse DMC providers up to actual cost, to reimburse counties the federal and state share of their certified public expenditures for services rendered during this emergency.

- Waiver of the Statewide Maximum Allowance (SMA) rate limitation on interim reimbursement and final settlement for Drug Medi-Cal (DMC) services provided in state plan counties. California's State Plan describes the reimbursement methodology for DMC services in Attachment 4.19-B, pages 38-41b (SPA 09-022 and SPA 15-013), which limits interim payments to DMC providers to the lower of the SMA or the USDR (Section E.1, page 41). Furthermore, the Medicaid State Plan also limits final reimbursement to lower of actual cost, usual and customary charges, or the SMA for DMC providers. DHCS is requesting authority to waive the SMA and usual and customary charge limitations on interim and final reimbursement for DMC state plan services.

6. **Clarification of Previous Requests**:

- Item 2 in the March 16, 2020 1135 Waiver requested to waive various federal and State Plan requirements pertaining to service authorization and utilization controls

imposed on covered benefits. DHCS seeks to clarify that the requested waivers would extend to any limitations for elective procedures and informed consent (including, but not necessarily limited, to 42 C.F.R. § 441.253) to enable provider to postpone elective procedures to prioritize COVID-19 response activities. DHCS suggests extending the current 180-day limit for beneficiary informed consent to 360 days.

- Item 5 in the March 16, 2020 1135 Waiver requested to waive restrictions existing restrictions on individual counseling sessions under the Drug Medi-Cal state plan. DHCS wants to clarify that we are requesting to waive Supplement 3 to Attachment 3.1-B, to allow individual visits in lieu of group visits, and that these visits may be conducted by telephone, telehealth, and/or in-person. Waive the current restriction on individual visits (only allowed for intake, crisis intervention, collateral services, and treatment and discharge planning). Allow individual visits to be used for counseling focused on short-term personal, family, job/school and other problems and their relationship to substance use. This waiver is needed so the services previously provided in groups can be done in individual sessions during the emergency, to prevent COVID-19 exposure.

- Item 6 in the March 16, 2020 1135 Waiver requested to waive State Plan Attachment 4.19-D, including any applicable Supplements, which establishes the payment methodology for Intermediate Care Facilities for the Developmentally Disabled (ICF-DD) and skilled nursing facilities (SNFs). The state wanted to clarify that the waiver being requested would apply to all SNF and ICF-DD facility types and the reimbursement flexibilities would not be limited solely to the costs associated with suspension of Day Programs. SNFs and ICF-DDs are experiencing increased cost pressures in a variety of areas as a result of the COVID-19 response and the state is seeking flexibility to allow consideration of all costs being incurred by facilities to ensure the health and safety of residents.

7. Flexibilities to be Requested under Section 1115 Authority (according to forthcoming CMS guidance):

- Waiver of the inmate exclusion (42 U.S.C. §1396d(a)(30)(A)) to allow for Medi-Cal claiming for services provided ***in*** jails and prisons for the testing, diagnosis and treatment of COVID-19 or services to ensure other care is provided in a safe way without transporting individuals to acute care facilities.

- Waiver of the 16-bed limitation/prohibition on receipt of federal financial participation for patients residing in Institutions for Mental Disease (IMD) pursuant to 42 U.S.C. §1396d(a)(30)(B). DHCS believes waiver of the IMD exclusion is necessary to temporarily increase bed capacity for affected beneficiaries and to allow facilities to claim for services provided for these

additional beds. Evaluation of less restritictive settings would be completed prior to placement.

During such difficult times for California and the nation, DHCS greatly appreciates the prompt attention exhibited by CMS to these matters and we look forward to the continued partnership.

Sincerely,
Original Signed By:

Jacey Cooper
Chief Deputy Director
Health Care Programs
State Medicaid Director

cc: Bradley P. Gilbert, MD, MPP
Director
Department of Health Care Services

Erika Sperbeck
Chief Deputy Director
Policy & Program Support
Department of Health Care

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken April 2, 2020
Regular Meeting of the CalOptima Board of Directors

Report Item
4. Consider Actions Related to Coronavirus (COVID-19) Pandemic

Contact
Nancy Huang, Chief Financial Officer (714) 246-8400
Michelle Laughlin, Executive Director Network Operations (714) 246-8400

Recommended Actions
1. Authorize Health Network Medi-Cal capitation rate increases for contracted Physician Hospital Consortia (PHC), Shared Risk Group (SRG), and Health Maintenance Organizations (HMO) by 5% from current levels for the period of April 1, 2020, through June 30, 2020;

2. Authorize waiver of the minimum stay requirement and expand types of services eligible for per diem payments for contracted Community-Based Adult Services (CBAS) providers for Medi-Cal and OneCare Connect;

3. Authorize unbudgeted expenditures from existing reserves of up to $14 million to provide funding for rates adjustments for Health Network capitation rates;

~~4. Authorize interim Medi-Cal rate for coronavirus testing for dates of service on or after February 4, 2020;~~ Amended 4/2/20

5. Authorize the Chief Executive Officer (CEO), with the assistance of Legal Counsel, to:

    a. Amend the Medi-Cal PHC, SRG, and HMO Health Network contracts to implement the 5% capitation rate increase; and
    b. Amend Medi-Cal and OneCare Connect contracts with CBAS providers effective March 13, 2020 to provide flexibility for services, in accordance with the Department of Health Care Services' (DHCS) section 1135 Waiver application.

Background
On January 31, 2020, the Secretary of Health and Human Services declared a public health emergency under section 319, of the Public Health Service Act (42 U.S.C. 247d) in response to a novel coronavirus known as SARS-CoV-2 (coronavirus). On March 13, 2020, the President of the United States declared a national emergency based on the spread of this coronavirus. Along with federal, state, and local agencies, CalOptima is taking action to continue efforts to protect the health and safety of our providers and members.

As an unprecedented safety measure, the state has issued self-quarantine and social distancing requirements for an unknown period of time. These requirements have and continue to affect CalOptima's provider networks as the coronavirus pandemic develops. One immediate downstream effect of these measures has been CBAS closures as a result of a reduction of in-person utilization. Left

unaddressed, this can rapidly jeopardize the viability of CalOptima's CBAS provider network. Moreover, it underscores the need for CalOptima to take necessary measures to ensure there is limited disruption of care and access to services for our members, which includes vulnerable individuals.

Discussion

CalOptima management recognizes that healthcare service delivery to our members has undergone significant changes during the coronavirus pandemic. Management recommends the following actions in order to provide immediate aid and service authorization flexibilities to CalOptima's provider network in order to ensure that members received access to covered, medically necessary health care services:

Medi-Cal Rate Enhancement for Health Networks

To provide immediate aid and support and maintain the viability of the health networks, Management proposes to:

1. Provide a 5% increase from current levels to contracted PHC, SRG and HMO Medi-Cal capitation rates for the period of April 1, 2020, through June 30, 2020. The estimated aggregate monthly fiscal impact is approximately $4.4 million.

2. Amend the Medi-Cal Health Network contracts to reflect this increase for the period stated above.

Special Reimbursement to CBAS providers

Staff anticipates face-to-face visits at CBAS centers to continue decreasing due to the Governor's stay at home executive order issued on March 19, 2020, and the County of Orange's social distancing requirements. CalOptima currently holds contracts with 31 CBAS centers, serving approximately 2,580 members. Preventing this is critical at this time, as CBAS centers serve CalOptima's most vulnerable senior members On March 19, 2020, the California Department of Health Care Services (DHCS) submitted a request for additional Section 1135 Waiver flexibilities related to coronavirus. This request included additional flexibilities related to the CBAS benefit and individual plan of care. In order to continue uninterrupted access to CBAS services, effective March 13, 2020, Management proposes to:

1. Waive the 1115 waiver requirement of a minimum of a four-hour stay at the center. This change will enable CalOptima members to receive appropriate services at home and remove barriers to access.

2. Expand the types of services eligible for per diem payments. Pursuant to DHCS' 1135 Waiver request, CalOptima will provide per diem payments to CBAS providers who provide:
   - Telephonic or live video interactions in lieu of face-to-face social/therapeutic visits and/or assessments;
   - Arrange for home delivered meals in absence of meals provided at the CBAS center; and/or
   - Provide physical therapy or occupational therapy in the home

3. Amend CBAS contracts to reflect the waiver of the minimum four-hour stay requirement and expansion of services pursuant to DHCS 1135 Waiver request.

~~Interim Medi-Cal Rate for Coronavirus Testing~~

~~The Centers for Medicare & Medicaid Services (CMS) established, for the Medicare program, procedure codes and provider reimbursement rates for coronavirus testing conducted on or after February 4, 2020. DHCS adopted these same procedure codes for the Medi-Cal program effective February 4, 2020. As of this writing, DHCS has not established Medi-Cal reimbursement rates for coronavirus testing.~~ Amended 4/2/20

~~Management proposes to adopt the Medicare provider reimbursement rates on an interim basis for CalOptima's Medi-Cal program for dates of service on or after February 4, 2020. Once DHCS establishes Medi-Cal reimbursement rates for coronavirus testing, CalOptima will make retroactive adjustments to Medi-Cal claims, as appropriate.~~ Amended 4/2/20

Fiscal Impact

The total funds for the Health Network Medi-Cal capitation rates for contracted PHCs, SRGs and HMOs will not exceed 5% of total medical capitation expenditures, in aggregate, in the CalOptima Fiscal Year (FY) 2019-20 Operating Budget. Staff projects the monthly incremental funding at approximately $4.4 million. An allocation of up to $14 million from existing reserves will fund this action.

The CalOptima FY 2019-20 Operating Budget includes funding for Professional medical expenditures for contracted CBAS providers. Currently, the net fiscal impact for the recommended action is unknown. However, assuming current utilization levels will continue, Staff anticipates the recommended action will not have an additional fiscal impact to the operating budget.

~~The fiscal impact for the recommended action to authorize an interim Medi-Cal rate for coronavirus testing is unknown at this time, since both utilization and costs estimates are difficult to quantify. However, Staff anticipates future funding received from DHCS for this purpose will fully offset expenses incurred by CalOptima.~~ Amended 4/2/20

Rationale for Recommendation

Providing additional provider payments during the coronavirus pandemic will ensure providers remain viable and accessible to our members, as well as increased financial security for the Orange County safety net system.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. DHCS Request for Additional Section 1135 Waiver Flexibilities Related to Novel Coronavirus Disease (COVID-19) National Emergency/Public Health Emergency dated March 19, 2020

/s/ Michael Schrader — **Authorized Signature**

03/26/2020 — **Date**

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State of California—Health and Human Services Agency
Department of Health Care Services

BRADLEY P. GILBERT, MD, MPP
DIRECTOR

GAVIN NEWSOM
GOVERNOR

March 19, 2020

Jackie Glaze
CMS Acting Director
Medicaid & CHIP Operations Group Center for Medicaid & CHIP
Services 7500 Security Boulevard
Baltimore, MD 21244
Jackie.Glaze@cms.hhs.gov

REQUEST FOR ADDITIONAL SECTION 1135 WAIVER FLEXIBILITIES RELATED TO NOVEL CORONAVIRUS DISEASE (COVID-19) NATIONAL EMERGENCY/PUBLIC HEALTH EMERGENCY

Dear Ms. Glaze:

The Department of Health Care Services (DHCS) writes to request approval for the below-detailed additional flexibilities under Section 1135 of the Social Security Act (42 U.S.C. § 1320b-5) as related to the Novel Coronavirus Disease (COVID-19). These flexibilities are in addition to the request submitted from DHCS on March 16, 2020. As you know, the COVID-19 outbreak was declared a national emergency on March 13, 2020, and was previously declared a nationwide public health emergency on January 31, 2020 (retroactive to January 27, 2020).

The below list represents California's additional requested flexibilities under the Section 1135 authority in connection with the COVID-19 outbreak and emergency based on further exploration of need. Because circumstances surrounding the COVID-19 emergency remain quite fluid, DHCS may subsequently request approval for additional flexibilities, which we can commit to doing promptly as soon as the need is discovered. Consistent with Section 1 of the President's March 13, 2020, national emergency declaration, DHCS requests a retroactive effective date of January 27, 2020, for the requested Section 1135 flexibilities to coincide with the effective start date of the Public Health Emergency, unless otherwise specified. In the event a requested flexibility below is not approvable under the Section 1135 authority, DHCS requests CMS technical assistance to identify any other authority (e.g. under the State Plan or Section 1115) for which approval may be available. Per our discussion with CMS on March 19, 2020, DHCS will request the flexibilities associated with Inmate and Institutions for Mental Disease (IMD) funding exclusions in the Section 1115 context (according to the forthcoming CMS instructions/Section 1115 template).

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In addition, DHCS requests confirmation that any approved flexibility granted with respect to fee-for-service Medi-Cal benefits and providers would apply equally, to the extent applicable, to our various federally approved delivery systems, such as Medi-Cal managed care plans (MCPs), county organized health systems, county mental health plans, and Drug Medi-Cal organized delivery systems (DMC-ODS) and to the State's standalone Children's Health Insurance Program.

1. **Service authorization and utilization controls**, including but not necessarily limited to:

- Waiver of Attachment 3.1 – A.1, page 2 of the State Plan, exclusion of adult receipt of acetaminophen-containing and cough/cold products.

- For individuals with developmental disabilities receiving services under the State Plan 1915(i) authority, the state requests retainer payments. Retainer payments are available only for absences (maximum 30 consecutive days) in excess of the average number of absences experienced by the provider during the 12 month period prior to 2020.

- For Community-Based Adult Services (CBAS) – CBAS Benefit and Individual Plan of Care (IPC), the state requests:
    - Flexibility to reduce day center activities/gatherings and limit exposure to vulnerable populations.
    - Flexibility to utilize telephonic or live video interactions in lieu of face-to-face social/therapeutic visits.
    - Flexibility to utilize telephonic or live video interactions in lieu of face-to-face assessments.
    - Flexibility to allow following services to be provided at a beneficiary's home:
        - Physical Therapy
        - Occupational Therapy
    - Flexibility to provide or arrange for home delivered meals in absence of meals provided at the CBAS Center.
    - Flexibility for DHCS and MCPs to provide per diem payments to CBAS providers who provide telephonic or live video interactions in lieu of face-to-face social/therapeutic visits and/or assessments, arrange for home delivered meals in absence of meals provided at the CBAS Center, and/or provide physical therapy or occupational therapy in the home.

2. **Eligibility Flexibilities**, including but not necessarily limited to:

    - Flexibility in the hospital presumptive eligibility (HPE) program to cover more than one HPE period in a given 12-month timeframe. To the extent a beneficiary seeks care for coronavirus but has already used an HPE period in the last 12 months, or tests negative and then seeks care for a suspected episode later in the same 12-month period, HPE can provide a fast, low-barrier way to provide immediate, temporary coverage during the emergency period.

3. **Telehealth/Telephonic/Virtual Visits**, including but not necessarily limited to:

    - Waiver of 42 C.F.R. §438.6(c)(1), as necessary, to permit the State to direct MCO and PIHP payments to network providers, where telehealth/telephonic service is medically appropriate and feasible, at the same rate the MCO or PIHP would pay if the service was provided in person, unless the MCO/PIHP and the provider otherwise agree to a different rate for the telehealth modality.

    - Similar to flexibility granted at the federal level, DHCS requests authority for the State not to impose penalties for noncompliance with the regulatory requirements under the Health Insurance Portability and Accountability Act (HIPAA) against covered health care providers in connection with the good faith provision of telehealth during the COVID-19 emergency.

4. **Administrative Activities**, regarding deadlines and timetables for performance of required activities, DHCS requests extension of time for activities conducted by the state, MCPs, and/or county mental health and substance use disorder prepaid inpatient health plans (PIHPs), as applicable, due to social distancing to reduce the spread of COVID-19 and to allow the state, MCP, and/or PIHP resources to prioritize COVID-19 response efforts including:

    - Waiver of the two-year claiming submission limit (42 USC §1320b-2; 45 CFR §95.1, et seq.) for federal financial participation or claiming adjustments with respect to medical assistance and administrative expenditures.

    - Waiver of the requirement in 42 CFR §447.45(d)(1), that DHCS require providers to submit all claims no later than 12 months from the date of service. DHCS is requesting authority to extend the 12-month timeframe for services provided with dates of service during this emergency.

    - Modification of the federal deadlines for submission of cost reports for Medicare and Medicaid (currently due Nov. 2020) by at least 6 months, with no late penalties, so that providers have time to file the appropriate documents. Many provider and hospital staff have been told to work remotely or have been reassigned to

emergency response activities, which will cause delays in meeting reporting timelines.

- Waiver of the timeframe required for financial oversight and medical compliance audits for PIHPs and State Plan Drug Medi-Cal counties. DHCS requests this waiver to allow flexibility regarding deploying staff resources to manage the emergency.

5. **Payment Rates**, including but not necessarily limited to:

- Waiver of the county interim rate setting methodology described beginning on page 10 of the Certified Public Expenditure (CPE) protocol approved through the 1915(b) waiver. The CPE protocol requires DHCS to calculate county interim rates using prior year cost reports trended forward using the Home Health Agency Market Basket Index or a CMS approved cost of living index. As utilization drops and costs increase during this emergency, DHCS is requesting authority to use alternative methodologies, at DHCS's discretion, to temporarily increase county interim rates.

- Waiver of the interim rate setting methodology described on page 5 and 6 of the Drug Medi-Cal Organized Delivery System (DMC ODS) Certified Public Expenditure protocol approved through the 1115 demonstration. The CPE protocol requires DHCS to reimburse DMC ODS counties on an interim basis pursuant to county developed and DHCS approved interim rates for each service, which are expected to be based upon the most recently calculated or estimated county costs for the specific service. DHCS is requesting authority, if counties reimburse DMC providers up to actual cost, to reimburse counties the federal and state share of their certified public expenditures for services rendered during this emergency.

- Waiver of the Statewide Maximum Allowance (SMA) rate limitation on interim reimbursement and final settlement for Drug Medi-Cal (DMC) services provided in state plan counties. California's State Plan describes the reimbursement methodology for DMC services in Attachment 4.19-B, pages 38-41b (SPA 09-022 and SPA 15-013), which limits interim payments to DMC providers to the lower of the SMA or the USDR (Section E.1, page 41). Furthermore, the Medicaid State Plan also limits final reimbursement to lower of actual cost, usual and customary charges, or the SMA for DMC providers. DHCS is requesting authority to waive the SMA and usual and customary charge limitations on interim and final reimbursement for DMC state plan services.

6. **Clarification of Previous Requests**:

- Item 2 in the March 16, 2020 1135 Waiver requested to waive various federal and State Plan requirements pertaining to service authorization and utilization controls

imposed on covered benefits. DHCS seeks to clarify that the requested waivers would extend to any limitations for elective procedures and informed consent (including, but not necessarily limited, to 42 C.F.R. § 441.253) to enable provider to postpone elective procedures to prioritize COVID-19 response activities. DHCS suggests extending the current 180-day limit for beneficiary informed consent to 360 days.

- Item 5 in the March 16, 2020 1135 Waiver requested to waive restrictions existing restrictions on individual counseling sessions under the Drug Medi-Cal state plan. DHCS wants to clarify that we are requesting to waive Supplement 3 to Attachment 3.1-B, to allow individual visits in lieu of group visits, and that these visits may be conducted by telephone, telehealth, and/or in-person. Waive the current restriction on individual visits (only allowed for intake, crisis intervention, collateral services, and treatment and discharge planning). Allow individual visits to be used for counseling focused on short-term personal, family, job/school and other problems and their relationship to substance use. This waiver is needed so the services previously provided in groups can be done in individual sessions during the emergency, to prevent COVID-19 exposure.

- Item 6 in the March 16, 2020 1135 Waiver requested to waive State Plan Attachment 4.19-D, including any applicable Supplements, which establishes the payment methodology for Intermediate Care Facilities for the Developmentally Disabled (ICF-DD) and skilled nursing facilities (SNFs). The state wanted to clarify that the waiver being requested would apply to all SNF and ICF-DD facility types and the reimbursement flexibilities would not be limited solely to the costs associated with suspension of Day Programs. SNFs and ICF-DDs are experiencing increased cost pressures in a variety of areas as a result of the COVID-19 response and the state is seeking flexibility to allow consideration of all costs being incurred by facilities to ensure the health and safety of residents.

7. Flexibilities to be Requested under Section 1115 Authority (according to forthcoming CMS guidance):

- Waiver of the inmate exclusion (42 U.S.C. §1396d(a)(30)(A)) to allow for Medi-Cal claiming for services provided ***in*** jails and prisons for the testing, diagnosis and treatment of COVID-19 or services to ensure other care is provided in a safe way without transporting individuals to acute care facilities.

- Waiver of the 16-bed limitation/prohibition on receipt of federal financial participation for patients residing in Institutions for Mental Disease (IMD) pursuant to 42 U.S.C. §1396d(a)(30)(B). DHCS believes waiver of the IMD exclusion is necessary to temporarily increase bed capacity for affected beneficiaries and to allow facilities to claim for services provided for these

additional beds. Evaluation of less restritictive settings would be completed prior to placement.

During such difficult times for California and the nation, DHCS greatly appreciates the prompt attention exhibited by CMS to these matters and we look forward to the continued partnership.

Sincerely,
Original Signed By:

Jacey Cooper
Chief Deputy Director
Health Care Programs
State Medicaid Director

cc: Bradley P. Gilbert, MD, MPP
Director
Department of Health Care Services

Erika Sperbeck
Chief Deputy Director
Policy & Program Support
Department of Health Care

AMENDMENT 10 TO
CONTRACT FOR HEALTH CARE SERVICES

THIS AMENDMENT 10 TO THE CONTRACT FOR HEALTH CARE SERVICES ("Amendment") is effective as of **January 1, 2022** by and between Orange County Health Authority, a Public Agency, dba CalOptima ("CalOptima"), and, _____("Physician"), with respect to the following facts:

RECITALS

A. CalOptima and Physician have entered into a Contract for Health Care Services ("Contract"), by which Physician has agreed to provide or arrange for the provision of Covered Services to Members.

B. On January 31, 2020, the Secretary of Health and Human Services declared a public health emergency under section 319 of the Public Health Service ACT (42 U.S.C. 247d) in response to a novel coronavirus known as SARS-CoV-2 (COVID-19), the COVID-19 Public Health Emergency ("COVID-19 PHE").

C. CalOptima and Physician have entered into amendments for the periods of April 1, 2020, through June 30, 2020, January 1, 2021, through June 30, 2021 and September 1, 2021 through December 31, 2021 that have included the Medi-Cal capitation base rate enhancement approved by the CalOptima Board of Directors for immediate aid due to the COVID-19 PHE.

D. CalOptima and Physician desire to amend the Contract to extend the Medi-Cal capitation base rate enhancement approved by the CalOptima Board of Directors through June 30, 2022 for immediate aid due to the COVID-19 PHE. This additional funding is to address the increasing COVID-19 related expenses and to continuously improve vaccination rates for CalOptima's members within the Medi-Cal focus populations.

NOW, THEREFORE, the parties agree as follows:

1. Attachment E-8, "MEDI-CAL RATE ENHANCEMENT" shall be deleted in its entirety and replaced with a new Attachment E-8 – Amendment 10 "MEDI-CAL RATE ENHANCEMENT" attached hereto.

2. CONTRACT REMAINS IN FULL FORCE AND EFFECT – Except as specifically amended by this Amendment, all other conditions contained in the Contract shall continue in full force and effect. This Amendment is subject to approval by the Government Agencies and by the CalOptima Board of Directors.

IN WITNESS WHEREOF, CalOptima and _____ have executed this Amendment.

FOR PHYSICIAN:	FOR CALOPTIMA:
_____	_____
Signature	Signature
_____	_____
Print Name	Print Name
_____	_____
Title	Title
_____	_____
Date	Date

ATTACHMENT E-8 – AMENDMENT 10

MEDI-CAL RATE ENHANCEMENT

For the period from September 1, 2021, through June 30, 2022, the base physician and base hospital capitation rates set forth in Attachment E-Amendment 8 for the Child/Adult and SPD aid code categories shall be increased by [redacted]%. This rate enhancement shall not apply to the capitation rates for ESRD and AIDS aid code categories, the Whole Child Model base capitation rates in Attachment E - Amendment 8, Adult Expansion Member capitation rates in Attachment E-1 Amendment 8, or the Health Homes Program supplemental capitation payments in Attachment E-4 - Amendment VI.

AMENDMENT __ TO
CONTRACT FOR HEALTH CARE SERVICES

THIS AMENDMENT __ TO THE CONTRACT FOR HEALTH CARE SERVICES ("Amendment") is effective as of **July 1, 2022** by and between Orange County Health Authority, a Public Agency, dba CalOptima ("CalOptima"), and, _____ ("HMO), with respect to the following facts:

RECITALS

A. CalOptima and HMO have entered into a Contract for Health Care Services ("Contract"), by which Physician has agreed to provide or arrange for the provision of Covered Services to Members.

B. On January 31, 2020, the Secretary of Health and Human Services declared a public health emergency under section 319 of the Public Health Service ACT (42 U.S.C. 247d) in response to a novel coronavirus known as SARS-CoV-2 ("COVID-19"), the COVID-19 Public Health Emergency ("COVID-19 PHE").

C. CalOptima and HMO have entered into amendments for the periods of April 1, 2020, through June 30, 2020, January 1, 2021, through June 30, 2021, September 1, 2021 through December 31, 2021 and January 1, 2022, through June 30, 2022, that have included the Medi-Cal capitation base rate enhancement approved by the CalOptima Board of Directors for immediate aid due to the COVID-19 PHE.

D. CalOptima and HMO desire to amend the Contract to extend the Medi-Cal capitation base rate enhancement approved by the CalOptima Board of Directors through June 30, 2023 for immediate aid due to the COVID-19 PHE.

NOW, THEREFORE, the parties agree as follows:

1. Attachment E-9, "MEDI-CAL RATE ENHANCEMENT" of the Contract shall be deleted in its entirety and replaced with a new Attachment E-9 "MEDI-CAL RATE ENHANCEMENT", which is attached hereto and incorporated into the Contract by this reference.

2. CONTRACT REMAINS IN FULL FORCE AND EFFECT – Except as specifically amended by this Amendment, all other conditions contained in the Contract shall continue in full force and effect. This Amendment is subject to approval by the Government Agencies and by the CalOptima Board of Directors. After the effective date of this Amendment, any reference to the Contract shall mean the Contract as amended and supplemented by this Amendment. Notwithstanding anything to the contrary in the Contract, in the event of a conflict between the terms and conditions of this Amendment and those contained within the Contract, the terms and conditions of this Amendment shall prevail. Capitalized terms not otherwise defined in this Amendment shall have the meanings ascribed to them in the Contract.

[signature page follows]

IN WITNESS WHEREOF, CalOptima and _____ have executed this Amendment.

FOR HMO:	FOR CALOPTIMA:
Signature	Signature
Print Name	Print Name
Title	Title
Date	Date

ATTACHMENT E-9

MEDI-CAL RATE ENHANCEMENT

For the period from September 1, 2021, through June 30, 2023, the base physician and base hospital capitation rates set forth in Attachment E - Amendment 8 for the Child/Adult and SPD aid code categories shall be increased by 7.5%. This rate enhancement shall not apply to the capitation rates for ESRD and AIDS aid code categories, the Whole Child Model base capitation rates in Attachment E - Amendment 8, Adult Expansion Member capitation rates in Attachment E-1 Amendment 8, or the Health Homes Program supplemental capitation payments in Attachment E-5 - Amendment VI. Following June 30, 2023, the 7.5% increase shall cease, and the rates under the Contract shall revert to pre- COVID-19 PHE levels unless the Contract is further amended by the parties.

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken June 2, 2022
Regular Meeting of the CalOptima Board of Directors

Report Item

26. Authorize Extension of a Supplemental Capitation Rate Increase for ARTA Western California Inc., Monarch Health Plan Inc., and Talbert Medical Group P.C., Medi-Cal Health Networks Only, for COVID-Related Expenses for Services Provided to CalOptima Medi-Cal Members and Authorize CEO to Execute Necessary Amendments

Contact

Yunkyung Kim, Chief Operating Officer, (714) 246-8408

Recommended Actions

1. Authorize an extension of capitation rate increases for the ARTA Western California Inc. (ARTA), Monarch Health Plan Inc. (Monarch), and Talbert Medical Group P.C (Talbert) Medi-Cal health networks, on Child, Adult and Seniors and Persons with Disabilities (SPD) Categories of Aid (COA) by 7.5% from Fiscal Year (FY) 2021-22 original budgeted base rates for the period of July 1, 2022, through June 30, 2023; and

2. Authorize the Chief Executive Officer (CEO) to execute amendments to the ARTA, Monarch, and Talbert Medi-Cal health network contracts, to implement health network capitation rate adjustments.

Background and Discussion

Staff requests that the CalOptima Board of Directors (Board) authorize extension of capitation rate increase for the ARTA, Monarch, and Talbert Medi-Cal health networks, for COVID-related expenses between July 1, 2022 and June 30, 2023. In response to COVID-19, the Board has authorized four temporary, short-term supplemental increases for contracted Medi-Cal health networks for certain medically necessary services provided to CalOptima members. The increases were implemented on December 20, 2021, September 2, 2021, January 7, 2021, and April 2, 2020

Management recognizes that continued support is necessary to help providers promote and improve vaccination rates, address additional variants of the COVID-19 virus, cover increased expenses for testing and treatment, and ensure uninterrupted, medically necessary Medi-Cal covered services for CalOptima members. Staff recommends authorizing extension of the capitation rate increase for the ARTA, Monarch, and Talbert health networks, from July 1, 2022 through June 30, 2023, and amending their contracts to reflect this increase.

Fiscal Impact

The recommended action is a budgeted item in the proposed CalOptima FY 2022-23 Operating Budget. The projected aggregate fiscal impact for all health networks is approximately $30 million.

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Rationale for Recommendation

Authorizing the capitation rate increase and amendment to the ARTA, Monarch, and Talbert Medi-Cal health networks will ensure the viability of CalOptima's provider network, strengthen access to member care and support Orange County's safety net system serving CalOptima members.

Concurrence

Troy R. Szabo, Outside General Counsel, Kennaday Leavitt

Attachments

1. Entities Covered by this Recommended Board Action
2. Board Action dated December 20, 2021: Consider Authorizing Extension of a Temporary, Short-term, Supplemental Capitation Rate Increase for all Contracted Medi-Cal Health Networks Except ARTA Western California Inc., Monarch Health Plan Inc., and Talbert Medical Group P.C for COVID-Related Expenses for Services Provided to CalOptima Medi-Cal Members. This Board Action includes the following:
    - Board Action dated September 2, 2021: Authorize Medi-Cal Health Network Capitation Rate Increases for the Period of September 1, 2021 through December 31, 2021, due to COVID-Related Expenses
    - Board Action dated January 7, 2021: Authorize Health Network Medi-Cal Rate Increases for the Period of January 1, 2021, through June 30, 2021, due to COVID-Related Expenses
    - Board Action dated April 2, 2020: Consider Actions Related to Coronavirus (COVID-19) Pandemic
3. Proposed Medi-Cal Health Network Amendment

/s/ Michael Hunn — *05/27/2022*

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**
ARTA Western California, Inc.	2175 Park Place	El Segundo	CA	90245
Monarch Health Plan, Inc.	11 Technology Dr.	Irvine	CA	92618
Talbert Medical Group, P.C.	2175 Park Place	El Segundo	CA	90245

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken December 20, 2021
Special Meeting of the CalOptima Board of Directors

Report Item

48. Consider Authorizing Extension of a Temporary, Short-Term, Supplemental Capitation Rate Increase for all Contracted Medi-Cal Health Networks Except ARTA Western California Inc., Monarch Health Plan Inc., and Talbert Medical Group P.C. for COVID-Related Expenses for Services Provided to CalOptima Medi-Cal Members

Contacts

Yunkyung Kim, Chief Operating Officer, (714) 246-8408
Michelle Laughlin, Executive Director, Network Operations, (657) 900-1116

Recommended Actions

Recommend authorizing the following actions for all Medi-Cal health networks except ARTA Western California Inc.(ARTA), Monarch Health Plan Inc. (Monarch), and Talbert Medical Group P.C. (Talbert):

1. Extending capitation rate increases for all contracted Physician Hospital Consortia (PHC), Shared Risk Group (SRG), and Health Maintenance Organization (HMO) Medi-Cal health networks except ARTA, Monarch, and Talbert on Child, Adult and Seniors and Persons with Disabilities (SPD) Categories of Aid (COA) by 7.5% from Fiscal Year (FY) 2021-22 original budgeted base rates for the period of January 1, 2022, through June 30, 2022;
2. Use of unbudgeted expenditures in an aggregate amount for all health networks up to $16.2 million from existing reserves to provide funding for Health Network capitation rate adjustments; and
3. Authorize the Chief Executive Officer (CEO), with the assistance of Legal Counsel, to amend all Medi-Cal PHC, SRG, and HMO Health Network contracts except ARTA, Monarch, and Talbert, to implement the health network capitation rate adjustments

Background

On January 31, 2020, the U.S. Secretary of Health and Human Services declared a public health emergency (PHE) under Section 319, of the Public Health Service Act (42 U.S.C. 247d) in response to a novel coronavirus known as SARS-CoV-2 (coronavirus). On March 13, 2020, the President of the United States declared a national emergency based on the spread of this coronavirus. Subsequently, the Governor of California and the Orange County Health Officer have similarly taken steps to slow the spread of the coronavirus and protect the public. As with federal, state, and local agencies, CalOptima is continuing efforts to support providers serving CalOptima members during the pandemic.

At its April 2, 2020, meeting, the Board authorized a temporary, short-term supplemental 5% health network Medi-Cal capitation rate increase from reserves for contracted PHCs, SRGs and HMOs for the period of April 1, 2020, through June 30, 2020, to support CalOptima's provider networks and ensure member access proactively at the beginning of the pandemic.

At its January 7, 2021, special meeting, the Board authorized another 5% Health Network Medi-Cal capitation rate increase for contracted PHCs, SRGs and HMOs, except Kaiser, on Child, Adult and SPD COAs for the period of January 1, 2021, through June 30, 2021.

At its September 2, 2021, meeting, the Board authorized a Health Network Medi-Cal capitation rate increase of 7.5% from current levels, (i.e., FY 2021-22 original budgeted base rates) for the period of September 1, 2021, through December 31, 2021.

Discussion

Management recognizes that continued support is necessary to help providers promote and improve vaccination rates, address additional variants of the COVID-19 virus, cover increased expenses for testing and treatment, and ensure uninterrupted, medically necessary Medi-Cal covered services for CalOptima members. Aligned with increased funding from the Department of Health Care Services (DHCS) for such expenses, staff recommends continuing enhanced funding to CalOptima providers. This action will help preserve the viability of CalOptima's Medi-Cal provider network and strengthen members' access to care in anticipation of higher expense levels post-pandemic.

To support our contracted health networks, Staff requests authority to:

1. Extend a 7.5% increase from FY 2021-22 original budgeted base rates to Medi-Cal capitation rates, and shared risk pool funding on Child, Adult and SPD COAs, for all Medi-Cal health networks except ARTA, Monarch, and Talbert for the period of January 1, 2022, through June 30, 2022. The projected aggregate fiscal impact is approximately $16.2 million for the six-month period and will be funded from existing reserves.

2. Amend all Medi-Cal health network contracts except ARTA, Monarch, and Talbert to reflect this increase for the period stated above.

Fiscal Impact

The total funds for the Health Network Medi-Cal capitation rates for contracted PHCs, SRGs and HMOs will not exceed 7.5% of total medical capitation expenditures, on Child, Adult and SPD COAs for the period of January 1, 2022, through June 30, 2022, in the CalOptima FY 2021-22 Operating Budget. The projected aggregate fiscal impact for all health networks is approximately $16.2 million for the six-month period and will be funded from existing reserves.

Rationale for Recommendation

Authorizing the Health Network Medi-Cal capitation rate increases for all Medi-Cal health networks except ARTA, Monarch, and Talbert will ensure the viability of CalOptima's provider network, strengthen access to member care and support Orange County's safety net system serving CalOptima members.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. Entities Covered by this Recommended Action
2. Board Action Dated September 2, 2021: Authorize Medi-Cal Health Network Capitation Rate Increases for the Period of September 1, 2021, through December 31, 2021, due to COVID-Related Expenses
3. Board Action Dated January 7, 2021: Authorize Health Network Medi-Cal Capitation Rate Increases for the Period of January 1, 2021, through June 30, 2021, due to COVID-Related Expenses
4. Board Action Dated April 2, 2020: Consider Actions Related to Coronavirus (COVID-19) Pandemic
5. Proposed Medi-Cal Health Network Amendment

/s/ Michael Hunn *12/15/2021*
Authorized Signature **Date**

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
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
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
United Care Medical Group, Inc.	600 City Parkway West	Orange	CA	92868

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken September 2, 2021
Regular Meeting of the CalOptima Board of Directors

Report Item

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

Contacts

Nancy Huang, Chief Financial Officer, (657) 235-6935
Michelle Laughlin, Executive Director, Network Operations, (657) 900-1116

Recommended Actions

1. Authorize 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. Authorize unbudgeted expenditures up to $10.4 million from existing reserves to provide funding for Health Network capitation rate adjustments; and
3. Authorize 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.

Background

On January 31, 2020, the Secretary of Health and Human Services declared a public health emergency (PHE) under section 319, of the Public Health Service Act (42 U.S.C. 247d) in response to a novel coronavirus known as SARS-CoV-2 (coronavirus). On March 13, 2020, the President of the United States declared a national emergency based on the spread of this coronavirus. Subsequently, the Governor and the Orange County Health Officer have similarly taken steps to slow the spread of the coronavirus and protect the public. As with federal, state, and local agencies, CalOptima is taking action to continue efforts to support providers serving CalOptima members during the pandemic.

At its April 2, 2020, meeting, the Board authorized a 5% health network Medi-Cal capitation rate increase from reserves for contracted PHCs, SRGs and HMOs for the period from April 1, 2020, through June 30, 2020, to support CalOptima's provider networks and ensure member access proactively at the beginning of the pandemic.

At its January 7, 2021, special meeting, the Board authorized another 5% Health Network Medi-Cal capitation rate increase for contracted PHCs, SRGs and HMOs, except Kaiser, on Child, Adult and SPD COAs for the period from January 1, 2021, through June 30, 2021.

Discussion

Management recognizes that the coronavirus pandemic continues to place significant stress on the healthcare providers and delivery system serving CalOptima members. In late June, the Centers for Disease Control and Prevention (CDC) issued new guidance and data related to the more contagious Delta variant. Orange County has experienced a surge of Delta variant cases leading to increased hospitalizations and strain on health care resources. In addition, the demand for coronavirus testing is

expected to increase as children return to school in the fall. This will be especially true for certain age groups who are not currently eligible to receive the vaccine.

In mid-July, the California Department of Health Care Services (DHCS) released its Medi-Cal COVID-19 Vaccine Incentive Program. This program will use $350 million dollars statewide to improve the vaccination rates among Medi-Cal beneficiaries. The focus populations include members who:

1. Are homebound and unable to travel to vaccination sites;
2. Are 50-64 years of age with multiple chronic diseases;
3. Self-identify as persons of color; and
4. With the return to school, are youth 12-25 years old.

The rate increase recommendation is intended to utilize and support health networks to improve vaccination rates for CalOptima's delegated members and create a vaccine strategy consistent with DHCS's COVID-19 Vaccine Incentive Program and CalOptima's Vaccine Response Plan. The health network's vaccine strategy will include working with primary care providers (PCPs) to conduct direct outreach to unvaccinated members assigned to the PCP offices and may include member outreach, implementation of best practices, health education strategies for members who are hesitant, development of partnerships with community organizations, and increased accessibility of vaccinations for hard-to-reach members (e.g., pop-up clinics, mobile units, vaccinations for homebound members). A health network will be responsible for meeting pre-identified outcome measures to demonstrate improvements in vaccination rates among DHCS-identified populations of focus. Each health network will collaborate with CalOptima's Quality Improvement Department to ensure a streamlined approach for CalOptima members.

In recognition of the demands the pandemic has placed on health networks, providing the supplemental payment increase for the referenced period for medically necessary Medi-Cal services is recommended. The increase will help preserve the viability of CalOptima's health networks and strengthen access to care considering the higher utilization levels including COVID-19-related testing and treatment.

In order to support our contracted health networks, Staff requests authority to:

1. Provide a 7.5% increase from current levels to contracted PHC, SRG and HMO Medi-Cal capitation rates (except for Kaiser), and shared risk pool funding for Child, Adult and SPD COAs, for the period from September 1, 2021, through December 31, 2021. The projected aggregate fiscal impact is approximately $10.4 million for the four-month period and will be funded from existing reserves.

2. Amend the Medi-Cal PHC, SRG, and HMO Health Network contracts, except Kaiser, to reflect this increase for the period stated above.

This additional funding will assist Health Networks to address the latest surge in Delta variant cases and projected increase in demand for coronavirus testing, and to promote an increase in vaccinations within the Medi-Cal focus populations identified by DHCS.

Fiscal Impact

The total funds for the Health Network Medi-Cal capitation rates for contracted PHCs, SRGs and HMOs will not exceed 7.5% of total medical capitation expenditures, on Child, Adult and SPD COAs for the period of September 1, 2021, through December 31, 2021, in the CalOptima Fiscal Year (FY) 2021-22 Operating Budget. The projected aggregate fiscal impact is approximately $10.4 million for the four-month period and will be funded from existing reserves.

As of this writing, DHCS has not released detailed guidance on their Medi-Cal COVID-19 Vaccine Incentive Program. Management anticipates that the use of reserves may be reduced depending on actual funding provided by DHCS for this purpose.

Rationale for Recommendation

Resuming the supplemental capitation rate increase for Medi-Cal PHC, SRG, and HMO Health Networks, except Kaiser, during the coronavirus pandemic will ensure providers remain viable and accessible to our members, as well as providing increased financial security for the Orange County safety net system.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. Entities Covered by this Recommended Action
2. Board Action Dated January 7, 2021: Authorize Health Network Medi-Cal Capitation Rate Increases for the Period of January 1, 2021, through June 30, 2021, due to COVID-Related Expenses
3. Board Action Dated April 2, 2020: Consider Actions Related to Coronavirus (COVID-19) Pandemic
4. Proposed Contract Amendment with Health Networks

/s/ Richard Sanchez — *08/26/2021*

Authorized Signature — **Date**

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
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

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken January 7, 2021
Special Meeting of the CalOptima Board of Directors

Report Item

7. Authorize Health Network Medi-Cal Capitation Rate Increases for the Period of January 1, 2021, through June 30, 2021, due to COVID-Related Expenses

Contacts

Richard Sanchez, Chief Executive Officer, (657) 900-1481
Nancy Huang, Chief Financial Officer, (657) 235-6935

Recommended Actions

1. Authorize 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 5.0% from current levels for the period of January 1, 2021 through June 30, 2021;
2. Authorize unbudgeted expenditures up to $9 million to provide funding for Health Network capitation rate adjustments; and
3. Authorize the Chief Executive Officer, 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.

Background

On January 31, 2020, the Secretary of Health and Human Services declared a public health emergency under section 319, of the Public Health Service Act (42 U.S.C. 247d) in response to a novel coronavirus known as SARS-CoV-2 (coronavirus). On March 13, 2020, the President of the United States declared a national emergency based on the spread of this coronavirus. Subsequently, the Governor and the Orange County Health Officer have similarly taken steps to slow the spread of the coronavirus and protect the public. As with federal, state, and local agencies, CalOptima is taking action to continue efforts to support providers serving CalOptima members during the pandemic.

At its April 2, 2020, meeting, the Board authorized a 5% health network Medi-Cal capitation rate increase from reserve for contracted PHCs, SRGs and HMOs for the period of April 1, 2020, through June 30, 2020 to support CalOptima's provider networks and ensure member access proactively in the beginning of pandemic.

On December 23, 2020, CalOptima received final Calendar Year 2021 Medi-Cal capitation rates from the California Department of Health Care Services (DHCS). The final rates included an update rate component for COVID-related adjustments.

Discussion

Management recognizes that the coronavirus pandemic has placed significant stress on healthcare providers and on the delivery system serving CalOptima members. Consistent with DHCS's rate adjustment methodology, staff has included COVID-related testing and treatment costs, as well as potential changes in utilization in the evaluation. As such, in order to support the viability of our contracted health networks, Management requests authority to:

1. Provide a 5.0% increase from current levels to contracted PHC, SRG and HMO Medi-Cal capitation rates, and shared risk pool funding on Child, Adult and SPD COAs, for the period of January 1, 2021, through June 30, 2021, except Kaiser. The estimated aggregate monthly fiscal impact is approximately $1.5 million.

2. Amend the Medi-Cal PHC, SRG, and HMO Health Network contracts, except Kaiser, to reflect this increase for the period stated above.

Fiscal Impact

The total funds for the Health Network Medi-Cal capitation rates for contracted PHCs, SRGs and HMOs will not exceed 5.0% of total medical capitation expenditures, on Child, Adult and SPD COAs, in the CalOptima Fiscal Year (FY) 2020-21 Operating Budget. The projected aggregate monthly fiscal impact is approximately $1.5 million or up to $9 million for the period of January 1, 2021, through June 30, 2021. It will be net budget neutral since additional funding from DHCS is anticipated to be sufficient to cover the unbudgeted Medi-Cal capitation rate increase.

Rationale for Recommendation

Providing additional provider payments during the coronavirus pandemic will ensure providers remain viable and accessible to our members, as well as increased financial security for the Orange County safety net system.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. Entities Covered by this Recommended Action
2. Board Action Dated April 2, 2020: Consider Actions Related to Coronavirus (COVID-19) Pandemic

/s/ Richard Sanchez — *12/31/2020*
Authorized Signature — **Date**

ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
Heritage Provider Network, Inc.	8510 Balboa Blvd., Ste. 285	Northridge	CA	91325
Monarch Health Plan, Inc.	11 Technology Dr.	Irvine	CA	92618
Prospect Health Plan, Inc.	600 City Parkway West, Ste. 800	Orange	CA	92868
CHOC Physicians Network and Children's Hospital of Orange County	1120 West La Veta Ave., Ste. 450	Orange	CA	92868
Family Choice Medical Group, Inc.	7631 Wyoming St., Ste. 202	Westminster	CA	92683
Fountain Valley Regional Hospital and Medical Center	17100 Euclid St.	Fountain Valley	CA	92708
AMVI Care Health Network	600 City Parkway West, Ste. 800	Orange	CA	92868
Orange County Physicians IPA Medical Group, Inc dba Noble Community Medical Associates, Inc.	10855 Business Center Dr., Ste. C	Cypress	CA	90630
Talbert Medical Group, P.C.	2175 Park Place	El Segundo	CA	90245
ARTA Western California, Inc.	2175 Park Place	El Segundo	CA	90245
United Care Medical Group, Inc.	600 City Parkway West	Orange	CA	92868
AltaMed Health Services Corporation	2040 Camfield Ave.	Los Angeles	CA	90040

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken April 2, 2020
Regular Meeting of the CalOptima Board of Directors

Report Item

4. Consider Actions Related to Coronavirus (COVID-19) Pandemic

Contact

Nancy Huang, Chief Financial Officer (714) 246-8400
Michelle Laughlin, Executive Director Network Operations (714) 246-8400

Recommended Actions

1. Authorize Health Network Medi-Cal capitation rate increases for contracted Physician Hospital Consortia (PHC), Shared Risk Group (SRG), and Health Maintenance Organizations (HMO) by 5% from current levels for the period of April 1, 2020, through June 30, 2020;

2. Authorize waiver of the minimum stay requirement and expand types of services eligible for per diem payments for contracted Community-Based Adult Services (CBAS) providers for Medi-Cal and OneCare Connect;

3. Authorize unbudgeted expenditures from existing reserves of up to $14 million to provide funding for rates adjustments for Health Network capitation rates;

~~4. Authorize interim Medi-Cal rate for coronavirus testing for dates of service on or after February 4, 2020;~~ Amended 4/2/20

5. Authorize the Chief Executive Officer (CEO), with the assistance of Legal Counsel, to:

    a. Amend the Medi-Cal PHC, SRG, and HMO Health Network contracts to implement the 5% capitation rate increase; and
    b. Amend Medi-Cal and OneCare Connect contracts with CBAS providers effective March 13, 2020 to provide flexibility for services, in accordance with the Department of Health Care Services' (DHCS) section 1135 Waiver application.

Background

On January 31, 2020, the Secretary of Health and Human Services declared a public health emergency under section 319, of the Public Health Service Act (42 U.S.C. 247d) in response to a novel coronavirus known as SARS-CoV-2 (coronavirus). On March 13, 2020, the President of the United States declared a national emergency based on the spread of this coronavirus. Along with federal, state, and local agencies, CalOptima is taking action to continue efforts to protect the health and safety of our providers and members.

As an unprecedented safety measure, the state has issued self-quarantine and social distancing requirements for an unknown period of time. These requirements have and continue to affect CalOptima's provider networks as the coronavirus pandemic develops. One immediate downstream effect of these measures has been CBAS closures as a result of a reduction of in-person utilization. Left

unaddressed, this can rapidly jeopardize the viability of CalOptima's CBAS provider network. Moreover, it underscores the need for CalOptima to take necessary measures to ensure there is limited disruption of care and access to services for our members, which includes vulnerable individuals.

Discussion

CalOptima management recognizes that healthcare service delivery to our members has undergone significant changes during the coronavirus pandemic. Management recommends the following actions in order to provide immediate aid and service authorization flexibilities to CalOptima's provider network in order to ensure that members received access to covered, medically necessary health care services:

Medi-Cal Rate Enhancement for Health Networks

To provide immediate aid and support and maintain the viability of the health networks, Management proposes to:

1. Provide a 5% increase from current levels to contracted PHC, SRG and HMO Medi-Cal capitation rates for the period of April 1, 2020, through June 30, 2020. The estimated aggregate monthly fiscal impact is approximately $4.4 million.

2. Amend the Medi-Cal Health Network contracts to reflect this increase for the period stated above.

Special Reimbursement to CBAS providers

Staff anticipates face-to-face visits at CBAS centers to continue decreasing due to the Governor's stay at home executive order issued on March 19, 2020, and the County of Orange's social distancing requirements. CalOptima currently holds contracts with 31 CBAS centers, serving approximately 2,580 members. Preventing this is critical at this time, as CBAS centers serve CalOptima's most vulnerable senior members On March 19, 2020, the California Department of Health Care Services (DHCS) submitted a request for additional Section 1135 Waiver flexibilities related to coronavirus. This request included additional flexibilities related to the CBAS benefit and individual plan of care. In order to continue uninterrupted access to CBAS services, effective March 13, 2020, Management proposes to:

1. Waive the 1115 waiver requirement of a minimum of a four-hour stay at the center. This change will enable CalOptima members to receive appropriate services at home and remove barriers to access.

2. Expand the types of services eligible for per diem payments. Pursuant to DHCS' 1135 Waiver request, CalOptima will provide per diem payments to CBAS providers who provide:
   - Telephonic or live video interactions in lieu of face-to-face social/therapeutic visits and/or assessments;
   - Arrange for home delivered meals in absence of meals provided at the CBAS center; and/or
   - Provide physical therapy or occupational therapy in the home

3. Amend CBAS contracts to reflect the waiver of the minimum four-hour stay requirement and expansion of services pursuant to DHCS 1135 Waiver request.

~~Interim Medi-Cal Rate for Coronavirus Testing~~

~~The Centers for Medicare & Medicaid Services (CMS) established, for the Medicare program, procedure codes and provider reimbursement rates for coronavirus testing conducted on or after February 4, 2020. DHCS adopted these same procedure codes for the Medi-Cal program effective February 4, 2020. As of this writing, DHCS has not established Medi-Cal reimbursement rates for coronavirus testing.~~ Amended 4/2/20

~~Management proposes to adopt the Medicare provider reimbursement rates on an interim basis for CalOptima's Medi-Cal program for dates of service on or after February 4, 2020. Once DHCS establishes Medi-Cal reimbursement rates for coronavirus testing, CalOptima will make retroactive adjustments to Medi-Cal claims, as appropriate.~~ Amended 4/2/20

Fiscal Impact

The total funds for the Health Network Medi-Cal capitation rates for contracted PHCs, SRGs and HMOs will not exceed 5% of total medical capitation expenditures, in aggregate, in the CalOptima Fiscal Year (FY) 2019-20 Operating Budget. Staff projects the monthly incremental funding at approximately $4.4 million. An allocation of up to $14 million from existing reserves will fund this action.

The CalOptima FY 2019-20 Operating Budget includes funding for Professional medical expenditures for contracted CBAS providers. Currently, the net fiscal impact for the recommended action is unknown. However, assuming current utilization levels will continue, Staff anticipates the recommended action will not have an additional fiscal impact to the operating budget.

~~The fiscal impact for the recommended action to authorize an interim Medi-Cal rate for coronavirus testing is unknown at this time, since both utilization and costs estimates are difficult to quantify. However, Staff anticipates future funding received from DHCS for this purpose will fully offset expenses incurred by CalOptima.~~ Amended 4/2/20

Rationale for Recommendation

Providing additional provider payments during the coronavirus pandemic will ensure providers remain viable and accessible to our members, as well as increased financial security for the Orange County safety net system.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. DHCS Request for Additional Section 1135 Waiver Flexibilities Related to Novel Coronavirus Disease (COVID-19) National Emergency/Public Health Emergency dated March 19, 2020

/s/ Michael Schrader *03/26/2020*

Authorized Signature **Date**

State of California—Health and Human Services Agency
Department of Health Care Services

BRADLEY P. GILBERT, MD, MPP
DIRECTOR

GAVIN NEWSOM
GOVERNOR

March 19, 2020

Jackie Glaze
CMS Acting Director
Medicaid & CHIP Operations Group Center for Medicaid & CHIP
Services 7500 Security Boulevard
Baltimore, MD 21244
Jackie.Glaze@cms.hhs.gov

REQUEST FOR ADDITIONAL SECTION 1135 WAIVER FLEXIBILITIES RELATED TO NOVEL CORONAVIRUS DISEASE (COVID-19) NATIONAL EMERGENCY/PUBLIC HEALTH EMERGENCY

Dear Ms. Glaze:

The Department of Health Care Services (DHCS) writes to request approval for the below-detailed additional flexibilities under Section 1135 of the Social Security Act (42 U.S.C. § 1320b-5) as related to the Novel Coronavirus Disease (COVID-19). These flexibilities are in addition to the request submitted from DHCS on March 16, 2020. As you know, the COVID-19 outbreak was declared a national emergency on March 13, 2020, and was previously declared a nationwide public health emergency on January 31, 2020 (retroactive to January 27, 2020).

The below list represents California's additional requested flexibilities under the Section 1135 authority in connection with the COVID-19 outbreak and emergency based on further exploration of need. Because circumstances surrounding the COVID-19 emergency remain quite fluid, DHCS may subsequently request approval for additional flexibilities, which we can commit to doing promptly as soon as the need is discovered. Consistent with Section 1 of the President's March 13, 2020, national emergency declaration, DHCS requests a retroactive effective date of January 27, 2020, for the requested Section 1135 flexibilities to coincide with the effective start date of the Public Health Emergency, unless otherwise specified. In the event a requested flexibility below is not approvable under the Section 1135 authority, DHCS requests CMS technical assistance to identify any other authority (e.g. under the State Plan or Section 1115) for which approval may be available. Per our discussion with CMS on March 19, 2020, DHCS will request the flexibilities associated with Inmate and Institutions for Mental Disease (IMD) funding exclusions in the Section 1115 context (according to the forthcoming CMS instructions/Section 1115 template).

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In addition, DHCS requests confirmation that any approved flexibility granted with respect to fee-for-service Medi-Cal benefits and providers would apply equally, to the extent applicable, to our various federally approved delivery systems, such as Medi-Cal managed care plans (MCPs), county organized health systems, county mental health plans, and Drug Medi-Cal organized delivery systems (DMC-ODS) and to the State's standalone Children's Health Insurance Program.

1. **Service authorization and utilization controls**, including but not necessarily limited to:

- Waiver of Attachment 3.1 – A.1, page 2 of the State Plan, exclusion of adult receipt of acetaminophen-containing and cough/cold products.

- For individuals with developmental disabilities receiving services under the State Plan 1915(i) authority, the state requests retainer payments. Retainer payments are available only for absences (maximum 30 consecutive days) in excess of the average number of absences experienced by the provider during the 12 month period prior to 2020.

- For Community-Based Adult Services (CBAS) – CBAS Benefit and Individual Plan of Care (IPC), the state requests:
    - Flexibility to reduce day center activities/gatherings and limit exposure to vulnerable populations.
    - Flexibility to utilize telephonic or live video interactions in lieu of face-to-face social/therapeutic visits.
    - Flexibility to utilize telephonic or live video interactions in lieu of face-to-face assessments.
    - Flexibility to allow following services to be provided at a beneficiary's home:
        - Physical Therapy
        - Occupational Therapy
    - Flexibility to provide or arrange for home delivered meals in absence of meals provided at the CBAS Center.
    - Flexibility for DHCS and MCPs to provide per diem payments to CBAS providers who provide telephonic or live video interactions in lieu of face-to-face social/therapeutic visits and/or assessments, arrange for home delivered meals in absence of meals provided at the CBAS Center, and/or provide physical therapy or occupational therapy in the home.

2. **Eligibility Flexibilities**, including but not necessarily limited to:

    - Flexibility in the hospital presumptive eligibility (HPE) program to cover more than one HPE period in a given 12-month timeframe. To the extent a beneficiary seeks care for coronavirus but has already used an HPE period in the last 12 months, or tests negative and then seeks care for a suspected episode later in the same 12-month period, HPE can provide a fast, low-barrier way to provide immediate, temporary coverage during the emergency period.

3. **Telehealth/Telephonic/Virtual Visits**, including but not necessarily limited to:

    - Waiver of 42 C.F.R. §438.6(c)(1), as necessary, to permit the State to direct MCO and PIHP payments to network providers, where telehealth/telephonic service is medically appropriate and feasible, at the same rate the MCO or PIHP would pay if the service was provided in person, unless the MCO/PIHP and the provider otherwise agree to a different rate for the telehealth modality.

    - Similar to flexibility granted at the federal level, DHCS requests authority for the State not to impose penalties for noncompliance with the regulatory requirements under the Health Insurance Portability and Accountability Act (HIPAA) against covered health care providers in connection with the good faith provision of telehealth during the COVID-19 emergency.

4. **Administrative Activities**, regarding deadlines and timetables for performance of required activities, DHCS requests extension of time for activities conducted by the state, MCPs, and/or county mental health and substance use disorder prepaid inpatient health plans (PIHPs), as applicable, due to social distancing to reduce the spread of COVID-19 and to allow the state, MCP, and/or PIHP resources to prioritize COVID-19 response efforts including:

    - Waiver of the two-year claiming submission limit (42 USC §1320b-2; 45 CFR §95.1, et seq.) for federal financial participation or claiming adjustments with respect to medical assistance and administrative expenditures.

    - Waiver of the requirement in 42 CFR §447.45(d)(1), that DHCS require providers to submit all claims no later than 12 months from the date of service. DHCS is requesting authority to extend the 12-month timeframe for services provided with dates of service during this emergency.

    - Modification of the federal deadlines for submission of cost reports for Medicare and Medicaid (currently due Nov. 2020) by at least 6 months, with no late penalties, so that providers have time to file the appropriate documents. Many provider and hospital staff have been told to work remotely or have been reassigned to

emergency response activities, which will cause delays in meeting reporting timelines.

- Waiver of the timeframe required for financial oversight and medical compliance audits for PIHPs and State Plan Drug Medi-Cal counties. DHCS requests this waiver to allow flexibility regarding deploying staff resources to manage the emergency.

5. **Payment Rates**, including but not necessarily limited to:

- Waiver of the county interim rate setting methodology described beginning on page 10 of the Certified Public Expenditure (CPE) protocol approved through the 1915(b) waiver. The CPE protocol requires DHCS to calculate county interim rates using prior year cost reports trended forward using the Home Health Agency Market Basket Index or a CMS approved cost of living index. As utilization drops and costs increase during this emergency, DHCS is requesting authority to use alternative methodologies, at DHCS's discretion, to temporarily increase county interim rates.

- Waiver of the interim rate setting methodology described on page 5 and 6 of the Drug Medi-Cal Organized Delivery System (DMC ODS) Certified Public Expenditure protocol approved through the 1115 demonstration. The CPE protocol requires DHCS to reimburse DMC ODS counties on an interim basis pursuant to county developed and DHCS approved interim rates for each service, which are expected to be based upon the most recently calculated or estimated county costs for the specific service. DHCS is requesting authority, if counties reimburse DMC providers up to actual cost, to reimburse counties the federal and state share of their certified public expenditures for services rendered during this emergency.

- Waiver of the Statewide Maximum Allowance (SMA) rate limitation on interim reimbursement and final settlement for Drug Medi-Cal (DMC) services provided in state plan counties. California's State Plan describes the reimbursement methodology for DMC services in Attachment 4.19-B, pages 38-41b (SPA 09-022 and SPA 15-013), which limits interim payments to DMC providers to the lower of the SMA or the USDR (Section E.1, page 41). Furthermore, the Medicaid State Plan also limits final reimbursement to lower of actual cost, usual and customary charges, or the SMA for DMC providers. DHCS is requesting authority to waive the SMA and usual and customary charge limitations on interim and final reimbursement for DMC state plan services.

6. **Clarification of Previous Requests**:

- Item 2 in the March 16, 2020 1135 Waiver requested to waive various federal and State Plan requirements pertaining to service authorization and utilization controls

imposed on covered benefits. DHCS seeks to clarify that the requested waivers would extend to any limitations for elective procedures and informed consent (including, but not necessarily limited, to 42 C.F.R. § 441.253) to enable provider to postpone elective procedures to prioritize COVID-19 response activities. DHCS suggests extending the current 180-day limit for beneficiary informed consent to 360 days.

- Item 5 in the March 16, 2020 1135 Waiver requested to waive restrictions existing restrictions on individual counseling sessions under the Drug Medi-Cal state plan. DHCS wants to clarify that we are requesting to waive Supplement 3 to Attachment 3.1-B, to allow individual visits in lieu of group visits, and that these visits may be conducted by telephone, telehealth, and/or in-person. Waive the current restriction on individual visits (only allowed for intake, crisis intervention, collateral services, and treatment and discharge planning). Allow individual visits to be used for counseling focused on short-term personal, family, job/school and other problems and their relationship to substance use. This waiver is needed so the services previously provided in groups can be done in individual sessions during the emergency, to prevent COVID-19 exposure.

- Item 6 in the March 16, 2020 1135 Waiver requested to waive State Plan Attachment 4.19-D, including any applicable Supplements, which establishes the payment methodology for Intermediate Care Facilities for the Developmentally Disabled (ICF-DD) and skilled nursing facilities (SNFs). The state wanted to clarify that the waiver being requested would apply to all SNF and ICF-DD facility types and the reimbursement flexibilities would not be limited solely to the costs associated with suspension of Day Programs. SNFs and ICF-DDs are experiencing increased cost pressures in a variety of areas as a result of the COVID-19 response and the state is seeking flexibility to allow consideration of all costs being incurred by facilities to ensure the health and safety of residents.

7. Flexibilities to be Requested under Section 1115 Authority (according to forthcoming CMS guidance):

- Waiver of the inmate exclusion (42 U.S.C. §1396d(a)(30)(A)) to allow for Medi-Cal claiming for services provided ***in*** jails and prisons for the testing, diagnosis and treatment of COVID-19 or services to ensure other care is provided in a safe way without transporting individuals to acute care facilities.

- Waiver of the 16-bed limitation/prohibition on receipt of federal financial participation for patients residing in Institutions for Mental Disease (IMD) pursuant to 42 U.S.C. §1396d(a)(30)(B). DHCS believes waiver of the IMD exclusion is necessary to temporarily increase bed capacity for affected beneficiaries and to allow facilities to claim for services provided for these

additional beds. Evaluation of less restritictive settings would be completed prior to placement.

During such difficult times for California and the nation, DHCS greatly appreciates the prompt attention exhibited by CMS to these matters and we look forward to the continued partnership.

Sincerely,
Original Signed By:

Jacey Cooper
Chief Deputy Director
Health Care Programs
State Medicaid Director

cc: Bradley P. Gilbert, MD, MPP
Director
Department of Health Care Services

Erika Sperbeck
Chief Deputy Director
Policy & Program Support
Department of Health Care

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken April 2, 2020
Regular Meeting of the CalOptima Board of Directors

Report Item
4. Consider Actions Related to Coronavirus (COVID-19) Pandemic

Contact
Nancy Huang, Chief Financial Officer (714) 246-8400
Michelle Laughlin, Executive Director Network Operations (714) 246-8400

Recommended Actions
1. Authorize Health Network Medi-Cal capitation rate increases for contracted Physician Hospital Consortia (PHC), Shared Risk Group (SRG), and Health Maintenance Organizations (HMO) by 5% from current levels for the period of April 1, 2020, through June 30, 2020;

2. Authorize waiver of the minimum stay requirement and expand types of services eligible for per diem payments for contracted Community-Based Adult Services (CBAS) providers for Medi-Cal and OneCare Connect;

3. Authorize unbudgeted expenditures from existing reserves of up to $14 million to provide funding for rates adjustments for Health Network capitation rates;

~~4. Authorize interim Medi-Cal rate for coronavirus testing for dates of service on or after February 4, 2020;~~ Amended 4/2/20

5. Authorize the Chief Executive Officer (CEO), with the assistance of Legal Counsel, to:

    a. Amend the Medi-Cal PHC, SRG, and HMO Health Network contracts to implement the 5% capitation rate increase; and
    b. Amend Medi-Cal and OneCare Connect contracts with CBAS providers effective March 13, 2020 to provide flexibility for services, in accordance with the Department of Health Care Services' (DHCS) section 1135 Waiver application.

Background
On January 31, 2020, the Secretary of Health and Human Services declared a public health emergency under section 319, of the Public Health Service Act (42 U.S.C. 247d) in response to a novel coronavirus known as SARS-CoV-2 (coronavirus). On March 13, 2020, the President of the United States declared a national emergency based on the spread of this coronavirus. Along with federal, state, and local agencies, CalOptima is taking action to continue efforts to protect the health and safety of our providers and members.

As an unprecedented safety measure, the state has issued self-quarantine and social distancing requirements for an unknown period of time. These requirements have and continue to affect CalOptima's provider networks as the coronavirus pandemic develops. One immediate downstream effect of these measures has been CBAS closures as a result of a reduction of in-person utilization. Left

unaddressed, this can rapidly jeopardize the viability of CalOptima's CBAS provider network. Moreover, it underscores the need for CalOptima to take necessary measures to ensure there is limited disruption of care and access to services for our members, which includes vulnerable individuals.

Discussion

CalOptima management recognizes that healthcare service delivery to our members has undergone significant changes during the coronavirus pandemic. Management recommends the following actions in order to provide immediate aid and service authorization flexibilities to CalOptima's provider network in order to ensure that members received access to covered, medically necessary health care services:

Medi-Cal Rate Enhancement for Health Networks

To provide immediate aid and support and maintain the viability of the health networks, Management proposes to:

1. Provide a 5% increase from current levels to contracted PHC, SRG and HMO Medi-Cal capitation rates for the period of April 1, 2020, through June 30, 2020. The estimated aggregate monthly fiscal impact is approximately $4.4 million.

2. Amend the Medi-Cal Health Network contracts to reflect this increase for the period stated above.

Special Reimbursement to CBAS providers

Staff anticipates face-to-face visits at CBAS centers to continue decreasing due to the Governor's stay at home executive order issued on March 19, 2020, and the County of Orange's social distancing requirements. CalOptima currently holds contracts with 31 CBAS centers, serving approximately 2,580 members. Preventing this is critical at this time, as CBAS centers serve CalOptima's most vulnerable senior members On March 19, 2020, the California Department of Health Care Services (DHCS) submitted a request for additional Section 1135 Waiver flexibilities related to coronavirus. This request included additional flexibilities related to the CBAS benefit and individual plan of care. In order to continue uninterrupted access to CBAS services, effective March 13, 2020, Management proposes to:

1. Waive the 1115 waiver requirement of a minimum of a four-hour stay at the center. This change will enable CalOptima members to receive appropriate services at home and remove barriers to access.

2. Expand the types of services eligible for per diem payments. Pursuant to DHCS' 1135 Waiver request, CalOptima will provide per diem payments to CBAS providers who provide:
   - Telephonic or live video interactions in lieu of face-to-face social/therapeutic visits and/or assessments;
   - Arrange for home delivered meals in absence of meals provided at the CBAS center; and/or
   - Provide physical therapy or occupational therapy in the home

3. Amend CBAS contracts to reflect the waiver of the minimum four-hour stay requirement and expansion of services pursuant to DHCS 1135 Waiver request.

~~Interim Medi-Cal Rate for Coronavirus Testing~~

~~The Centers for Medicare & Medicaid Services (CMS) established, for the Medicare program, procedure codes and provider reimbursement rates for coronavirus testing conducted on or after February 4, 2020. DHCS adopted these same procedure codes for the Medi-Cal program effective February 4, 2020. As of this writing, DHCS has not established Medi-Cal reimbursement rates for coronavirus testing.~~ Amended 4/2/20

~~Management proposes to adopt the Medicare provider reimbursement rates on an interim basis for CalOptima's Medi-Cal program for dates of service on or after February 4, 2020. Once DHCS establishes Medi-Cal reimbursement rates for coronavirus testing, CalOptima will make retroactive adjustments to Medi-Cal claims, as appropriate.~~ Amended 4/2/20

Fiscal Impact

The total funds for the Health Network Medi-Cal capitation rates for contracted PHCs, SRGs and HMOs will not exceed 5% of total medical capitation expenditures, in aggregate, in the CalOptima Fiscal Year (FY) 2019-20 Operating Budget. Staff projects the monthly incremental funding at approximately $4.4 million. An allocation of up to $14 million from existing reserves will fund this action.

The CalOptima FY 2019-20 Operating Budget includes funding for Professional medical expenditures for contracted CBAS providers. Currently, the net fiscal impact for the recommended action is unknown. However, assuming current utilization levels will continue, Staff anticipates the recommended action will not have an additional fiscal impact to the operating budget.

~~The fiscal impact for the recommended action to authorize an interim Medi-Cal rate for coronavirus testing is unknown at this time, since both utilization and costs estimates are difficult to quantify. However, Staff anticipates future funding received from DHCS for this purpose will fully offset expenses incurred by CalOptima.~~ Amended 4/2/20

Rationale for Recommendation

Providing additional provider payments during the coronavirus pandemic will ensure providers remain viable and accessible to our members, as well as increased financial security for the Orange County safety net system.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. DHCS Request for Additional Section 1135 Waiver Flexibilities Related to Novel Coronavirus Disease (COVID-19) National Emergency/Public Health Emergency dated March 19, 2020

/s/ Michael Schrader *03/26/2020*

Authorized Signature **Date**

State of California—Health and Human Services Agency
Department of Health Care Services

BRADLEY P. GILBERT, MD, MPP
DIRECTOR

GAVIN NEWSOM
GOVERNOR

March 19, 2020

Jackie Glaze
CMS Acting Director
Medicaid & CHIP Operations Group Center for Medicaid & CHIP
Services 7500 Security Boulevard
Baltimore, MD 21244
Jackie.Glaze@cms.hhs.gov

REQUEST FOR ADDITIONAL SECTION 1135 WAIVER FLEXIBILITIES RELATED TO NOVEL CORONAVIRUS DISEASE (COVID-19) NATIONAL EMERGENCY/PUBLIC HEALTH EMERGENCY

Dear Ms. Glaze:

The Department of Health Care Services (DHCS) writes to request approval for the below-detailed additional flexibilities under Section 1135 of the Social Security Act (42 U.S.C. § 1320b-5) as related to the Novel Coronavirus Disease (COVID-19). These flexibilities are in addition to the request submitted from DHCS on March 16, 2020. As you know, the COVID-19 outbreak was declared a national emergency on March 13, 2020, and was previously declared a nationwide public health emergency on January 31, 2020 (retroactive to January 27, 2020).

The below list represents California's additional requested flexibilities under the Section 1135 authority in connection with the COVID-19 outbreak and emergency based on further exploration of need. Because circumstances surrounding the COVID-19 emergency remain quite fluid, DHCS may subsequently request approval for additional flexibilities, which we can commit to doing promptly as soon as the need is discovered. Consistent with Section 1 of the President's March 13, 2020, national emergency declaration, DHCS requests a retroactive effective date of January 27, 2020, for the requested Section 1135 flexibilities to coincide with the effective start date of the Public Health Emergency, unless otherwise specified. In the event a requested flexibility below is not approvable under the Section 1135 authority, DHCS requests CMS technical assistance to identify any other authority (e.g. under the State Plan or Section 1115) for which approval may be available. Per our discussion with CMS on March 19, 2020, DHCS will request the flexibilities associated with Inmate and Institutions for Mental Disease (IMD) funding exclusions in the Section 1115 context (according to the forthcoming CMS instructions/Section 1115 template).

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In addition, DHCS requests confirmation that any approved flexibility granted with respect to fee-for-service Medi-Cal benefits and providers would apply equally, to the extent applicable, to our various federally approved delivery systems, such as Medi-Cal managed care plans (MCPs), county organized health systems, county mental health plans, and Drug Medi-Cal organized delivery systems (DMC-ODS) and to the State's standalone Children's Health Insurance Program.

1. **Service authorization and utilization controls**, including but not necessarily limited to:

- Waiver of Attachment 3.1 – A.1, page 2 of the State Plan, exclusion of adult receipt of acetaminophen-containing and cough/cold products.

- For individuals with developmental disabilities receiving services under the State Plan 1915(i) authority, the state requests retainer payments. Retainer payments are available only for absences (maximum 30 consecutive days) in excess of the average number of absences experienced by the provider during the 12 month period prior to 2020.

- For Community-Based Adult Services (CBAS) – CBAS Benefit and Individual Plan of Care (IPC), the state requests:
    - Flexibility to reduce day center activities/gatherings and limit exposure to vulnerable populations.
    - Flexibility to utilize telephonic or live video interactions in lieu of face-to-face social/therapeutic visits.
    - Flexibility to utilize telephonic or live video interactions in lieu of face-to-face assessments.
    - Flexibility to allow following services to be provided at a beneficiary's home:
        - Physical Therapy
        - Occupational Therapy
    - Flexibility to provide or arrange for home delivered meals in absence of meals provided at the CBAS Center.
    - Flexibility for DHCS and MCPs to provide per diem payments to CBAS providers who provide telephonic or live video interactions in lieu of face-to-face social/therapeutic visits and/or assessments, arrange for home delivered meals in absence of meals provided at the CBAS Center, and/or provide physical therapy or occupational therapy in the home.

2. **Eligibility Flexibilities**, including but not necessarily limited to:

    - Flexibility in the hospital presumptive eligibility (HPE) program to cover more than one HPE period in a given 12-month timeframe. To the extent a beneficiary seeks care for coronavirus but has already used an HPE period in the last 12 months, or tests negative and then seeks care for a suspected episode later in the same 12-month period, HPE can provide a fast, low-barrier way to provide immediate, temporary coverage during the emergency period.

3. **Telehealth/Telephonic/Virtual Visits**, including but not necessarily limited to:

    - Waiver of 42 C.F.R. §438.6(c)(1), as necessary, to permit the State to direct MCO and PIHP payments to network providers, where telehealth/telephonic service is medically appropriate and feasible, at the same rate the MCO or PIHP would pay if the service was provided in person, unless the MCO/PIHP and the provider otherwise agree to a different rate for the telehealth modality.

    - Similar to flexibility granted at the federal level, DHCS requests authority for the State not to impose penalties for noncompliance with the regulatory requirements under the Health Insurance Portability and Accountability Act (HIPAA) against covered health care providers in connection with the good faith provision of telehealth during the COVID-19 emergency.

4. **Administrative Activities**, regarding deadlines and timetables for performance of required activities, DHCS requests extension of time for activities conducted by the state, MCPs, and/or county mental health and substance use disorder prepaid inpatient health plans (PIHPs), as applicable, due to social distancing to reduce the spread of COVID-19 and to allow the state, MCP, and/or PIHP resources to prioritize COVID-19 response efforts including:

    - Waiver of the two-year claiming submission limit (42 USC §1320b-2; 45 CFR §95.1, et seq.) for federal financial participation or claiming adjustments with respect to medical assistance and administrative expenditures.

    - Waiver of the requirement in 42 CFR §447.45(d)(1), that DHCS require providers to submit all claims no later than 12 months from the date of service. DHCS is requesting authority to extend the 12-month timeframe for services provided with dates of service during this emergency.

    - Modification of the federal deadlines for submission of cost reports for Medicare and Medicaid (currently due Nov. 2020) by at least 6 months, with no late penalties, so that providers have time to file the appropriate documents. Many provider and hospital staff have been told to work remotely or have been reassigned to

emergency response activities, which will cause delays in meeting reporting timelines.

- Waiver of the timeframe required for financial oversight and medical compliance audits for PIHPs and State Plan Drug Medi-Cal counties. DHCS requests this waiver to allow flexibility regarding deploying staff resources to manage the emergency.

5. **Payment Rates**, including but not necessarily limited to:

- Waiver of the county interim rate setting methodology described beginning on page 10 of the Certified Public Expenditure (CPE) protocol approved through the 1915(b) waiver. The CPE protocol requires DHCS to calculate county interim rates using prior year cost reports trended forward using the Home Health Agency Market Basket Index or a CMS approved cost of living index. As utilization drops and costs increase during this emergency, DHCS is requesting authority to use alternative methodologies, at DHCS's discretion, to temporarily increase county interim rates.

- Waiver of the interim rate setting methodology described on page 5 and 6 of the Drug Medi-Cal Organized Delivery System (DMC ODS) Certified Public Expenditure protocol approved through the 1115 demonstration. The CPE protocol requires DHCS to reimburse DMC ODS counties on an interim basis pursuant to county developed and DHCS approved interim rates for each service, which are expected to be based upon the most recently calculated or estimated county costs for the specific service. DHCS is requesting authority, if counties reimburse DMC providers up to actual cost, to reimburse counties the federal and state share of their certified public expenditures for services rendered during this emergency.

- Waiver of the Statewide Maximum Allowance (SMA) rate limitation on interim reimbursement and final settlement for Drug Medi-Cal (DMC) services provided in state plan counties. California's State Plan describes the reimbursement methodology for DMC services in Attachment 4.19-B, pages 38-41b (SPA 09-022 and SPA 15-013), which limits interim payments to DMC providers to the lower of the SMA or the USDR (Section E.1, page 41). Furthermore, the Medicaid State Plan also limits final reimbursement to lower of actual cost, usual and customary charges, or the SMA for DMC providers. DHCS is requesting authority to waive the SMA and usual and customary charge limitations on interim and final reimbursement for DMC state plan services.

6. **Clarification of Previous Requests**:

- Item 2 in the March 16, 2020 1135 Waiver requested to waive various federal and State Plan requirements pertaining to service authorization and utilization controls

imposed on covered benefits. DHCS seeks to clarify that the requested waivers would extend to any limitations for elective procedures and informed consent (including, but not necessarily limited, to 42 C.F.R. § 441.253) to enable provider to postpone elective procedures to prioritize COVID-19 response activities. DHCS suggests extending the current 180-day limit for beneficiary informed consent to 360 days.

- Item 5 in the March 16, 2020 1135 Waiver requested to waive restrictions existing restrictions on individual counseling sessions under the Drug Medi-Cal state plan. DHCS wants to clarify that we are requesting to waive Supplement 3 to Attachment 3.1-B, to allow individual visits in lieu of group visits, and that these visits may be conducted by telephone, telehealth, and/or in-person. Waive the current restriction on individual visits (only allowed for intake, crisis intervention, collateral services, and treatment and discharge planning). Allow individual visits to be used for counseling focused on short-term personal, family, job/school and other problems and their relationship to substance use. This waiver is needed so the services previously provided in groups can be done in individual sessions during the emergency, to prevent COVID-19 exposure.

- Item 6 in the March 16, 2020 1135 Waiver requested to waive State Plan Attachment 4.19-D, including any applicable Supplements, which establishes the payment methodology for Intermediate Care Facilities for the Developmentally Disabled (ICF-DD) and skilled nursing facilities (SNFs). The state wanted to clarify that the waiver being requested would apply to all SNF and ICF-DD facility types and the reimbursement flexibilities would not be limited solely to the costs associated with suspension of Day Programs. SNFs and ICF-DDs are experiencing increased cost pressures in a variety of areas as a result of the COVID-19 response and the state is seeking flexibility to allow consideration of all costs being incurred by facilities to ensure the health and safety of residents.

7. Flexibilities to be Requested under Section 1115 Authority (according to forthcoming CMS guidance):

- Waiver of the inmate exclusion (42 U.S.C. §1396d(a)(30)(A)) to allow for Medi-Cal claiming for services provided ***in*** jails and prisons for the testing, diagnosis and treatment of COVID-19 or services to ensure other care is provided in a safe way without transporting individuals to acute care facilities.

- Waiver of the 16-bed limitation/prohibition on receipt of federal financial participation for patients residing in Institutions for Mental Disease (IMD) pursuant to 42 U.S.C. §1396d(a)(30)(B). DHCS believes waiver of the IMD exclusion is necessary to temporarily increase bed capacity for affected beneficiaries and to allow facilities to claim for services provided for these

additional beds. Evaluation of less restritictive settings would be completed prior to placement.

During such difficult times for California and the nation, DHCS greatly appreciates the prompt attention exhibited by CMS to these matters and we look forward to the continued partnership.

Sincerely,
Original Signed By:

Jacey Cooper
Chief Deputy Director
Health Care Programs
State Medicaid Director

cc: Bradley P. Gilbert, MD, MPP
Director
Department of Health Care Services

Erika Sperbeck
Chief Deputy Director
Policy & Program Support
Department of Health Care

AMENDMENT IX TO
CONTRACT FOR HEALTH CARE SERVICES

THIS AMENDMENT IX TO THE CONTRACT FOR HEALTH CARE SERVICES ("Amendment") is effective as of _____ by and between Orange County Health Authority, a Public Agency, dba CalOptima ("CalOptima"), and, _____("HMO"), with respect to the following facts:

RECITALS

A. CalOptima and HMO have entered into a Contract for Health Care Services ("Contract"), by which Physician has agreed to provide or arrange for the provision of Covered Services to Members.

B. On January 31, 2020, the Secretary of Health and Human Services declared a public health emergency under section 319 of the Public Health Service ACT (42 U.S.C. 247d) in response to a novel coronavirus known as SARS-CoV-2 (COVID-19), the COVID-19 Public Health Emergency ("COVID-19 PHE").

C. CalOptima and HMO have entered into amendments for the periods of April 1, 2020, through June 30, 2020, and January 1, 2021, through June 30, 2021 that have included the Medi-Cal capitation base rate enhancement approved by the CalOptima Board of Directors for immediate aid due to the COVID-19 PHE.

D. CalOptima and HMO desire to amend the Contract to include the Medi-Cal capitation base rate enhancement approved by the CalOptima Board of Directors for immediate aid due to the COVID-19 PHE.

NOW, THEREFORE, the parties agree as follows:

1. Attachment E-9, "MEDI-CAL RATE ENHANCEMENT" shall be added to the Contract and is attached hereto.

2. CONTRACT REMAINS IN FULL FORCE AND EFFECT – Except as specifically amended by this Amendment, all other conditions contained in the Contract shall continue in full force and effect. This Amendment is subject to approval by the Government Agencies and by the CalOptima Board of Directors.

IN WITNESS WHEREOF, CalOptima and _____ have executed this Amendment:

FOR HMO:	FOR CALOPTIMA:
_____	_____
SIGNATURE	SIGNATURE
_____	Ladan Khamseh
PRINT NAME	PRINT NAME
_____	Chief Operating Officer
TITLE	TITLE

DATE

DATE

ATTACHMENT E-9

MEDI-CAL RATE ENHANCEMENT

For the period from September 1, 2021, through December 31, 2021, the base physician and base hospital capitation rates set forth in Attachment E-Amendment VI for the Child/Adult and SPD aid code categories shall be increased by _%. This rate enhancement shall not apply to the capitation rates for ESRD and AIDS aid code categories, the Whole Child Model base capitation rates in Attachment E - Amendment VI, Adult Expansion Member capitation rates in Attachment E-1 Amendment V, or the Health Homes Program supplemental capitation payments in Attachment E-5 - Amendment VI.

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken January 7, 2021
Special Meeting of the CalOptima Board of Directors

Report Item

7. Authorize Health Network Medi-Cal Capitation Rate Increases for the Period of January 1, 2021, through June 30, 2021, due to COVID-Related Expenses

Contacts

Richard Sanchez, Chief Executive Officer, (657) 900-1481
Nancy Huang, Chief Financial Officer, (657) 235-6935

Recommended Actions

1. Authorize 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 5.0% from current levels for the period of January 1, 2021 through June 30, 2021;
2. Authorize unbudgeted expenditures up to $9 million to provide funding for Health Network capitation rate adjustments; and
3. Authorize the Chief Executive Officer, 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.

Background

On January 31, 2020, the Secretary of Health and Human Services declared a public health emergency under section 319, of the Public Health Service Act (42 U.S.C. 247d) in response to a novel coronavirus known as SARS-CoV-2 (coronavirus). On March 13, 2020, the President of the United States declared a national emergency based on the spread of this coronavirus. Subsequently, the Governor and the Orange County Health Officer have similarly taken steps to slow the spread of the coronavirus and protect the public. As with federal, state, and local agencies, CalOptima is taking action to continue efforts to support providers serving CalOptima members during the pandemic.

At its April 2, 2020, meeting, the Board authorized a 5% health network Medi-Cal capitation rate increase from reserve for contracted PHCs, SRGs and HMOs for the period of April 1, 2020, through June 30, 2020 to support CalOptima's provider networks and ensure member access proactively in the beginning of pandemic.

On December 23, 2020, CalOptima received final Calendar Year 2021 Medi-Cal capitation rates from the California Department of Health Care Services (DHCS). The final rates included an update rate component for COVID-related adjustments.

Discussion

Management recognizes that the coronavirus pandemic has placed significant stress on healthcare providers and on the delivery system serving CalOptima members. Consistent with DHCS's rate adjustment methodology, staff has included COVID-related testing and treatment costs, as well as potential changes in utilization in the evaluation. As such, in order to support the viability of our contracted health networks, Management requests authority to:

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1. Provide a 5.0% increase from current levels to contracted PHC, SRG and HMO Medi-Cal capitation rates, and shared risk pool funding on Child, Adult and SPD COAs, for the period of January 1, 2021, through June 30, 2021, except Kaiser. The estimated aggregate monthly fiscal impact is approximately $1.5 million.

2. Amend the Medi-Cal PHC, SRG, and HMO Health Network contracts, except Kaiser, to reflect this increase for the period stated above.

Fiscal Impact
The total funds for the Health Network Medi-Cal capitation rates for contracted PHCs, SRGs and HMOs will not exceed 5.0% of total medical capitation expenditures, on Child, Adult and SPD COAs, in the CalOptima Fiscal Year (FY) 2020-21 Operating Budget. The projected aggregate monthly fiscal impact is approximately $1.5 million or up to $9 million for the period of January 1, 2021, through June 30, 2021. It will be net budget neutral since additional funding from DHCS is anticipated to be sufficient to cover the unbudgeted Medi-Cal capitation rate increase.

Rationale for Recommendation
Providing additional provider payments during the coronavirus pandemic will ensure providers remain viable and accessible to our members, as well as increased financial security for the Orange County safety net system.

Concurrence
Gary Crockett, Chief Counsel

Attachments
1. Entities Covered by this Recommended Action
2. Board Action Dated April 2, 2020: Consider Actions Related to Coronavirus (COVID-19) Pandemic

/s/ Richard Sanchez — *12/31/2020*
Authorized Signature — **Date**

ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
Heritage Provider Network, Inc.	8510 Balboa Blvd., Ste. 285	Northridge	CA	91325
Monarch Health Plan, Inc.	11 Technology Dr.	Irvine	CA	92618
Prospect Health Plan, Inc.	600 City Parkway West, Ste. 800	Orange	CA	92868
CHOC Physicians Network and Children's Hospital of Orange County	1120 West La Veta Ave., Ste. 450	Orange	CA	92868
Family Choice Medical Group, Inc.	7631 Wyoming St., Ste. 202	Westminster	CA	92683
Fountain Valley Regional Hospital and Medical Center	17100 Euclid St.	Fountain Valley	CA	92708
AMVI Care Health Network	600 City Parkway West, Ste. 800	Orange	CA	92868
Orange County Physicians IPA Medical Group, Inc dba Noble Community Medical Associates, Inc.	10855 Business Center Dr., Ste. C	Cypress	CA	90630
Talbert Medical Group, P.C.	2175 Park Place	El Segundo	CA	90245
ARTA Western California, Inc.	2175 Park Place	El Segundo	CA	90245
United Care Medical Group, Inc.	600 City Parkway West	Orange	CA	92868
AltaMed Health Services Corporation	2040 Camfield Ave.	Los Angeles	CA	90040

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken April 2, 2020
Regular Meeting of the CalOptima Board of Directors

Report Item

4. Consider Actions Related to Coronavirus (COVID-19) Pandemic

Contact

Nancy Huang, Chief Financial Officer (714) 246-8400
Michelle Laughlin, Executive Director Network Operations (714) 246-8400

Recommended Actions

1. Authorize Health Network Medi-Cal capitation rate increases for contracted Physician Hospital Consortia (PHC), Shared Risk Group (SRG), and Health Maintenance Organizations (HMO) by 5% from current levels for the period of April 1, 2020, through June 30, 2020;

2. Authorize waiver of the minimum stay requirement and expand types of services eligible for per diem payments for contracted Community-Based Adult Services (CBAS) providers for Medi-Cal and OneCare Connect;

3. Authorize unbudgeted expenditures from existing reserves of up to $14 million to provide funding for rates adjustments for Health Network capitation rates;

~~4. Authorize interim Medi-Cal rate for coronavirus testing for dates of service on or after February 4, 2020;~~ Amended 4/2/20

5. Authorize the Chief Executive Officer (CEO), with the assistance of Legal Counsel, to:

    a. Amend the Medi-Cal PHC, SRG, and HMO Health Network contracts to implement the 5% capitation rate increase; and
    b. Amend Medi-Cal and OneCare Connect contracts with CBAS providers effective March 13, 2020 to provide flexibility for services, in accordance with the Department of Health Care Services' (DHCS) section 1135 Waiver application.

Background

On January 31, 2020, the Secretary of Health and Human Services declared a public health emergency under section 319, of the Public Health Service Act (42 U.S.C. 247d) in response to a novel coronavirus known as SARS-CoV-2 (coronavirus). On March 13, 2020, the President of the United States declared a national emergency based on the spread of this coronavirus. Along with federal, state, and local agencies, CalOptima is taking action to continue efforts to protect the health and safety of our providers and members.

As an unprecedented safety measure, the state has issued self-quarantine and social distancing requirements for an unknown period of time. These requirements have and continue to affect CalOptima's provider networks as the coronavirus pandemic develops. One immediate downstream effect of these measures has been CBAS closures as a result of a reduction of in-person utilization. Left

unaddressed, this can rapidly jeopardize the viability of CalOptima's CBAS provider network. Moreover, it underscores the need for CalOptima to take necessary measures to ensure there is limited disruption of care and access to services for our members, which includes vulnerable individuals.

Discussion

CalOptima management recognizes that healthcare service delivery to our members has undergone significant changes during the coronavirus pandemic. Management recommends the following actions in order to provide immediate aid and service authorization flexibilities to CalOptima's provider network in order to ensure that members received access to covered, medically necessary health care services:

Medi-Cal Rate Enhancement for Health Networks

To provide immediate aid and support and maintain the viability of the health networks, Management proposes to:

1. Provide a 5% increase from current levels to contracted PHC, SRG and HMO Medi-Cal capitation rates for the period of April 1, 2020, through June 30, 2020. The estimated aggregate monthly fiscal impact is approximately $4.4 million.

2. Amend the Medi-Cal Health Network contracts to reflect this increase for the period stated above.

Special Reimbursement to CBAS providers

Staff anticipates face-to-face visits at CBAS centers to continue decreasing due to the Governor's stay at home executive order issued on March 19, 2020, and the County of Orange's social distancing requirements. CalOptima currently holds contracts with 31 CBAS centers, serving approximately 2,580 members. Preventing this is critical at this time, as CBAS centers serve CalOptima's most vulnerable senior members On March 19, 2020, the California Department of Health Care Services (DHCS) submitted a request for additional Section 1135 Waiver flexibilities related to coronavirus. This request included additional flexibilities related to the CBAS benefit and individual plan of care. In order to continue uninterrupted access to CBAS services, effective March 13, 2020, Management proposes to:

1. Waive the 1115 waiver requirement of a minimum of a four-hour stay at the center. This change will enable CalOptima members to receive appropriate services at home and remove barriers to access.

2. Expand the types of services eligible for per diem payments. Pursuant to DHCS' 1135 Waiver request, CalOptima will provide per diem payments to CBAS providers who provide:
   - Telephonic or live video interactions in lieu of face-to-face social/therapeutic visits and/or assessments;
   - Arrange for home delivered meals in absence of meals provided at the CBAS center; and/or
   - Provide physical therapy or occupational therapy in the home

3. Amend CBAS contracts to reflect the waiver of the minimum four-hour stay requirement and expansion of services pursuant to DHCS 1135 Waiver request.

~~Interim Medi-Cal Rate for Coronavirus Testing~~

~~The Centers for Medicare & Medicaid Services (CMS) established, for the Medicare program, procedure codes and provider reimbursement rates for coronavirus testing conducted on or after February 4, 2020. DHCS adopted these same procedure codes for the Medi-Cal program effective February 4, 2020. As of this writing, DHCS has not established Medi-Cal reimbursement rates for coronavirus testing.~~ Amended 4/2/20

~~Management proposes to adopt the Medicare provider reimbursement rates on an interim basis for CalOptima's Medi-Cal program for dates of service on or after February 4, 2020. Once DHCS establishes Medi-Cal reimbursement rates for coronavirus testing, CalOptima will make retroactive adjustments to Medi-Cal claims, as appropriate.~~ Amended 4/2/20

Fiscal Impact

The total funds for the Health Network Medi-Cal capitation rates for contracted PHCs, SRGs and HMOs will not exceed 5% of total medical capitation expenditures, in aggregate, in the CalOptima Fiscal Year (FY) 2019-20 Operating Budget. Staff projects the monthly incremental funding at approximately $4.4 million. An allocation of up to $14 million from existing reserves will fund this action.

The CalOptima FY 2019-20 Operating Budget includes funding for Professional medical expenditures for contracted CBAS providers. Currently, the net fiscal impact for the recommended action is unknown. However, assuming current utilization levels will continue, Staff anticipates the recommended action will not have an additional fiscal impact to the operating budget.

~~The fiscal impact for the recommended action to authorize an interim Medi-Cal rate for coronavirus testing is unknown at this time, since both utilization and costs estimates are difficult to quantify. However, Staff anticipates future funding received from DHCS for this purpose will fully offset expenses incurred by CalOptima.~~ Amended 4/2/20

Rationale for Recommendation

Providing additional provider payments during the coronavirus pandemic will ensure providers remain viable and accessible to our members, as well as increased financial security for the Orange County safety net system.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. DHCS Request for Additional Section 1135 Waiver Flexibilities Related to Novel Coronavirus Disease (COVID-19) National Emergency/Public Health Emergency dated March 19, 2020

/s/ Michael Schrader — **Authorized Signature**

03/26/2020 — **Date**

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State of California—Health and Human Services Agency
Department of Health Care Services

BRADLEY P. GILBERT, MD, MPP
DIRECTOR

GAVIN NEWSOM
GOVERNOR

March 19, 2020

Jackie Glaze
CMS Acting Director
Medicaid & CHIP Operations Group Center for Medicaid & CHIP
Services 7500 Security Boulevard
Baltimore, MD 21244
Jackie.Glaze@cms.hhs.gov

REQUEST FOR ADDITIONAL SECTION 1135 WAIVER FLEXIBILITIES RELATED TO NOVEL CORONAVIRUS DISEASE (COVID-19) NATIONAL EMERGENCY/PUBLIC HEALTH EMERGENCY

Dear Ms. Glaze:

The Department of Health Care Services (DHCS) writes to request approval for the below-detailed additional flexibilities under Section 1135 of the Social Security Act (42 U.S.C. § 1320b-5) as related to the Novel Coronavirus Disease (COVID-19). These flexibilities are in addition to the request submitted from DHCS on March 16, 2020. As you know, the COVID-19 outbreak was declared a national emergency on March 13, 2020, and was previously declared a nationwide public health emergency on January 31, 2020 (retroactive to January 27, 2020).

The below list represents California's additional requested flexibilities under the Section 1135 authority in connection with the COVID-19 outbreak and emergency based on further exploration of need. Because circumstances surrounding the COVID-19 emergency remain quite fluid, DHCS may subsequently request approval for additional flexibilities, which we can commit to doing promptly as soon as the need is discovered. Consistent with Section 1 of the President's March 13, 2020, national emergency declaration, DHCS requests a retroactive effective date of January 27, 2020, for the requested Section 1135 flexibilities to coincide with the effective start date of the Public Health Emergency, unless otherwise specified. In the event a requested flexibility below is not approvable under the Section 1135 authority, DHCS requests CMS technical assistance to identify any other authority (e.g. under the State Plan or Section 1115) for which approval may be available. Per our discussion with CMS on March 19, 2020, DHCS will request the flexibilities associated with Inmate and Institutions for Mental Disease (IMD) funding exclusions in the Section 1115 context (according to the forthcoming CMS instructions/Section 1115 template).

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In addition, DHCS requests confirmation that any approved flexibility granted with respect to fee-for-service Medi-Cal benefits and providers would apply equally, to the extent applicable, to our various federally approved delivery systems, such as Medi-Cal managed care plans (MCPs), county organized health systems, county mental health plans, and Drug Medi-Cal organized delivery systems (DMC-ODS) and to the State's standalone Children's Health Insurance Program.

1. **Service authorization and utilization controls**, including but not necessarily limited to:

- Waiver of Attachment 3.1 – A.1, page 2 of the State Plan, exclusion of adult receipt of acetaminophen-containing and cough/cold products.

- For individuals with developmental disabilities receiving services under the State Plan 1915(i) authority, the state requests retainer payments. Retainer payments are available only for absences (maximum 30 consecutive days) in excess of the average number of absences experienced by the provider during the 12 month period prior to 2020.

- For Community-Based Adult Services (CBAS) – CBAS Benefit and Individual Plan of Care (IPC), the state requests:
    - Flexibility to reduce day center activities/gatherings and limit exposure to vulnerable populations.
    - Flexibility to utilize telephonic or live video interactions in lieu of face-to-face social/therapeutic visits.
    - Flexibility to utilize telephonic or live video interactions in lieu of face-to-face assessments.
    - Flexibility to allow following services to be provided at a beneficiary's home:
        - Physical Therapy
        - Occupational Therapy
    - Flexibility to provide or arrange for home delivered meals in absence of meals provided at the CBAS Center.
    - Flexibility for DHCS and MCPs to provide per diem payments to CBAS providers who provide telephonic or live video interactions in lieu of face-to-face social/therapeutic visits and/or assessments, arrange for home delivered meals in absence of meals provided at the CBAS Center, and/or provide physical therapy or occupational therapy in the home.

2. **Eligibility Flexibilities**, including but not necessarily limited to:

    - Flexibility in the hospital presumptive eligibility (HPE) program to cover more than one HPE period in a given 12-month timeframe. To the extent a beneficiary seeks care for coronavirus but has already used an HPE period in the last 12 months, or tests negative and then seeks care for a suspected episode later in the same 12-month period, HPE can provide a fast, low-barrier way to provide immediate, temporary coverage during the emergency period.

3. **Telehealth/Telephonic/Virtual Visits**, including but not necessarily limited to:

    - Waiver of 42 C.F.R. §438.6(c)(1), as necessary, to permit the State to direct MCO and PIHP payments to network providers, where telehealth/telephonic service is medically appropriate and feasible, at the same rate the MCO or PIHP would pay if the service was provided in person, unless the MCO/PIHP and the provider otherwise agree to a different rate for the telehealth modality.

    - Similar to flexibility granted at the federal level, DHCS requests authority for the State not to impose penalties for noncompliance with the regulatory requirements under the Health Insurance Portability and Accountability Act (HIPAA) against covered health care providers in connection with the good faith provision of telehealth during the COVID-19 emergency.

4. **Administrative Activities**, regarding deadlines and timetables for performance of required activities, DHCS requests extension of time for activities conducted by the state, MCPs, and/or county mental health and substance use disorder prepaid inpatient health plans (PIHPs), as applicable, due to social distancing to reduce the spread of COVID-19 and to allow the state, MCP, and/or PIHP resources to prioritize COVID-19 response efforts including:

    - Waiver of the two-year claiming submission limit (42 USC §1320b-2; 45 CFR §95.1, et seq.) for federal financial participation or claiming adjustments with respect to medical assistance and administrative expenditures.

    - Waiver of the requirement in 42 CFR §447.45(d)(1), that DHCS require providers to submit all claims no later than 12 months from the date of service. DHCS is requesting authority to extend the 12-month timeframe for services provided with dates of service during this emergency.

    - Modification of the federal deadlines for submission of cost reports for Medicare and Medicaid (currently due Nov. 2020) by at least 6 months, with no late penalties, so that providers have time to file the appropriate documents. Many provider and hospital staff have been told to work remotely or have been reassigned to

emergency response activities, which will cause delays in meeting reporting timelines.

- Waiver of the timeframe required for financial oversight and medical compliance audits for PIHPs and State Plan Drug Medi-Cal counties. DHCS requests this waiver to allow flexibility regarding deploying staff resources to manage the emergency.

5. **Payment Rates**, including but not necessarily limited to:

- Waiver of the county interim rate setting methodology described beginning on page 10 of the Certified Public Expenditure (CPE) protocol approved through the 1915(b) waiver. The CPE protocol requires DHCS to calculate county interim rates using prior year cost reports trended forward using the Home Health Agency Market Basket Index or a CMS approved cost of living index. As utilization drops and costs increase during this emergency, DHCS is requesting authority to use alternative methodologies, at DHCS's discretion, to temporarily increase county interim rates.

- Waiver of the interim rate setting methodology described on page 5 and 6 of the Drug Medi-Cal Organized Delivery System (DMC ODS) Certified Public Expenditure protocol approved through the 1115 demonstration. The CPE protocol requires DHCS to reimburse DMC ODS counties on an interim basis pursuant to county developed and DHCS approved interim rates for each service, which are expected to be based upon the most recently calculated or estimated county costs for the specific service. DHCS is requesting authority, if counties reimburse DMC providers up to actual cost, to reimburse counties the federal and state share of their certified public expenditures for services rendered during this emergency.

- Waiver of the Statewide Maximum Allowance (SMA) rate limitation on interim reimbursement and final settlement for Drug Medi-Cal (DMC) services provided in state plan counties. California's State Plan describes the reimbursement methodology for DMC services in Attachment 4.19-B, pages 38-41b (SPA 09-022 and SPA 15-013), which limits interim payments to DMC providers to the lower of the SMA or the USDR (Section E.1, page 41). Furthermore, the Medicaid State Plan also limits final reimbursement to lower of actual cost, usual and customary charges, or the SMA for DMC providers. DHCS is requesting authority to waive the SMA and usual and customary charge limitations on interim and final reimbursement for DMC state plan services.

6. **Clarification of Previous Requests**:

- Item 2 in the March 16, 2020 1135 Waiver requested to waive various federal and State Plan requirements pertaining to service authorization and utilization controls

imposed on covered benefits. DHCS seeks to clarify that the requested waivers would extend to any limitations for elective procedures and informed consent (including, but not necessarily limited, to 42 C.F.R. § 441.253) to enable provider to postpone elective procedures to prioritize COVID-19 response activities. DHCS suggests extending the current 180-day limit for beneficiary informed consent to 360 days.

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- Item 6 in the March 16, 2020 1135 Waiver requested to waive State Plan Attachment 4.19-D, including any applicable Supplements, which establishes the payment methodology for Intermediate Care Facilities for the Developmentally Disabled (ICF-DD) and skilled nursing facilities (SNFs). The state wanted to clarify that the waiver being requested would apply to all SNF and ICF-DD facility types and the reimbursement flexibilities would not be limited solely to the costs associated with suspension of Day Programs. SNFs and ICF-DDs are experiencing increased cost pressures in a variety of areas as a result of the COVID-19 response and the state is seeking flexibility to allow consideration of all costs being incurred by facilities to ensure the health and safety of residents.

7. Flexibilities to be Requested under Section 1115 Authority (according to forthcoming CMS guidance):

- Waiver of the inmate exclusion (42 U.S.C. §1396d(a)(30)(A)) to allow for Medi-Cal claiming for services provided ***in*** jails and prisons for the testing, diagnosis and treatment of COVID-19 or services to ensure other care is provided in a safe way without transporting individuals to acute care facilities.

- Waiver of the 16-bed limitation/prohibition on receipt of federal financial participation for patients residing in Institutions for Mental Disease (IMD) pursuant to 42 U.S.C. §1396d(a)(30)(B). DHCS believes waiver of the IMD exclusion is necessary to temporarily increase bed capacity for affected beneficiaries and to allow facilities to claim for services provided for these

additional beds. Evaluation of less restritictive settings would be completed prior to placement.

During such difficult times for California and the nation, DHCS greatly appreciates the prompt attention exhibited by CMS to these matters and we look forward to the continued partnership.

Sincerely,
Original Signed By:

Jacey Cooper
Chief Deputy Director
Health Care Programs
State Medicaid Director

cc: Bradley P. Gilbert, MD, MPP
Director
Department of Health Care Services

Erika Sperbeck
Chief Deputy Director
Policy & Program Support
Department of Health Care

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken April 2, 2020
Regular Meeting of the CalOptima Board of Directors

Report Item
4. Consider Actions Related to Coronavirus (COVID-19) Pandemic

Contact
Nancy Huang, Chief Financial Officer (714) 246-8400
Michelle Laughlin, Executive Director Network Operations (714) 246-8400

Recommended Actions
1. Authorize Health Network Medi-Cal capitation rate increases for contracted Physician Hospital Consortia (PHC), Shared Risk Group (SRG), and Health Maintenance Organizations (HMO) by 5% from current levels for the period of April 1, 2020, through June 30, 2020;

2. Authorize waiver of the minimum stay requirement and expand types of services eligible for per diem payments for contracted Community-Based Adult Services (CBAS) providers for Medi-Cal and OneCare Connect;

3. Authorize unbudgeted expenditures from existing reserves of up to $14 million to provide funding for rates adjustments for Health Network capitation rates;

~~4. Authorize interim Medi-Cal rate for coronavirus testing for dates of service on or after February 4, 2020;~~ Amended 4/2/20

5. Authorize the Chief Executive Officer (CEO), with the assistance of Legal Counsel, to:

    a. Amend the Medi-Cal PHC, SRG, and HMO Health Network contracts to implement the 5% capitation rate increase; and
    b. Amend Medi-Cal and OneCare Connect contracts with CBAS providers effective March 13, 2020 to provide flexibility for services, in accordance with the Department of Health Care Services' (DHCS) section 1135 Waiver application.

Background
On January 31, 2020, the Secretary of Health and Human Services declared a public health emergency under section 319, of the Public Health Service Act (42 U.S.C. 247d) in response to a novel coronavirus known as SARS-CoV-2 (coronavirus). On March 13, 2020, the President of the United States declared a national emergency based on the spread of this coronavirus. Along with federal, state, and local agencies, CalOptima is taking action to continue efforts to protect the health and safety of our providers and members.

As an unprecedented safety measure, the state has issued self-quarantine and social distancing requirements for an unknown period of time. These requirements have and continue to affect CalOptima's provider networks as the coronavirus pandemic develops. One immediate downstream effect of these measures has been CBAS closures as a result of a reduction of in-person utilization. Left

unaddressed, this can rapidly jeopardize the viability of CalOptima's CBAS provider network. Moreover, it underscores the need for CalOptima to take necessary measures to ensure there is limited disruption of care and access to services for our members, which includes vulnerable individuals.

Discussion

CalOptima management recognizes that healthcare service delivery to our members has undergone significant changes during the coronavirus pandemic. Management recommends the following actions in order to provide immediate aid and service authorization flexibilities to CalOptima's provider network in order to ensure that members received access to covered, medically necessary health care services:

Medi-Cal Rate Enhancement for Health Networks

To provide immediate aid and support and maintain the viability of the health networks, Management proposes to:

1. Provide a 5% increase from current levels to contracted PHC, SRG and HMO Medi-Cal capitation rates for the period of April 1, 2020, through June 30, 2020. The estimated aggregate monthly fiscal impact is approximately $4.4 million.

2. Amend the Medi-Cal Health Network contracts to reflect this increase for the period stated above.

Special Reimbursement to CBAS providers

Staff anticipates face-to-face visits at CBAS centers to continue decreasing due to the Governor's stay at home executive order issued on March 19, 2020, and the County of Orange's social distancing requirements. CalOptima currently holds contracts with 31 CBAS centers, serving approximately 2,580 members. Preventing this is critical at this time, as CBAS centers serve CalOptima's most vulnerable senior members On March 19, 2020, the California Department of Health Care Services (DHCS) submitted a request for additional Section 1135 Waiver flexibilities related to coronavirus. This request included additional flexibilities related to the CBAS benefit and individual plan of care. In order to continue uninterrupted access to CBAS services, effective March 13, 2020, Management proposes to:

1. Waive the 1115 waiver requirement of a minimum of a four-hour stay at the center. This change will enable CalOptima members to receive appropriate services at home and remove barriers to access.

2. Expand the types of services eligible for per diem payments. Pursuant to DHCS' 1135 Waiver request, CalOptima will provide per diem payments to CBAS providers who provide:
   - Telephonic or live video interactions in lieu of face-to-face social/therapeutic visits and/or assessments;
   - Arrange for home delivered meals in absence of meals provided at the CBAS center; and/or
   - Provide physical therapy or occupational therapy in the home

3. Amend CBAS contracts to reflect the waiver of the minimum four-hour stay requirement and expansion of services pursuant to DHCS 1135 Waiver request.

~~Interim Medi-Cal Rate for Coronavirus Testing~~

~~The Centers for Medicare & Medicaid Services (CMS) established, for the Medicare program, procedure codes and provider reimbursement rates for coronavirus testing conducted on or after February 4, 2020. DHCS adopted these same procedure codes for the Medi-Cal program effective February 4, 2020. As of this writing, DHCS has not established Medi-Cal reimbursement rates for coronavirus testing.~~ Amended 4/2/20

~~Management proposes to adopt the Medicare provider reimbursement rates on an interim basis for CalOptima's Medi-Cal program for dates of service on or after February 4, 2020. Once DHCS establishes Medi-Cal reimbursement rates for coronavirus testing, CalOptima will make retroactive adjustments to Medi-Cal claims, as appropriate.~~ Amended 4/2/20

Fiscal Impact

The total funds for the Health Network Medi-Cal capitation rates for contracted PHCs, SRGs and HMOs will not exceed 5% of total medical capitation expenditures, in aggregate, in the CalOptima Fiscal Year (FY) 2019-20 Operating Budget. Staff projects the monthly incremental funding at approximately $4.4 million. An allocation of up to $14 million from existing reserves will fund this action.

The CalOptima FY 2019-20 Operating Budget includes funding for Professional medical expenditures for contracted CBAS providers. Currently, the net fiscal impact for the recommended action is unknown. However, assuming current utilization levels will continue, Staff anticipates the recommended action will not have an additional fiscal impact to the operating budget.

~~The fiscal impact for the recommended action to authorize an interim Medi-Cal rate for coronavirus testing is unknown at this time, since both utilization and costs estimates are difficult to quantify. However, Staff anticipates future funding received from DHCS for this purpose will fully offset expenses incurred by CalOptima.~~ Amended 4/2/20

Rationale for Recommendation

Providing additional provider payments during the coronavirus pandemic will ensure providers remain viable and accessible to our members, as well as increased financial security for the Orange County safety net system.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. DHCS Request for Additional Section 1135 Waiver Flexibilities Related to Novel Coronavirus Disease (COVID-19) National Emergency/Public Health Emergency dated March 19, 2020

/s/ Michael Schrader — **Authorized Signature**

03/26/2020 — **Date**

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State of California—Health and Human Services Agency
Department of Health Care Services

BRADLEY P. GILBERT, MD, MPP
DIRECTOR

GAVIN NEWSOM
GOVERNOR

March 19, 2020

Jackie Glaze
CMS Acting Director
Medicaid & CHIP Operations Group Center for Medicaid & CHIP
Services 7500 Security Boulevard
Baltimore, MD 21244
Jackie.Glaze@cms.hhs.gov

REQUEST FOR ADDITIONAL SECTION 1135 WAIVER FLEXIBILITIES RELATED TO NOVEL CORONAVIRUS DISEASE (COVID-19) NATIONAL EMERGENCY/PUBLIC HEALTH EMERGENCY

Dear Ms. Glaze:

The Department of Health Care Services (DHCS) writes to request approval for the below-detailed additional flexibilities under Section 1135 of the Social Security Act (42 U.S.C. § 1320b-5) as related to the Novel Coronavirus Disease (COVID-19). These flexibilities are in addition to the request submitted from DHCS on March 16, 2020. As you know, the COVID-19 outbreak was declared a national emergency on March 13, 2020, and was previously declared a nationwide public health emergency on January 31, 2020 (retroactive to January 27, 2020).

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In addition, DHCS requests confirmation that any approved flexibility granted with respect to fee-for-service Medi-Cal benefits and providers would apply equally, to the extent applicable, to our various federally approved delivery systems, such as Medi-Cal managed care plans (MCPs), county organized health systems, county mental health plans, and Drug Medi-Cal organized delivery systems (DMC-ODS) and to the State's standalone Children's Health Insurance Program.

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6. **Clarification of Previous Requests**:

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additional beds. Evaluation of less restritictive settings would be completed prior to placement.

During such difficult times for California and the nation, DHCS greatly appreciates the prompt attention exhibited by CMS to these matters and we look forward to the continued partnership.

Sincerely,
Original Signed By:

Jacey Cooper
Chief Deputy Director
Health Care Programs
State Medicaid Director

cc: Bradley P. Gilbert, MD, MPP
Director
Department of Health Care Services

Erika Sperbeck
Chief Deputy Director
Policy & Program Support
Department of Health Care

AMENDMENT 10 TO
CONTRACT FOR HEALTH CARE SERVICES

THIS AMENDMENT 10 TO THE CONTRACT FOR HEALTH CARE SERVICES ("Amendment") is effective as of **January 1, 2022** by and between Orange County Health Authority, a Public Agency, dba CalOptima ("CalOptima"), and, _____("Physician"), with respect to the following facts:

RECITALS

A. CalOptima and Physician have entered into a Contract for Health Care Services ("Contract"), by which Physician has agreed to provide or arrange for the provision of Covered Services to Members.

B. On January 31, 2020, the Secretary of Health and Human Services declared a public health emergency under section 319 of the Public Health Service ACT (42 U.S.C. 247d) in response to a novel coronavirus known as SARS-CoV-2 (COVID-19), the COVID-19 Public Health Emergency ("COVID-19 PHE").

C. CalOptima and Physician have entered into amendments for the periods of April 1, 2020, through June 30, 2020, January 1, 2021, through June 30, 2021 and September 1, 2021 through December 31, 2021 that have included the Medi-Cal capitation base rate enhancement approved by the CalOptima Board of Directors for immediate aid due to the COVID-19 PHE.

D. CalOptima and Physician desire to amend the Contract to extend the Medi-Cal capitation base rate enhancement approved by the CalOptima Board of Directors through June 30, 2022 for immediate aid due to the COVID-19 PHE. This additional funding is to address the increasing COVID-19 related expenses and to continuously improve vaccination rates for CalOptima's members within the Medi-Cal focus populations.

NOW, THEREFORE, the parties agree as follows:

1. Attachment E-8, "MEDI-CAL RATE ENHANCEMENT" shall be deleted in its entirety and replaced with a new Attachment E-8 – Amendment 10 "MEDI-CAL RATE ENHANCEMENT" attached hereto.

2. CONTRACT REMAINS IN FULL FORCE AND EFFECT – Except as specifically amended by this Amendment, all other conditions contained in the Contract shall continue in full force and effect. This Amendment is subject to approval by the Government Agencies and by the CalOptima Board of Directors.

IN WITNESS WHEREOF, CalOptima and _____ have executed this Amendment.

FOR PHYSICIAN:	FOR CALOPTIMA:
_____	_____
Signature	Signature
_____	_____
Print Name	Print Name
_____	_____
Title	Title
_____	_____
Date	Date

ATTACHMENT E-8 – AMENDMENT 10

MEDI-CAL RATE ENHANCEMENT

For the period from September 1, 2021, through June 30, 2022, the base physician and base hospital capitation rates set forth in Attachment E-Amendment 8 for the Child/Adult and SPD aid code categories shall be increased by [redacted]%. This rate enhancement shall not apply to the capitation rates for ESRD and AIDS aid code categories, the Whole Child Model base capitation rates in Attachment E - Amendment 8, Adult Expansion Member capitation rates in Attachment E-1 Amendment 8, or the Health Homes Program supplemental capitation payments in Attachment E-4 - Amendment VI.

AMENDMENT __ TO
CONTRACT FOR HEALTH CARE SERVICES

THIS AMENDMENT __ TO THE CONTRACT FOR HEALTH CARE SERVICES ("Amendment") is effective as of **July 1, 2022** by and between Orange County Health Authority, a Public Agency, dba CalOptima ("CalOptima"), and, _____ ("HMO), with respect to the following facts:

RECITALS

A. CalOptima and HMO have entered into a Contract for Health Care Services ("Contract"), by which Physician has agreed to provide or arrange for the provision of Covered Services to Members.

B. On January 31, 2020, the Secretary of Health and Human Services declared a public health emergency under section 319 of the Public Health Service ACT (42 U.S.C. 247d) in response to a novel coronavirus known as SARS-CoV-2 ("COVID-19"), the COVID-19 Public Health Emergency ("COVID-19 PHE").

C. CalOptima and HMO have entered into amendments for the periods of April 1, 2020, through June 30, 2020, January 1, 2021, through June 30, 2021, September 1, 2021 through December 31, 2021 and January 1, 2022, through June 30, 2022, that have included the Medi-Cal capitation base rate enhancement approved by the CalOptima Board of Directors for immediate aid due to the COVID-19 PHE.

D. CalOptima and HMO desire to amend the Contract to extend the Medi-Cal capitation base rate enhancement approved by the CalOptima Board of Directors through June 30, 2023 for immediate aid due to the COVID-19 PHE.

NOW, THEREFORE, the parties agree as follows:

1. Attachment E-9, "MEDI-CAL RATE ENHANCEMENT" of the Contract shall be deleted in its entirety and replaced with a new Attachment E-9 "MEDI-CAL RATE ENHANCEMENT", which is attached hereto and incorporated into the Contract by this reference.

2. CONTRACT REMAINS IN FULL FORCE AND EFFECT – Except as specifically amended by this Amendment, all other conditions contained in the Contract shall continue in full force and effect. This Amendment is subject to approval by the Government Agencies and by the CalOptima Board of Directors. After the effective date of this Amendment, any reference to the Contract shall mean the Contract as amended and supplemented by this Amendment. Notwithstanding anything to the contrary in the Contract, in the event of a conflict between the terms and conditions of this Amendment and those contained within the Contract, the terms and conditions of this Amendment shall prevail. Capitalized terms not otherwise defined in this Amendment shall have the meanings ascribed to them in the Contract.

[signature page follows]

IN WITNESS WHEREOF, CalOptima and _____ have executed this Amendment.

FOR HMO:	FOR CALOPTIMA:
Signature	Signature
Print Name	Print Name
Title	Title
Date	Date

ATTACHMENT E-9

MEDI-CAL RATE ENHANCEMENT

For the period from September 1, 2021, through June 30, 2023, the base physician and base hospital capitation rates set forth in Attachment E - Amendment 8 for the Child/Adult and SPD aid code categories shall be increased by 7.5%. This rate enhancement shall not apply to the capitation rates for ESRD and AIDS aid code categories, the Whole Child Model base capitation rates in Attachment E - Amendment 8, Adult Expansion Member capitation rates in Attachment E-1 Amendment 8, or the Health Homes Program supplemental capitation payments in Attachment E-5 - Amendment VI. Following June 30, 2023, the 7.5% increase shall cease, and the rates under the Contract shall revert to pre- COVID-19 PHE levels unless the Contract is further amended by the parties.

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken June 2, 2022
Regular Meeting of the CalOptima Board of Directors

Report Item

27. Authorize Extension of a Temporary, Short-Term Supplemental Payment Increase for Certain Contracted CalOptima Community Network and CalOptima Direct Medi-Cal Fee-for-Service Hospitals, for COVID 19-Related Expenses for Services Provided to CalOptima Community Network and CalOptima Direct-Administrative Medi-Cal Members

Contact

Yunkyung Kim, Chief Operating Officer (714) 246-8408

Recommended Actions

Authorize an extension of a temporary, short-term supplemental payment increase of 5% from Fiscal Year (FY) 2021-22 original budgeted funding levels for compliant CalOptima Community Network (CCN) and CalOptima Direct-Administrative (COD-A) Medi-Cal fee-for-service (FFS) hospitals, for certain medically necessary services provided to CCN and COD-A Medi-Cal members for dates of service July 1, 2022, through June 30, 2023.

Background & Discussion

Staff requests the CalOptima Board of Directors (Board) authorize an extension of a temporary, supplemental payment increase to FFS hospitals for COVID 19-related expenses between July 1, 2022, through June 30, 2023.

In response to COVID-19, the Board authorized three temporary, short-term supplemental payment increase of 5% to contracted CCN and COD-A Medi-Cal FFS hospitals for certain medically necessary services. The increases were implemented between January 1, 2021, to June 30, 2021; September 1, 2021, to December 31, 2021; and January 1, 2022, to June 30, 2022.

This supplemental payment increase under consideration is intended to continue supporting providers in anticipation of higher expense levels, promote and improve vaccination rates, address additional variants of the COVID-19 virus, cover increased expenses for testing and treatment, and ensure uninterrupted, medically necessary Medi-Cal covered services to our members.

To continue supporting providers with COVID-19-related expenses and members' access to care, staff recommends authorizing extension of the supplemental payment increase, excluding those services listed in Attachment 3 for dates of service July 1, 2022, through June 30, 2023.

Fiscal Impact

The recommended action is a budgeted item in the proposed CalOptima FY 2022-23 Operating Budget. The projected aggregate fiscal impact is approximately $11 million.

Rationale for Recommendation

Authorizing extension of the temporary, COVID-19-related supplemental payment increase for contracted CCN and COD-A Medi-Cal FFS hospitals will preserve the viability of CalOptima's Medi-

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Cal FFS hospitals, strengthen members' access care, and support Orange County's safety net system serving CalOptima members.

Concurrence

Troy R. Szabo, Outside General Counsel, Kennaday Leavitt

Attachments

1. Entities Covered by this Recommended Board Action
2. Board Action Dated February 3, 2022: Ratify Extension of a Temporary, Short-Term Supplemental Payment Increase for Certain Contracted CalOptima Community Network and CalOptima Direct Medi-Cal Fee-for-Service Hospitals, for COVID-Related Expenses for Services Provided to CalOptima Community Network and CalOptima Direct-Administrative Medi-Cal Members. This Board action includes the following:
    - Board Action Dated September 2, 2021: 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-Administrative Medi-Cal Members
    - Board Action Dated February 4, 2021: Consider Authorizing a Temporary, Short-Term Supplemental Payment Increase for Contracted Medi-Cal CalOptima Community Network and CalOptima Direct-Administrative Medi-Cal Fee-for-Service Hospitals for Mitigation of COVID-19-Related Expenses.
3. Services Excluded from Temporary Increase

/s/ Michael Hunn — *05/27/2022*

Authorized Signature — **Date**

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ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
Hoag Memorial Hospital Presbyterian	1 Hoag Dr	Newport Beach	CA	9.27E+08
Hoag Memorial Hospital Presbyterian	16200 San Canyon Ave	Irvine	CA	92618
Huntington Beach Hospital	17772 Beach Blvd	Huntington Beach	CA	92647
Keck Medical Center of USC	1500 San Pablo St	Los Angeles	CA	90033
Kindred Hospital - Brea	875 N Brea Blvd	Brea	CA	92821
Kindred Hospital - La Mirada	14900 E Imperial Hwy	La Mirada	CA	90638
Kindred Hospital - Santa Ana	1901 N College Ave	Santa Ana	CA	92706
Kindred Hospital - Westminster	200 Hospital Circle	Westminster	CA	92683
La Palma Intercommunity Hospital	7901 Walker St	La Palma	CA	90623
Long Beach Memorial Medical Center	2801 Atlantic Ave	Long Beach	CA	90806
MemorialCare Miller Children's and Women's Hospital	2801 Atlantic Ave	Long Beach	CA	90806
MemorialCare Orange Coast Medical Center	9920 Talbert Ave	Fountain Valley	CA	92708
MemorialCare Saddleback Medical Center	24451 Health Center Dr	Laguna Hills	CA	92653
Orange County Global Medical Center	1001 N Tustin Ave	Santa Ana	CA	92705
Placentia Linda Hospital	1301 N Rose Dr	Placentia	CA	9.29E+08
Pomona Valley Hospital Medical Center	1798 N Garey Ave	Pomona	CA	91767
Providence Mission Hospital	27700 Medical Center Rd	Mission Viejo	CA	92691
Providence Mission Hospital	31872 Coast Hwy	Laguna Beach	CA	92651
Providence Mission Hospital Regional Medical Ctr	27700 Medical Center Rd	Mission Viejo	CA	92691
Providence Mission Hospital Regional Medical Ctr	31872 Coast Hwy	Laguna Beach	CA	92651
Providence St Joseph Hospital	1100 W Stewart Dr	Orange	CA	92868
Providence St Joseph Hospital of Orange	1100 W Stewart Dr	Orange	CA	92868
Providence St Jude Medical Center	101 E Valencia Mesa Dr	Fullerton	CA	92835
Providence St Jude Medical Center	101 E Valencia Mesa Dr	Fullerton	CA	92835
South Coast Global Medical Center	2701 S Bristol St	Santa Ana	CA	92704
UCI Medical Center	101 The City Dr South	Orange	CA	92868
USC Kenneth Norris Jr Hospital	1441 Eastlake Ave	Los Angeles	CA	90089
West Anaheim Medical Center	3033 W Orange Ave	Anaheim	CA	92804
Whittier Hospital Medical Center	9080 Colima Rd	Whittier	CA	90605
Hoag Memorial Hospital Presbyterian	1 Hoag Dr	Newport Beach	CA	9.27E+08
Hoag Memorial Hospital Presbyterian	16200 San Canyon Ave	Irvine	CA	92618
Huntington Beach Hospital	17772 Beach Blvd	Huntington Beach	CA	92647
Keck Medical Center of USC	1500 San Pablo St	Los Angeles	CA	90033
Kindred Hospital - Brea	875 N Brea Blvd	Brea	CA	92821
Kindred Hospital - La Mirada	14900 E Imperial Hwy	La Mirada	CA	90638
Kindred Hospital - Santa Ana	1901 N College Ave	Santa Ana	CA	92706
Kindred Hospital - Westminster	200 Hospital Circle	Westminster	CA	92683
La Palma Intercommunity Hospital	7901 Walker St	La Palma	CA	90623

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken February 3, ~~2021~~ 2022
Regular Meeting of the CalOptima Board of Directors

Rev. 2/3/2022

Report Item

18. Ratify Extension of a Temporary, Short-Term Supplemental Payment Increase for Certain Contracted CalOptima Community Network and CalOptima Direct Medi-Cal Fee-for-Service Hospitals, for COVID-Related Expenses for Services Provided to CalOptima Community Network and CalOptima Direct-Administrative Medi-Cal Members

Contact

Yunkyung Kim, Chief Operating Officer (714) 246-8408

Recommended Actions

Ratify:

1. Extension of a temporary, short-term supplemental payment increase of 5% from Fiscal Year (FY) 2021-22 original budgeted funding levels, for compliant, CalOptima Community Network (CCN) and CalOptima Direct-Administrative (COD-A) Medi-Cal Fee-for-Service (FFS) Hospitals, for certain medically necessary services provided to CCN and COD-A Medi-Cal members for dates of service January 1, 2022, through June 30, 2022; and
2. Use of unbudgeted expenditures up to $5.5 million from existing reserves to provide funding for the supplemental payment increase to Medi-Cal FFS hospitals

Background & Discussion

Staff requests the CalOptima Board of Directors (Board) ratify both an extension of a temporary, supplemental payment increase to FFS Hospitals for COVID-related expenses between January 1, 2022, through June 30, 2022, as well as use of unbudgeted reserve funds to support the increase.

In response to COVID-19, the Board, at its February 4, 2021, meeting, authorized a temporary, short-term supplemental payment increase of 5% to contracted CCN and COD-A Medi-Cal FFS Hospitals for certain medically necessary services through June 30, 2021. The Board also authorized additional increased compensation to Long Term Acute Care Hospitals (LTAC) for authorized inpatient services provided to CalOptima members through June 30, 2021. At its September 2, 2021, meeting, the Board authorized resuming the supplemental increase through December 31, 2021.

The supplemental payment increase under consideration is intended to support providers in anticipation of higher expense levels, promote and improve vaccination rates, address additional variants of the COVID-19 virus, cover increased expenses for testing and treatment, and ensure uninterrupted, medically necessary Medi-Cal covered services to our members.

To continue supporting providers with COVID-related expenses and members' access to care, staff recommends ratifying extension of the supplemental payment increase, excluding those services listed in Attachment 4, for dates of service January 1, 2022, through June 30, 2022.

Fiscal Impact

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The recommended action to ratify extension of a temporary, short-term supplemental payment increase of 5% from FY 2021-22 original budgeted funding levels for the period of January 1, 2022, through June 30, 2022, for CCN and COD-A Medi-Cal FFS Hospitals is an unbudgeted item. The projected aggregate fiscal impact is approximately $5.5 million for the six-month period and will be funded from existing reserves.

Rationale for Recommendation

Ratifying the temporary, COVID-related supplemental payment increase for contracted CCN and COD-A Medi-Cal FFS Hospitals will preserve the viability of CalOptima's Medi-Cal FFS hospitals, strengthen members' access care and support Orange County's safety net system serving CalOptima members.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. Entities Covered by this Recommended Board Action
2. Board Action Dated September 2, 2021: 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
3. Board Action Dated February 4, 2021: Consider Authorizing a Temporary, Short-Term Supplemental Payment Increase for Contracted Medi-Cal CalOptima Community Network and CalOptima Direct-Administrative Medi-Cal Fee-for-Service Hospitals for Mitigation of COVID-
   19-Related Expenses
4. Services Excluded from Temporary Increase

/s/ Michael Hunn *01/27/2022*
Authorized Signature **Date**

ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
Anaheim Regional Medical Center	1111 W La Palma Ave	Anaheim	CA	92801
Whittier Hospital Medical Center	9080 Colima Rd	Whittier	CA	90605
Foothill Regional Medical Center	14662 Newport Ave	Tustin	CA	92780
Anaheim Global Medical Center	1025 S Anaheim Blvd	Anaheim	CA	92805
Beverly Hospital	309 W Beverly Blvd	Montebello	CA	90640
Chapman Global Medical Center	2601 E Chapman Ave	Orange	CA	92869
College Hospital Costa Mesa	301 Victoria St	Costa Mesa	CA	92627
CHOC Children's at Mission Hospital	27700 Medical Center Rd	Mission Viejo	CA	92691
Childrens Hospital of Los Angeles	4650 W Sunset Blvd	Los Angeles	CA	90027
Children's Hospital of Orange County	1201 W La Veta Ave	Orange	CA	92868
Encompass Health Rehabilitation Hospital of Tustin	14851 Yorba St	Tustin	CA	92780
Fountain Valley Regional Hospital & Medical Center	17100 Euclid St	Fountain Valley	CA	92708
HealthBridge Children's Hospital - Orange	393 S Tustin St	Orange	CA	92866
Hoag Memorial Hospital Presbyterian	1 Hoag Dr	Newport Beach	CA	92663
Long Beach Memorial Medical Center	2801 Atlantic Ave	Long Beach	CA	90806
Long Beach Memorial Medical Ctr Miller Children's	2801 Atlantic Ave	Long Beach	CA	90806
Providence Mission Hospital	27700 Medical Center Rd	Mission Viejo	CA	92691
Providence Mission Hospital Regional Medical Ctr	27700 Medical Center Rd	Mission Viejo	CA	92691
Orange Coast Memorial Medical Center	9920 Talbert Ave	Fountain Valley	CA	92708
Orange County Global Medical Center	1001 N Tustin Ave	Santa Ana	CA	92705
Placentia Linda Hospital	1301 N Rose Dr	Placentia	CA	92870
Pomona Valley Hospital Medical Center	1798 N Garey Ave	Pomona	CA	91767
West Anaheim Medical Center	3033 W Orange Ave	Anaheim	CA	92804
Garden Grove Hospital Medical Center	12601 Garden Grove Blvd	Garden Grove	CA	92843
Huntington Beach Hospital	17772 Beach Blvd	Huntington Beach	CA	92647
La Palma Intercommunity Hospital	7901 Walker St	La Palma	CA	90623
UCI Medical Center	101 The City Dr South	Orange	CA	92868
Saddleback Memorial Medical Center	24451 Health Center Dr	Laguna Hills	CA	92653
South Coast Global Medical Center	2701 S Bristol St	Santa Ana	CA	92704
Kindred Hospital - La Mirada	14900 E Imperial Hwy	La Mirada	CA	90638
Kindred Hospital - Santa Ana	1901 N College Ave	Santa Ana	CA	92706
Providence St Joseph Hospital	1100 W Stewart Dr	Orange	CA	92868
Providence St Jude Medical Center	101 E Valencia Mesa Dr	Fullerton	CA	92835
Kindred Hospital - Brea	875 N Brea Blvd	Brea	CA	92821
Kindred Hospital - Westminster	200 Hospital Circle	Westminster	CA	92683

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken September 2, 2021
Regular Meeting of the CalOptima Board of Directors

Report Item

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

Contacts

Nancy Huang, Chief Financial Officer, (657) 235-6935
Michelle Laughlin, Executive Director, Network Operations, (657) 900-1116

Recommended Actions

1. Authorize 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. Authorize unbudgeted expenditures up to $3.6 million from existing reserves to provide funding for the supplemental payment increase to Medi-Cal FFS hospitals

Background

On January 31, 2020, the Secretary of Health and Human Services declared a public health emergency (PHE) under section 319, of the Public Health Service Act (42 U.S.C. 247d) in response to a novel coronavirus known as SARS-CoV-2 (coronavirus). On March 13, 2020, the President of the United States declared a national emergency based on the spread of this coronavirus. Subsequently, the Governor and the Orange County Health Officer have similarly taken steps to slow the spread of the coronavirus and protect the public. As with federal, state, and local agencies, CalOptima is taking action to continue efforts to support providers serving CalOptima members during the pandemic.

At its February 4, 2021, meeting, the Board authorized a short-term supplemental increase of 5% from current levels to contracted CCN and COD-A Medi-Cal FFS Hospitals for certain medically necessary services provided between January 1, 2021, and June 30, 2021. The Board authorized additional increased compensation to Long Term Acute Care Hospitals (LTAC) for authorized inpatient services provided to CalOptima Members, setting reimbursement at the Chronic/Maintenance Level of Care for Members admitted on or after January 1, 2021, through June 30, 2021.

Discussion

Management recognizes that the coronavirus pandemic continues to place significant stress on healthcare providers and delivery system serving CalOptima members. In late June, the Centers for Disease Control and Prevention (CDC) issued new guidance and data related to the more contagious Delta variant. Orange County has experienced a surge of Delta variant cases leading to increased hospitalizations and strain on health care resources.

In mid-July, the California Department of Health Care Services (DHCS) released its Medi-Cal COVID-19 Vaccine Incentive Program. This program will use $350 million dollars statewide to improve the vaccination rates among Medi-Cal beneficiaries. The focus populations include members who:

1. Are homebound and unable to travel to vaccination sites;
2. Are 50-64 years of age with multiple chronic diseases;
3. Self-identify as persons of color; and
4. With the return to school, are youth 12-25 years old.

This additional funding will assist hospitals in addressing the latest surge in Delta variant cases, and help improve vaccination rates for CalOptima members by promoting an increase in vaccinations within the Medi-Cal focus populations identified by DHCS.

In recognition of the demands the pandemic has placed on hospitals, providing the supplemental payment increase for the referenced period for claims of CCN and COD-A Medi-Cal members, for medically necessary Medi-Cal services is recommended. The increase will help preserve the viability of CalOptima's FFS Medi-Cal hospitals, and strengthen access to care in light of the higher utilization levels including COVID-19-related treatment.

Staff recommends approving the temporary, supplemental 5% increase, excluding those services listed in Attachment 3, and necessary unbudgeted expenditures to implement this increase for dates of service September 1, 2021, through December 31, 2021.

Fiscal Impact

The recommended action to authorize resuming a temporary, short-term supplemental payment increase of 5% from current levels for the period of September 1, 2021, through December 31, 2021, for claims of members associated with compliant, contracted Medi-Cal FFS Hospitals is an unbudgeted item. The projected aggregate fiscal impact is approximately $3.6 million for the four-month period and will be funded from existing reserves.

As of this writing, DHCS has not released detailed guidance on their Medi-Cal COVID-19 Vaccine Incentive Program. Management anticipates that the use of reserves may be reduced depending on actual funding provided by DHCS for this purpose.

Rationale for Recommendation

Resuming the temporary, PHE-related supplemental payment is intended to ensure the viability of contracted CCN and COD-A Medi-Cal FFS Hospitals, and strengthens access for member care and supports the Orange County's hospital care delivery system serving CalOptima members during the pandemic.

Concurrence
Gary Crockett, Chief Counsel

Attachments
1. Entities Covered by this Recommended Action
2. Board Action Dated February 4, 2021: Consider Authorizing a Temporary, Short-Term Supplemental Payment Increase for Contracted Medi-Cal CalOptima Community Network and CalOptima Direct-Administrative Medi-Cal Fee-for-Service Hospitals for Mitigation of COVID-19-Related Expenses
3. Services Excluded from Temporary Increase

/s/ Richard Sanchez *08/25/2021*
Authorized Signature **Date**

ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
Anaheim Regional Medical Center	1111 W La Palma Ave	Anaheim	CA	92801
Whittier Hospital Medical Center	9080 Colima Rd	Whittier	CA	90605
Foothill Regional Medical Center	14662 Newport Ave	Tustin	CA	92780
Anaheim Global Medical Center	1025 S Anaheim Blvd	Anaheim	CA	92805
Beverly Hospital	309 W Beverly Blvd	Montebello	CA	90640
Chapman Global Medical Center	2601 E Chapman Ave	Orange	CA	92869
College Hospital Costa Mesa	301 Victoria St	Costa Mesa	CA	92627
CHOC Children's at Mission Hospital	27700 Medical Center Rd	Mission Viejo	CA	92691
Childrens Hospital of Los Angeles	4650 W Sunset Blvd	Los Angeles	CA	90027
Children's Hospital of Orange County	1201 W La Veta Ave	Orange	CA	92868
Encompass Health Rehabilitation Hospital of Tustin	14851 Yorba St	Tustin	CA	92780
Fountain Valley Regional Hospital & Medical Center	17100 Euclid St	Fountain Valley	CA	92708
HealthBridge Children's Hospital - Orange	393 S Tustin St	Orange	CA	92866
Hoag Memorial Hospital Presbyterian	1 Hoag Dr	Newport Beach	CA	92663
Long Beach Memorial Medical Center	2801 Atlantic Ave	Long Beach	CA	90806
Long Beach Memorial Medical Ctr Miller Children's	2801 Atlantic Ave	Long Beach	CA	90806
Providence Mission Hospital	27700 Medical Center Rd	Mission Viejo	CA	92691
Providence Mission Hospital Regional Medical Ctr	27700 Medical Center Rd	Mission Viejo	CA	92691
Orange Coast Memorial Medical Center	9920 Talbert Ave	Fountain Valley	CA	92708
Orange County Global Medical Center	1001 N Tustin Ave	Santa Ana	CA	92705
Placentia Linda Hospital	1301 N Rose Dr	Placentia	CA	92870
Pomona Valley Hospital Medical Center	1798 N Garey Ave	Pomona	CA	91767
West Anaheim Medical Center	3033 W Orange Ave	Anaheim	CA	92804
Garden Grove Hospital Medical Center	12601 Garden Grove Blvd	Garden Grove	CA	92843
Huntington Beach Hospital	17772 Beach Blvd	Huntington Beach	CA	92647
La Palma Intercommunity Hospital	7901 Walker St	La Palma	CA	90623
UCI Medical Center	101 The City Dr South	Orange	CA	92868
Saddleback Memorial Medical Center	24451 Health Center Dr	Laguna Hills	CA	92653
South Coast Global Medical Center	2701 S Bristol St	Santa Ana	CA	92704
Kindred Hospital - La Mirada	14900 E Imperial Hwy	La Mirada	CA	90638
Kindred Hospital - Santa Ana	1901 N College Ave	Santa Ana	CA	92706
Providence St Joseph Hospital	1100 W Stewart Dr	Orange	CA	92868
Providence St Jude Medical Center	101 E Valencia Mesa Dr	Fullerton	CA	92835
Kindred Hospital - Brea	875 N Brea Blvd	Brea	CA	92821
Kindred Hospital - Westminster	200 Hospital Circle	Westminster	CA	92683

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken February 4, 2021
Regular Meeting of the CalOptima Board of Directors

Report Item

20. Consider Authorizing a Temporary, Short-Term Supplemental Payment Increase for Contracted Medi-Cal CalOptima Community Network and CalOptima Direct-Administrative Medi-Cal Fee-for-Service Hospitals for Mitigation of COVID-19 Related Expenses

Contacts

Ladan Khamseh, Chief Operations Officer, (714) 246-8866
Michelle Laughlin, Executive, Director Network Operations, (657) 900-1116

Recommended Actions

1. Authorize a temporary, short-term supplemental payment increase of 5% from current levels, for compliant contracted CalOptima Community Network (CCN) and CalOptima Direct (COD) Medi-Cal Fee-for-Service (FFS) Hospitals for certain medically necessary services provided on dates of service January 1, 2021 through June 30, 2021;

2. Authorize the Chief Executive Officer, with the assistance of Legal Counsel, to amend contracts with Long Term Acute Care Hospitals (LTAC) to increase compensation for authorized inpatient services provided to CalOptima Members at the Chronic/Maintenance Level of Care for Members admitted on or after January 1, 2021, and through June 30, 2021, to offset the impacts of the COVID-19 Public Health Emergency (PHE). The increased compensation will apply to authorized dates of service between January 1, 2021, and June 30, 2021; and

3. Authorize unbudgeted expenditures up to $5.0 million to provide funding for the supplemental payment increase to Medi-Cal FFS hospitals.

Background

On January 31, 2020, the Secretary of Health and Human Services declared a public health emergency under Section 319 of the Public Health Service Act (42 U.S.C. 247d) in response to a novel coronavirus known as SARS-CoV-2 (coronavirus). On March 13, 2020, the President of the United States declared a national emergency based on the spread of this coronavirus. Subsequently, the Governor and the Orange County Health Officer have taken similar steps to slow the spread of the coronavirus and protect the public. In collaboration with federal, state and local agencies, CalOptima is taking action to continue efforts to support providers serving CalOptima members during the pandemic.

In response to the public health emergency, the Board authorized a Medi-Cal capitation rate increase to CalOptima's health networks on April 2, 2020. Following receipt of the final Calendar Year 2021 Medi-Cal capitation rates from the California Department of Health Care Services (DHCS) (which included an updated rate component for COVID-19-related adjustments), the Board authorized a second capitation rate increase for Medi-Cal health networks on January 7, 2021.

Discussion

In recognition of the unprecedented and dynamic nature of the pandemic and the strain it has placed on hospitals, a supplemental payment increase for contracted CCN and COD-A Medi-Cal FFS hospitals is recommended. CalOptima's recommends that the Board approve a supplemental payment increase for contracted Medi-Cal FFS hospitals on qualifying claims during the period of January 1, 2021, through June 30, 2021. This increase is intended to support CalOptima's contracted hospitals for covered services, for a limited period. The increase is intended to support CalOptima's Medi-Cal FFS hospitals and strengthen access to care, given potential utilization changes and COVID-19-related testing and treatment in the current environment.

This item applies solely to CalOptima's contracted hospitals, including LTAC hospitals, which play a key role in treating members infected with COVID-19, and preventing the spread of COVID-19 throughout the community. Long Term Acute Care Hospitals are acute care hospitals designed for patients requiring inpatient care for an extended period of time. Admitting access to LTAC hospitals has been a key concern for members who require longer term hospital care. CalOptima's reimbursement for LTAC services falls into two levels of care: "LTAC," for which CalOptima pays a higher acute level reimbursement rate, and "chronic maintenance," a level of care that is reimbursed at a lower rate. To ensure member access to LTACs during this public health emergency, staff recommends amending contracts with LTAC hospitals to increase compensation for authorized Medi-Cal inpatient services provided to CalOptima Members at the Chronic/Maintenance Level of Care for Members admitted on or after January 1, 2021, and through June 30, 2021, to offset the impacts of the COVID-19 PHE. The increased compensation will apply to authorized dates of service between January 1, 2021, and June 30, 2021. This will be in addition to the 5% supplemental payment increase, for all authorized services for members in these facilities. Contractual billing and authorization requirements will remain in place; however, the LTAC reimbursement rate will be applied during this temporary period. Attachment 1 provides additional details regarding exclusions from the Temporary, Short-Term Supplemental Payment Increase.

Pending Board approval, the 5% supplemental payment increase will be administered to eligible hospitals for identified services through the claims payment system. Staff will provide notice to the providers covered by this recommended action of the 5% increase. Staff proposes making supplemental payment increases beginning in February 2021. Adjudicated and paid claims for dates of service between January 1, 2021, and the supplemental payment processing date (a February date to be determined) will receive a 5% supplemental payment adjustment. Moving forward, the 5% supplemental payment will be made monthly, for paid claims identified subsequent to the prior monthly supplemental payment, on a rolling time schedule. Staff plans to identify and process the supplemental payment at the claim line level that, at a minimum, identify the eligible date of service, covered billing service code and payment. CalOptima staff anticipates that supplemental payments will be issued to eligible hospitals monthly from prior month's payment by the end of each month. Supplemental payments on identified claims will be made so long as timely filing requirements have been met. Since supplemental payments are provided as an additional payment to already adjudicated and paid claims,

timely payment requirements, such as interest, will not be applied. However, staff will monitor the process to ensure that the supplemental payment adjustments are processed and paid appropriately. Additionally, current policies and procedures related to provider payment recoupment, grievance and appeals, and provider dispute resolution will be followed where applicable.

Fiscal Impact

The recommended action to authorize a temporary, short-term supplemental payment increase of 5% from current levels for contracted CCN and COD-A Medi-Cal FFS Hospitals is an unbudgeted item. The projected aggregate fiscal impact is approximately $5.0 million for the six-month period. Staff anticipates the net fiscal impact will be budget neutral, as decreased utilization of certain services within the Medi-Cal program in the current fiscal year will be sufficient to support the additional costs in unbudgeted FFS payments.

Rationale for Recommendation

The temporary, public health emergency-related supplemental payment is intended to ensure the viability of CalOptima's FFS Medi-Cal contracted hospitals, strengthens access for member care and supports the Orange County's hospital care delivery system serving CalOptima members during the pandemic.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. List of Exclusions from Temporary, Short-Term Supplemental Payment Increase

/s/ Richard Sanchez *01/27/2021*
Authorized Signature **Date**

List of Exclusions from Temporary, Short-Term Supplemental Payment Increase
▪ Pharmacy and Pharmacy Benefit Management Services, and other contracted Administrative Service providers for which CalOptima covers the cost of claims
▪ Non-pharmacy administered drugs
▪ Long Term Care services
▪ Durable Medical Equipment; Orthotics and Prosthetics and other medical devices
▪ Members in CalOptima's Program for All Inclusive Care for the Elderly (PACE), OneCare, and OneCare Connect
▪ Crossover Claims
▪ Other supplemental or directed payments, such as Proposition 56
▪ Claims paid by Letter of Agreement (LOA)

Services excluded from Temporary, Short-Term Supplemental Payment Increase
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▪ Claims paid by Letter of Agreement (LOA)

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken February 4, 2021
Regular Meeting of the CalOptima Board of Directors

Report Item

20. Consider Authorizing a Temporary, Short-Term Supplemental Payment Increase for Contracted Medi-Cal CalOptima Community Network and CalOptima Direct-Administrative Medi-Cal Fee-for-Service Hospitals for Mitigation of COVID-19 Related Expenses

Contacts

Ladan Khamseh, Chief Operations Officer, (714) 246-8866
Michelle Laughlin, Executive, Director Network Operations, (657) 900-1116

Recommended Actions

1. Authorize a temporary, short-term supplemental payment increase of 5% from current levels, for compliant contracted CalOptima Community Network (CCN) and CalOptima Direct (COD) Medi-Cal Fee-for-Service (FFS) Hospitals for certain medically necessary services provided on dates of service January 1, 2021 through June 30, 2021;

2. Authorize the Chief Executive Officer, with the assistance of Legal Counsel, to amend contracts with Long Term Acute Care Hospitals (LTAC) to increase compensation for authorized inpatient services provided to CalOptima Members at the Chronic/Maintenance Level of Care for Members admitted on or after January 1, 2021, and through June 30, 2021, to offset the impacts of the COVID-19 Public Health Emergency (PHE). The increased compensation will apply to authorized dates of service between January 1, 2021, and June 30, 2021; and

3. Authorize unbudgeted expenditures up to $5.0 million to provide funding for the supplemental payment increase to Medi-Cal FFS hospitals.

Background

On January 31, 2020, the Secretary of Health and Human Services declared a public health emergency under Section 319 of the Public Health Service Act (42 U.S.C. 247d) in response to a novel coronavirus known as SARS-CoV-2 (coronavirus). On March 13, 2020, the President of the United States declared a national emergency based on the spread of this coronavirus. Subsequently, the Governor and the Orange County Health Officer have taken similar steps to slow the spread of the coronavirus and protect the public. In collaboration with federal, state and local agencies, CalOptima is taking action to continue efforts to support providers serving CalOptima members during the pandemic.

In response to the public health emergency, the Board authorized a Medi-Cal capitation rate increase to CalOptima's health networks on April 2, 2020. Following receipt of the final Calendar Year 2021 Medi-Cal capitation rates from the California Department of Health Care Services (DHCS) (which included an updated rate component for COVID-19-related adjustments), the Board authorized a second capitation rate increase for Medi-Cal health networks on January 7, 2021.

Discussion

In recognition of the unprecedented and dynamic nature of the pandemic and the strain it has placed on hospitals, a supplemental payment increase for contracted CCN and COD-A Medi-Cal FFS hospitals is recommended. CalOptima's recommends that the Board approve a supplemental payment increase for contracted Medi-Cal FFS hospitals on qualifying claims during the period of January 1, 2021, through June 30, 2021. This increase is intended to support CalOptima's contracted hospitals for covered services, for a limited period. The increase is intended to support CalOptima's Medi-Cal FFS hospitals and strengthen access to care, given potential utilization changes and COVID-19-related testing and treatment in the current environment.

This item applies solely to CalOptima's contracted hospitals, including LTAC hospitals, which play a key role in treating members infected with COVID-19, and preventing the spread of COVID-19 throughout the community. Long Term Acute Care Hospitals are acute care hospitals designed for patients requiring inpatient care for an extended period of time. Admitting access to LTAC hospitals has been a key concern for members who require longer term hospital care. CalOptima's reimbursement for LTAC services falls into two levels of care: "LTAC," for which CalOptima pays a higher acute level reimbursement rate, and "chronic maintenance," a level of care that is reimbursed at a lower rate. To ensure member access to LTACs during this public health emergency, staff recommends amending contracts with LTAC hospitals to increase compensation for authorized Medi-Cal inpatient services provided to CalOptima Members at the Chronic/Maintenance Level of Care for Members admitted on or after January 1, 2021, and through June 30, 2021, to offset the impacts of the COVID-19 PHE. The increased compensation will apply to authorized dates of service between January 1, 2021, and June 30, 2021. This will be in addition to the 5% supplemental payment increase, for all authorized services for members in these facilities. Contractual billing and authorization requirements will remain in place; however, the LTAC reimbursement rate will be applied during this temporary period. Attachment 1 provides additional details regarding exclusions from the Temporary, Short-Term Supplemental Payment Increase.

Pending Board approval, the 5% supplemental payment increase will be administered to eligible hospitals for identified services through the claims payment system. Staff will provide notice to the providers covered by this recommended action of the 5% increase. Staff proposes making supplemental payment increases beginning in February 2021. Adjudicated and paid claims for dates of service between January 1, 2021, and the supplemental payment processing date (a February date to be determined) will receive a 5% supplemental payment adjustment. Moving forward, the 5% supplemental payment will be made monthly, for paid claims identified subsequent to the prior monthly supplemental payment, on a rolling time schedule. Staff plans to identify and process the supplemental payment at the claim line level that, at a minimum, identify the eligible date of service, covered billing service code and payment. CalOptima staff anticipates that supplemental payments will be issued to eligible hospitals monthly from prior month's payment by the end of each month. Supplemental payments on identified claims will be made so long as timely filing requirements have been met. Since supplemental payments are provided as an additional payment to already adjudicated and paid claims,

timely payment requirements, such as interest, will not be applied. However, staff will monitor the process to ensure that the supplemental payment adjustments are processed and paid appropriately. Additionally, current policies and procedures related to provider payment recoupment, grievance and appeals, and provider dispute resolution will be followed where applicable.

Fiscal Impact

The recommended action to authorize a temporary, short-term supplemental payment increase of 5% from current levels for contracted CCN and COD-A Medi-Cal FFS Hospitals is an unbudgeted item. The projected aggregate fiscal impact is approximately $5.0 million for the six-month period. Staff anticipates the net fiscal impact will be budget neutral, as decreased utilization of certain services within the Medi-Cal program in the current fiscal year will be sufficient to support the additional costs in unbudgeted FFS payments.

Rationale for Recommendation

The temporary, public health emergency-related supplemental payment is intended to ensure the viability of CalOptima's FFS Medi-Cal contracted hospitals, strengthens access for member care and supports the Orange County's hospital care delivery system serving CalOptima members during the pandemic.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. List of Exclusions from Temporary, Short-Term Supplemental Payment Increase

/s/ Richard Sanchez *01/27/2021*
Authorized Signature **Date**

List of Exclusions from Temporary, Short-Term Supplemental Payment Increase
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▪ Other supplemental or directed payments, such as Proposition 56
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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken June 2, 2022
Regular Meeting of the CalOptima Board of Directors

Report Item

28. Adopt Resolution No. 22-0602-02 Approving and Adopting Updated CalOptima Human Resources Policies and Appropriation of Funds and Authorization of Unbudgeted Expenditures

Contacts

Michael Hunn, Chief Executive Officer, (657) 900-1481
Brigette Hoey, Chief Human Resources Officer, (714) 246-8405

Recommended Actions

1. Adopt resolution approving updated CalOptima policies:
    a. GA. 8020: 9/80 Work Schedule
    b. GA. 8027: Anti-Harassment Policy
    c. GA. 8036: Education Reimbursement
    d. GA. 8042: Supplemental Compensation
    e. GA. 8050: Confidentiality
    f. GA. 8058. Salary Schedule
2. Appropriate funds and authorize unbudgeted expenditures in an amount up to $58,050 from existing reserves to fund the Supplemental Compensation Internet Stipend for the period of June 5, 2022 through June 30, 2022.

Background

Near CalOptima's inception, the Board of Directors delegated authority to the Chief Executive Officer to develop and implement employee policies and procedures, and to amend them as appropriate from time to time, subject to bi-annual updates to the Board. CalOptima's Bylaws require that the Board adopt by resolution, and from time to time amend, procedures, practices, and policies for, among other things, hiring employees and managing personnel.

Discussion

GA. 8020: 9/80 Work Schedule: This policy describes CalOptima's alternate workweek schedule commonly referred to as a 9/80 Work Schedule. The changes are intended to align this policy to the Telework Program Guidelines.

Policy Section	Proposed Change	Rationale	Impact
II.C.	Updated to restrict availability of 9/80 schedule for Executive Level Positions.	Aligns with Telework Policy restrictions for Executive Level Positions.	Aligns with related policies.
II.C.	Removed statement prohibiting employees from having a 9/80 schedule and	Aligns with removal of this restriction from the Telework Policy and Employee Handbook.	Aligns with related policies.

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	participating in the Telework Program.		
IV.A-D & V.D.	Removed 9/80 Workweek Request Forms from policy attachments and added as a reference.	Allows for ease of future form modifications to provide clarity and improve ease of use.	Improves process for form modification.
IX.	Added Glossary Term for Executive Level Positions	Term was added to policy.	Provides clarity.

GA. 8027: Anti-Harassment Policy: This policy describes CalOptima's zero tolerance standard for discrimination, harassment, and retaliation and sets forth a procedure for promptly investigating complaints thereof.

Policy Section	Proposed Change	Rationale	Impact
Throughout	Full policy overhaul based on the California Department of Fair Employment and Housing's Equal Employment Opportunity (EEO) sample policy.	Ensure full compliance with State of California requirements regarding EEO, investigations, and training for unlawful harassment and to align with sample EEO policy.	Improved alignment with state requirements and clarity that policy requirements are met.
Section III. Table, Employee Section	Minor text edits and added statements regarding employee responsibilities for a harassment free work environment and cooperation in inquiry or investigations.	Clarify who the employee may report a complaint to.	Provides clarity.
Section III. Table, Employee Section	Added statements regarding employee responsibilities for a harassment free work environment and cooperation in inquiry or investigations.	Clarify employee responsibilities in the process.	Provides clarity.
Section III. Table, Supervisor Section	Added statements regarding supervisor responsibilities to cooperate in inquiry or investigation and keep complaints confidential.	Clarify supervisor responsibilities in the process.	Provides clarity.
Section III. Table, HR Section, bullet 1	Moved bullet on policy dissemination to new section II.	Not part of the complaint/investigation procedure.	Improves flow of policy.
Section III. Table, HR Section, bullets 2-6	Significant changes to HR processes for receipt, investigation, and recommended actions as a result of a complaint.	Align policy with practice and clarify roles between HR and department leader.	Aligns policy with practice.
Section IV.	Added attachment for Employee Complaint Intake Form.	Include form (that is already in use) as a policy attachment.	Provides transparency.

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Section IX	Additions, deletions, and updates to glossary terms.	Align included terms with current policy.	Provides clarity

GA. 8036: Education Reimbursement: This policy describes CalOptima's pre-approval process for the educational reimbursement program established to offer repayment of reasonable educational and professional development expenses to eligible employees for work-related courses and/or programs, including courses offering credits towards professional licensure or certification requirements. Staff proposes to increase the reimbursement for qualifying courses (i) to eligible full-time employees from $2,000 for non-degree program and $3,500 for degree program to $5,250 regardless of the program, and (ii) to eligible part-time employees from $1,000 to $2,600 for all programs per fiscal year for tuition expenses.

Policy Section	Proposed Change	Rationale	Impact
II.C.	Increased fiscal year max benefit to $5,250 for full-time employees and $2,600 for part-time employees. Made the max benefit amount universal regardless of type of learning (degree or non-degree).	Improves benefit offered to our employees, encourages continuous learning, and makes CalOptima competitive with other like plans. Provides additional support for non-degree programs/learning that benefit CalOptima such as LVN, RN, PMP, and certifications that can hold similar value to the organization as a degree.	Provides more attractive benefit for recruitment and retention.
II.C.1.	Added statement about employee tax liability for reimbursements above IRS limits (currently $5,250).	CalOptima approves education reimbursement based on fiscal year and Board approved budget. IRS limits are based on calendar year, making it possible for reimbursements to exceed non-taxable limits in a calendar year.	Provides clarity.
III.Table Human Resources 4-6	Modified language to follow Accounting's current process for reimbursement.	Method of payment and accounting process may change. Modifying the language accounts for current, or future, defined process.	Reduces future policy changes in this area.
IV. & V.	Moved Education Expense Reimbursement Prior Authorization Request Form an Attachment to a Reference.	Allows for ease of future form modifications to provide clarity improve ease of use.	Improves process for form modifications.

GA. 8042: Supplemental Compensation: CalOptima recently transitioned many temporary teleworkers to full or partial telework. Teleworkers have either a CalOptima issued cell phone or a "soft phone" through their CalOptima computer; however, they are required to provide their internet connectivity. In consideration of the average costs associated with high-speed internet, staff recommends the following internet stipend under GA.8042 Supplemental Compensation.

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- Full-time employees designated either full telework, partial telework, or community worker will receive twenty-five dollars ($25) per pay period commencing with the first full pay period following designation of full or partial telework or community worker status.

The internet stipend will become effective June 5, 2022.

Policy Section	Proposed Change	Rationale	Impact
II.I.	Added "Internet Stipend" at $25 per pay period for full and partial teleworkers. Executive level positions are not eligible.	To mitigate the connectivity costs associated with full and partial telework.	Provides compensation parity with other compensated costs.
III.B.	Revised statement regarding holiday hours used for the purposes of calculating overtime.	Clarity and accuracy.	Provides clarity and accuracy.
III.H	Added procedure for "Internet Stipend". Includes source of information for calculation of compensation.	Provide procedures for new supplemental compensation pay type.	Provides clarity.

GA. 8050: Confidentiality: This policy outlines CalOptima's guidelines for protecting proprietary, private, and confidential information. The changes are intended to provide clarification.

Policy Section	Proposed Change	Rationale	Impact
Throughout	Edited to reflect "proprietary, private, and/or confidential" in that order.	Consistency	Improves consistency throughout policy
II.B.	Section rewritten to more clearly define proprietary, private, and confidential information.	Clarity	Improves clarity
III.A.4.	Added statement regarding employee obligation to report issues.	Clarifies employee expectations and requirements	Provides clarity and expectations of employees
III.G.1.	Edited statement to include requirement that all new hires shall acknowledge that they have received, read, and understand this policy and agree to comply with it.	Clarity	Provides clarity and aligns with practice
III.H.	Added statement regarding employee ideas regarding proprietary, private, and/or confidential information and how to share them.	Clarity	Provides clarity and method of submitting ideas

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IX.	Added definition for covered service and covered services. Updated definitions for employee and member.	Clarity	Provides clarity

GA. 8058 Salary Schedule: CalOptima Policy GA.8058 Salary Schedule and Attachment A are presented with the proposed changes as follows: two (2) job title changes to better reflect actual job responsibilities within a job series; six (6) new job titles to meet agency and program needs; twenty-two (22) position pay grade minimum changes reflective of increasing the minimum of pay grade A to $20/hour, a two percent (2%) consecutive increase to pay range minimums for grade B and C; and recalculation of pay grade midpoints respectively. No change to incumbent rate of pay is required. Pay grade maximums remain unchanged.

Policy Section	Proposed Change	Rationale	Impact
Attachment A, throughout	6 new job titles added and 2 job titles changed	Added or changed titles to distinguish between job level and/or duties.	Ability to better distinguish between job level and/or duties.
Attachment A, throughout	3 pay grades with increased pay grade minimums and pay grade mid-points adjusted accordingly.	Increased the minimums to reflect the current market	Improved outlook for recruitment and retention

Fiscal Impact

The recommended action to revise GA.8036 is a budgeted item. Education reimbursement funds included in the Fiscal Year (FY) 2021-22 Operating Budget is sufficient to support additional costs for the month of June 2022. The proposed FY 2022-23 Operating Budget includes $150,000 for education reimbursement. To the extent there is any additional fiscal impact above the budgeted amount, such impact will be addressed in separate Board actions.

The recommended action to revise GA.8042 is an unbudgeted item. A proposed allocation of up to $58,050 from existing reserves will fund internet stipends for the period of June 5, 2022, through June 30, 2022. The annual fiscal impact for internet stipends is approximately $755,000. Staff will include updated administrative expenses in the proposed FY 2022-23 Operating Budget.

The recommended action to revise GA.8058 to add and revise job titles and implement salary range adjustments for three (3) pay grades has no additional impact.

The recommended action to revise CalOptima policies GA.8020, GA.8027, and GA.8050 is operational in nature and has no additional fiscal impact beyond what was incorporated in the FY 2021-22 Operating Budget.

Concurrence
Troy R. Szabo, Outside General Counsel, Kennaday Leavitt

Attachments
1. Resolution No. 22-0602-02, Approve Updated Human Resources Policies and Appropriation of Funds and Authorization of Unbudgeted Expenditures
2. Revised CalOptima Policies:
    a. GA. 8020: 9/80 Work Schedule
    b. GA. 8027: Anti-Harassment Policy and Attachment A
    c. GA. 8036: Education Reimbursement
    d. GA. 8042: Supplemental Compensation and Attachments A-B
    e. GA. 8050: Confidentiality
    f. GA. 8058. Salary Schedule and Attachment A

/s/ Michael Hunn *05/27/2022*
Authorized Signature **Date**

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RESOLUTION NO. 22-0602-02

RESOLUTION OF THE BOARD OF DIRECTORS ORANGE COUNTY HEALTH AUTHORITY
d.b.a. CalOptima

APPROVE UPDATED CALOPTIMA POLICIES

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 Policies:

a. GA.8020: 9/80 Work Schedule
b. GA.8027: Anti-Harassment Policy and Attachment A
c. GA.8036: Education Reimbursement
d. GA.8042: Supplemental Compensation with Attachments A-B
e. GA.8050: Confidentiality
f. GA.8058: Salary Schedule and Attachment A

APPROVED AND ADOPTED by the Board of Directors of the Orange County Health Authority, d.b.a., CalOptima this 2nd day of June, 2022.

AYES: _____
NOES: _____
ABSENT: _____
ABSTAIN: _____

/s/_____
Title: Chair, Board of Directors
Printed Name and Title: Andrew Do, Chair, CalOptima Board of Directors

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

Policy:	GA.8020
Title:	**9/80 Work Schedule**
Department:	CalOptima Administrative
Section:	Human Resources
CEO Approval:	
Effective Date:	01/05/2012
Revised Date:	TBD
Applicable to:	☐ Medi-Cal ☐ OneCare ☐ OneCare Connect ☐ PACE ☒ Administrative

I. PURPOSE

This policy outlines how CalOptima will administer an alternate workweek schedule commonly referred to as a 9/80 Work Schedule.

II. POLICY

A. Based on operational needs, department managers may establish 9/80 Work Schedules within their departments. A 9/80 Work Schedule is eighty (80) hours of work in a two (2) week period worked over nine (9) days, instead of the traditional ten (10) days. This alternate work schedule may provide the department with improved coverage and scheduling and employees with another way to manage work and non-work responsibilities.

B. Customer Service Remains a Priority: The 9/80 Work Schedule is not an entitlement and will not be provided at the expense of service to the public and must not adversely affect workloads or the organization's or a department's ability to provide coverage and maintain service levels. Department managers, at their discretion, may discontinue an individual's, group's, or department's participation in the 9/80 Work Schedule based on business needs.

C. Eligibility: After completing initial on-boarding and training requirements, full-time employees may be eligible, with supervisory approval, to participate in the 9/80 Work Schedule. An employee must obtain supervisory approval to participate in the 9/80 Work Schedule. A 9/80 schedule is not available for ~~Director level positions and above~~Executive Level Positions, unless ~~-~~approved ~~-~~by the Chief Executive Officer. Initial training requirements may vary by department, but typically do not exceed ninety (90) calendar days. Individual 9/80 Work Schedules are set based on the pre-determined schedules for payroll and at the discretion of the department manager who will designate the hours for each day, as well as the day off, based on business needs, which shall be consistent with the 9/80 Federal Labor Standards Act (FLSA) Workweek definition. Employees not meeting job standards, expectations, and/or on a Performance Improvement Plan may not participate in the compressed work schedule until performance standards are met. Managers will review such exceptions with Human Resources (HR) before denying the option. Individuals who do not wish to participate may continue to work a standard forty (40) hour-week, eight (8) hours a day.~~Employees will not be eligible to participate in both the telework program and the 9/80 Work Schedule during the same period. Employees eligible for both may only request one (1) alternative at a tim~~

D. Approval: An employee must complete a 9/80 Workweek Request Form, acknowledge that they received and read this policy, and obtain supervisory approval before submitting the form to HR. Non-Exempt Employees cannot begin their 9/80 Work Schedule until they have received ~~formal~~written approval from HR that outlines the approved 9/80 schedule start date.

E. Transitioning to the 9/80 Work Schedule: When an employee transitions from an eight (8) hour per day workweek to a 9/80 Work Schedule, there will be a necessary change in the beginning of the ~~workweek.~~FLSA Workweek. This results in a situation in which some of the hours fall into both the old ~~workweek~~FLSA Workweek and the new ~~workweek~~FLSA Workweek. This could result in fewer or more than eighty (80) hours on an employee's paycheck for that transitional period. If the result is more than eighty (80) hours, a calculation of overtime will be made for an employee eligible for overtime, which includes those hours in both the old and new workweeks, and the greater of the two (2) amounts will be paid to the employee at time and a half. When possible, HR may require a Non-Exempt Employee to work a half ~~(½)~~ partial day during the transition week to both minimize overtime worked and ensure that the employee receives a full paycheck.

F. Hours of Work: CalOptima daily start times will continue to be flexible with each employee committing to a starting time no earlier than 6:00 a.m. Lunch breaks are pre-approved for one-half (1/2) hour. The option to extend to one (1) hour is based on manager's approval.

G. Paid Time Off (PTO): PTO accrual will remain the same for participating employees. When an employee takes a day off pursuant to CalOptima Policy GA.8018: Paid Time Off, the accrual will be depleted by the number of scheduled hours for that day. For example, if an employee takes a PTO day on one (1) of their nine (9) hour days, nine (9) hours of PTO time will be removed from their total available PTO hours. Holiday pay shall remain at eight (8) hours. When a holiday falls on a regular nine (9) hour ~~work day~~workday for a Non-Exempt Employee, the employee has the option of using one (1) hour of accrued PTO time, or if approved by their supervisor, the option of working one (1) hour of make-up time. Should a holiday fall on an employee's scheduled day off, the employee will be permitted to take off eight hours in-lieu of the holiday time off in the same workweek as the holiday.

H. Overtime: It is possible an employee's 9/80 Work Schedule may not generally correspond with CalOptima's pay periods; therefore, adjustments to overtime compensation due cannot be calculated until the completion of the employee's workweek. This may result in one (1) pay period's delay in the employee receiving the overtime compensation.

I. Employee Conduct: Employees must obtain approval to adjust their work schedule and work hours. Failure to adhere to assigned work hours, tardiness, and excessive absenteeism may lead to revocation of the 9/80 Work Schedule for the individual. If necessary, as a condition of participating in the 9/80 Work Schedule, employees must agree to work on a scheduled day off for an urgent situation, or as compelled by business needs as determined by the employee's manager. Non-Exempt employees required to work on their scheduled day off may incur overtime if the total hours worked in the FLSA workweek exceed forty (40) hours. Employees are encouraged to use days off to attend to personal business like medical/dental appointments for themselves and family members.

J. Termination of Program: The 9/80 Work Schedule is an optional program. CalOptima reserves the right to, at any time, discontinue the entire program and/or an individual employee's participation in the program, for any reason at management discretion. Should a manager choose to remove an employee from participating in the 9/80 Work Schedule, the manager must consult with HR in advance to develop a transition plan. Employees are not allowed to change their work schedules

without prior approval from HR and their manager. Any changes in schedules by Non-Exempt Employees must be within the same FLSA workweek.

III. PROCEDURE

Responsible Party	Action
Employee	Complete the 9/80 Workweek Request Form and forward to supervisor for review and approval. ▪ Non-Exempt Employees must submit the applicable request form to HR no less than two (2) weeks in advance of the requested 9/80 start date. ▪ Exempt employees must submit the form at least one (1) week in advance of the requested 9/80 start date.
Supervisor	Review form and approve or deny. ▪ Establish work schedule with the employee. ▪ If approved, forward form to HR in advance of the requested 9/80 Work Schedule start date.
Human Resources	~~Reviews~~Review request and approve or deny. ▪ If approved, determine ~~an~~ employee's new workweek and send an email to the employee to outline when the new workweek will begin and what hours must be worked in the transition week to minimize overtime.

IV. ATTACHMENT(S)

Not Applicable
~~A. Friday 9/80 Workweek Request Form (Exempt)~~
~~B. Friday 9/80 Workweek Request Form (Non-Exempt)~~
~~C. Monday 9/80 Workweek Request Form (Exempt)~~
~~D. Monday 9/80 Workweek Request Form (Non-Exempt)~~

V. REFERENCE(S)

A. CalOptima Employee Handbook
B. CalOptima Policy GA.8018: Paid Time Off
C. Title 29, Code of Federal Regulations (C.F.R.), §778.105
D. 9/80 Worksheet Request Forms (Exempt & Non-Exempt)

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

Date	Meeting
01/05/2012	Regular Meeting of the CalOptima Board of Directors
05/01/2014	Regular Meeting of the CalOptima Board of Directors
11/06/2014	Regular Meeting of the CalOptima Board of Directors
12/03/2015	Regular Meeting of the CalOptima Board of Directors
12/01/2016	Regular Meeting of the CalOptima Board of Directors
12/03/2020	Regular Meeting of the CalOptima Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	01/05/2012	GA.8020	9/80 Work Schedule	Administrative
Revised	02/01/2014	GA.8020	9/80 Work Schedule	Administrative
Revised	10/01/2014	GA.8020	9/80 Work Schedule	Administrative
Revised	12/01/2016	GA.8020	9/80 Work Schedule	Administrative
Revised	12/03/2020	GA.8020	9/80 Work Schedule	Administrative
Revised	TBD	GA.8020	9/80 Work Schedule	Administrative

IX. GLOSSARY

Term	Definition
9/80 Work Schedule	The 9/80 alternate work schedule consists of eight (8) business days of nine (9) hours per day and one (1) business day of eight (8) hours, for a total of eighty (80) hours during two (2) consecutive workweeks. The eight (8) hour ~~work day~~workday must be on the same day of the week as the employee's regularly scheduled day off. Therefore, under the 9/80 Work Schedule, one calendar week will consist of forty-four (44) hours (four (4) nine (9) hour days and one (1) eight (8) hour day) and the alternating calendar week will consist of thirty-six (36) hours (four (4) nine (9) hour days and one (1) day off). However, each workweek will only consist of forty (40) hours, in accordance with the 9/80 Federal Labor Standards Act (FLSA) Workweek.
9/80 Federal Labor Standards Act (FLSA) Workweek	Under the Fair Labor Standards Act, the workweek is defined as a fixed and regularly recurring period of seven (7) consecutive twenty-four (24) hour periods, or one hundred sixty-eight (168) hours (29 C.F.R. §778.105). The 9/80 workweek begins on the employee's eight (8) hour day, exactly four (4) hours after the scheduled start time~~,~~ and ends exactly three (3) hours and fifty-nine (59) minutes after the scheduled start time on the same day the following week. This is commonly referred to as a "day divide," in which four (4) hours of the eight (8) hour day occurs in one (1) week, and four (4) hours occurs in the following week. Department supervisors/managers and HR can answer questions about day divides.
Executive Level Position	The position of Executive Director or above.
Exempt Employee	Exempt status is determined by the Human Resources Department based on the position title and duties and responsibilities of the position and consistent with the federal Fair Labor Standards Act (FLSA) regulations. Although an employee's classification may meet applicable federal and/or state exemption criteria, the position may nevertheless be designated as non-exempt. For purposes of this policy, exempt employees do not earn overtime compensation.
Non-Exempt Employee	Non-Exempt status applies to all employees who are not identified by Human Resources as exempt. Non-Exempt employees are paid on an hourly basis and are eligible for overtime compensation. Although an employee's classification may qualify for applicable federal exemptions from the FLSA exemption criteria, the position may nevertheless be designated as non-exempt.
Performance Improvement Plan	A developmental coaching tool used to document performance and behavioral deficiencies or issues and create an action plan with goals and due dates to help employees correct and/or improve performance and behavior while still holding them accountable for past performance.

Policy:	GA.8020
Title:	**9/80 Work Schedule**
Department:	CalOptima Administrative
Section:	Human Resources
CEO Approval:	
Effective Date:	01/05/2012
Revised Date:	TBD
Applicable to:	☐ Medi-Cal ☐ OneCare ☐ OneCare Connect ☐ PACE ☒ Administrative

I. PURPOSE

This policy outlines how CalOptima will administer an alternate workweek schedule commonly referred to as a 9/80 Work Schedule.

II. POLICY

A. Based on operational needs, department managers may establish 9/80 Work Schedules within their departments. A 9/80 Work Schedule is eighty (80) hours of work in a two (2) week period worked over nine (9) days, instead of the traditional ten (10) days. This alternate work schedule may provide the department with improved coverage and scheduling and employees with another way to manage work and non-work responsibilities.

B. Customer Service Remains a Priority: The 9/80 Work Schedule is not an entitlement and will not be provided at the expense of service to the public and must not adversely affect workloads or the organization's or a department's ability to provide coverage and maintain service levels. Department managers, at their discretion, may discontinue an individual's, group's, or department's participation in the 9/80 Work Schedule based on business needs.

C. Eligibility: After completing initial on-boarding and training requirements, full-time employees may be eligible, with supervisory approval, to participate in the 9/80 Work Schedule. An employee must obtain supervisory approval to participate in the 9/80 Work Schedule. A 9/80 schedule is not available for Executive Level Positions, unless approved by the Chief Executive Officer. Initial training requirements may vary by department, but typically do not exceed ninety (90) calendar days. Individual 9/80 Work Schedules are set based on the pre-determined schedules for payroll and at the discretion of the department manager who will designate the hours for each day, as well as the day off, based on business needs, which shall be consistent with the 9/80 Federal Labor Standards Act (FLSA) Workweek definition. Employees not meeting job standards, expectations, and/or on a Performance Improvement Plan may not participate in the compressed work schedule until performance standards are met. Managers will review such exceptions with Human Resources (HR) before denying the option. Individuals who do not wish to participate may continue to work a standard forty (40) hour-week, eight (8) hours a day.

D. Approval: An employee must complete a 9/80 Workweek Request Form, acknowledge that they received and read this policy, and obtain supervisory approval before submitting the form to HR.

Non-Exempt Employees cannot begin their 9/80 Work Schedule until they have received written approval from HR that outlines the approved 9/80 schedule start date.

E. Transitioning to the 9/80 Work Schedule: When an employee transitions from an eight (8) hour per day workweek to a 9/80 Work Schedule, there will be a necessary change in the beginning of the FLSA Workweek. This results in a situation in which some of the hours fall into both the old FLSA Workweek and the new FLSA Workweek. This could result in fewer or more than eighty (80) hours on an employee's paycheck for that transitional period. If the result is more than eighty (80) hours, a calculation of overtime will be made for an employee eligible for overtime, which includes those hours in both the old and new workweeks, and the greater of the two (2) amounts will be paid to the employee at time and a half. When possible, HR may require a Non-Exempt Employee to work a half partial day during the transition week to both minimize overtime worked and ensure that the employee receives a full paycheck.

F. Hours of Work: CalOptima daily start times will continue to be flexible with each employee committing to a starting time no earlier than 6:00 a.m. Lunch breaks are pre-approved for one-half (1/2) hour. The option to extend to one (1) hour is based on manager's approval.

G. Paid Time Off (PTO): PTO accrual will remain the same for participating employees. When an employee takes a day off pursuant to CalOptima Policy GA.8018: Paid Time Off, the accrual will be depleted by the number of scheduled hours for that day. For example, if an employee takes a PTO day on one (1) of their nine (9) hour days, nine (9) hours of PTO time will be removed from their total available PTO hours. Holiday pay shall remain at eight (8) hours. When a holiday falls on a regular nine (9) hour workday for a Non-Exempt Employee, the employee has the option of using one (1) hour of accrued PTO time, or if approved by their supervisor, the option of working one (1) hour of make-up time. Should a holiday fall on an employee's scheduled day off, the employee will be permitted to take off eight hours in-lieu of the holiday time off in the same workweek as the holiday.

H. Overtime: It is possible an employee's 9/80 Work Schedule may not generally correspond with CalOptima's pay periods; therefore, adjustments to overtime compensation due cannot be calculated until the completion of the employee's workweek. This may result in one (1) pay period's delay in the employee receiving the overtime compensation.

I. Employee Conduct: Employees must obtain approval to adjust their work schedule and work hours. Failure to adhere to assigned work hours, tardiness, and excessive absenteeism may lead to revocation of the 9/80 Work Schedule for the individual. If necessary, as a condition of participating in the 9/80 Work Schedule, employees must agree to work on a scheduled day off for an urgent situation, or as compelled by business needs as determined by the employee's manager. Non-Exempt employees required to work on their scheduled day off may incur overtime if the total hours worked in the FLSA workweek exceed forty (40) hours. Employees are encouraged to use days off to attend to personal business like medical/dental appointments for themselves and family members.

J. Termination of Program: The 9/80 Work Schedule is an optional program. CalOptima reserves the right to, at any time, discontinue the entire program and/or an individual employee's participation in the program, for any reason at management discretion. Should a manager choose to remove an employee from participating in the 9/80 Work Schedule, the manager must consult with HR in advance to develop a transition plan. Employees are not allowed to change their work schedules without prior approval from HR and their manager. Any changes in schedules by Non-Exempt Employees must be within the same FLSA workweek.

III. PROCEDURE

Responsible Party	Action
Employee	Complete the 9/80 Workweek Request Form and forward to supervisor for review and approval. ▪ Non-Exempt Employees must submit the applicable request form to HR no less than two (2) weeks in advance of the requested 9/80 start date. ▪ Exempt employees must submit the form at least one (1) week in advance of the requested 9/80 start date.
Supervisor	Review form and approve or deny. ▪ Establish work schedule with the employee. ▪ If approved, forward form to HR in advance of the requested 9/80 Work Schedule start date.
Human Resources	Review request and approve or deny. ▪ If approved, determine employee's new workweek and send an email to the employee to outline when the new workweek will begin and what hours must be worked in the transition week to minimize overtime.

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

A. CalOptima Employee Handbook
B. CalOptima Policy GA.8018: Paid Time Off
C. Title 29, Code of Federal Regulations (C.F.R.), §778.105
D. 9/80 Worksheet Request Forms (Exempt & Non-Exempt)

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

Date	Meeting
01/05/2012	Regular Meeting of the CalOptima Board of Directors
05/01/2014	Regular Meeting of the CalOptima Board of Directors
11/06/2014	Regular Meeting of the CalOptima Board of Directors
12/03/2015	Regular Meeting of the CalOptima Board of Directors
12/01/2016	Regular Meeting of the CalOptima Board of Directors
12/03/2020	Regular Meeting of the CalOptima Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	01/05/2012	GA.8020	9/80 Work Schedule	Administrative
Revised	02/01/2014	GA.8020	9/80 Work Schedule	Administrative
Revised	10/01/2014	GA.8020	9/80 Work Schedule	Administrative
Revised	12/01/2016	GA.8020	9/80 Work Schedule	Administrative
Revised	12/03/2020	GA.8020	9/80 Work Schedule	Administrative
Revised	TBD	GA.8020	9/80 Work Schedule	Administrative

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Performance Improvement Plan	A developmental coaching tool used to document performance and behavioral deficiencies or issues and create an action plan with goals and due dates to help employees correct and/or improve performance and behavior while still holding them accountable for past performance.

Policy:	GA.8027
Title:	~~Unlawful~~ Anti-~~Harassment~~Harassment
Department:	CalOptima Administrative
Section:	Human Resources
CEO Approval:	*/s/*
Effective Date:	01/05/2012
Revised Date:	TBD
Applicable to:	☐ Medi-Cal ☐ OneCare ☐ OneCare Connect ☐ PACE ☒ Administrative

I. PURPOSE

This policy outlines CalOptima's zero tolerance for ~~harassment, discrimination~~Discrimination, Harassment, and ~~retaliation (collectively referred herein as "unlawful harassment").~~Retaliation and sets forth a procedure for promptly investigating complaints thereof.

II. POLICY

A. CalOptima is committed to providing a professional work environment that is free of Discrimination and Harassment based on one or more protected category(ies), and an environment free from Retaliation for participating in any protected activity(ies) covered by this policy. CalOptima is committed to providing equal employment opportunities to all Employees and applicants for employment. Accordingly, CalOptima has adopted and shall maintain this Anti-Harassment Policy designed to encourage professional and respectful behavior and prevent discriminating, harassing, or retaliatory conduct in our workplace. CalOptima shall implement appropriate corrective action(s), up to and including termination, in response to any violation of CalOptima's Anti-Harassment Policy, even if the violation does not rise to the level of unlawful conduct.

B. CalOptima prohibits Discrimination and Harassment based on the following categories: race, color, hairstyle, religion, religious creed (including religious dress and grooming practices), national origin, ancestry, citizenship, physical or mental disability, medical condition (including cancer and genetic characteristics), genetic information, marital status, registered domestic partner status, sex (including pregnancy, childbirth, breastfeeding, or related medical conditions), sex stereotype, gender, transitioning status, gender identity, gender expression, age (40 years and over), sexual orientation, veteran and/or military status, protected medical leaves (requesting or approved for leave under the Family and Medical Leave Act or the California Family Rights Act), domestic violence victim status, political affiliation, and any other status protected by state or federal law. In addition, CalOptima prohibits Retaliation against a person who engages reasonably and in good faith in activities protected under this policy. Reporting or assisting in reporting suspected violations of this policy and cooperating in investigations or proceedings arising out of an alleged violation of this policy are protected activities.

C. All Employees are expected to assume responsibility for maintaining a work environment that is

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free from Discrimination, Harassment and Retaliation. The law prohibits supervisors, managers and co-workers, as well as third parties with whom CalOptima employees come into contact in the workplace, from engaging in unlawful Discrimination, Harassment and Retaliation. Employees are encouraged to promptly report conduct that they reasonably believe violates this policy so that CalOptima shall have an opportunity to address and resolve any concerns. Managers and supervisors are required to promptly report conduct that they believe violates this policy. CalOptima is committed to responding to alleged violations of this policy in a timely and fair manner and to taking appropriate action aimed at ending the prohibited conduct.

D. Complaints/reports under this policy must be based on a reasonable belief of misconduct and made in good faith. CalOptima will not tolerate intentional false accusations of Discrimination, Harassment, or Retaliation. A finding of any intentional false accusations is considered a violation of this policy and may result in corrective action up to and including termination.

E. This policy applies to agents, contractors, volunteers, job applicants, and employees. In addition, this policy extends to conduct with a connection to an Employee's work, even when the conduct takes place away from CalOptima's premises, such as a business trip or business-related social function. CalOptima's policy prohibiting discrimination against CalOptima Members is addressed in CalOptima Policy HH.1104: Complaints of Discrimination.

F. CalOptima shall take appropriate steps and implement processes to protect Employees from unlawful Discrimination, Harassment and Retaliation in the workplace, including:

1. Employees are encouraged to timely report and file a complaint regarding suspected or actual inappropriate conduct in violation of this policy and/or applicable laws, and, whenever possible, to put the complaint or concern in writing. Employees may designate the report or complaint as confidential, which may remain confidential to the extent possible based on the circumstances and applicable laws, except with respect to the investigation, which may not be completely confidential. Employees can file complaints directly with their immediate supervisor, manager, or the Human Resources Department.

2. Supervisors and managers are required to forward all complaints, oral and/or written, alleging violation(s) of this policy to the Human Resources Department.

3. The Human Resources Department or designee will review any report or complaint of inappropriate conduct in violation of this policy and will complete a timely, thorough, and impartial review and/or investigation, when appropriate, that provides all parties appropriate due process and reaches reasonable conclusions based on the evidence collected.

4. Impacted parties are required to reasonably participate in the review and/or investigation of complaints alleging inappropriate conduct in violation of this policy.

5. The complainant and respondent will be timely informed of appropriate information related to the progress of the review or investigation, including the findings and closure of an investigation.

6. If, at the end of the investigation, inappropriate conduct or violation(s) of this policy or applicable law are found, CalOptima shall take appropriate remedial measures.

7. Employees reporting inappropriate conduct, along with employees participating in the investigation as witnesses, shall not be retaliated against for filing a complaint or participating in the investigation process.

G. Employees may also file a complaint directly with the United States Equal Employment Opportunity Commission (EEOC) or California Department of Fair Employment and Housing (DFEH), or other appropriate state or federal agency(ies). They may also file a civil action in the appropriate court, subject to applicable laws.

H. Prohibited Conduct

1. Discrimination: CalOptima prohibits discrimination based on any one or more protected characteristics as described in Section II.B. of this policy. Prohibited discrimination includes unequal treatment based upon the Employee or applicant's association with a member of these protected classes. Discrimination may include but is not necessarily limited to: allowing the applicant's or Employee's protected category to be a factor in hiring, promotion, compensation or other employment related decision, unless otherwise permitted by applicable law; and providing unwarranted assistance or withholding work-related assistance, cooperation, and/or information to applicants or Employees because of their protected category.

2. Harassment: CalOptima prohibits harassing, disrespectful or unprofessional conduct, including harassing, disrespectful or unprofessional conduct based on any one or more protected characteristics as described in Section II.B. of this policy. Prohibited harassment can be verbal (such as slurs, jokes, insults, epithets, gestures, or teasing), visual (such as the posting or distribution of offensive posters, symbols, cartoons, drawings, computer displays, or emails), or physical (such as physically threatening another person, blocking someone's way, making physical contact in an unwelcome manner, etc.).

3. Sexual Harassment: CalOptima prohibits Discrimination and Harassment based on sex (including pregnancy, childbirth, breastfeeding, or related medical conditions), sex stereotype, sexual orientation, gender, gender identity, or gender expression. Sexually harassing conduct need not be motivated by sexual desire and may include situations that began as reciprocal relationships, but that later cease to be reciprocal. Sexual harassment may involve harassment of a person of the same gender as the harasser, regardless of either person's sexual orientation or gender identity. Prohibited Sexual Harassment falls into two categories: (1) "*quid pro quo*" ("this for that") when someone conditions a job, promotion, or other work benefit based on submission to sexual advances or other conduct based on sex; or (2) "hostile work environment" when unwelcome comments or conduct based on sex unreasonably interferes with your work performance or creates an intimidating, hostile, or offensive work environment. Prohibited Sexual Harassment may include all the actions described above as Harassment, as well as other unwelcome sex-based conduct, such as, but not limited to:

a. Unwelcome or unsolicited sexual advances;

b. Offering employment benefits in exchange for sexual favors;

c. Leering or gestures;

d. Displaying sexually suggestive objects, pictures, cartoons, or posters;

e. Derogatory comments, epithets, slurs, or jokes;

f. Graphic comments, sexually degrading words, conversations regarding sexual activities, or suggestive or obscene messages or invitations; or

g. Physical ~~CalOptima is committed to providing a work environment that is free of harassment, discrimination, and retaliation. Harassment and/or discrimination based on race, Sex, Sex Stereotype, gender, Gender Identity,~~ touching or assault, as well as impeding or blocking movements, or other verbal or physical conduct of a sexual nature.

4. Retaliation: CalOptima prohibits retaliation against an Employee because the Employee has engaged in protected activity. Protected activities may include, but are not limited to, reporting or assisting in reporting suspected violations of this policy or other applicable laws and/or cooperating in investigations or proceedings arising out of an alleged violation of this policy or other applicable laws. CalOptima shall not take any adverse employment action, based on the Employee's protected activity, that materially affects the terms and conditions of the Employee's employment status or is reasonably likely to deter the Employee from engaging in protected activity. Examples of Retaliation under this policy include, but are not limited to: demotion; suspension; reduction in pay; termination; denial of a merit salary increase; failure to hire or consider for hire; refusing to promote or consider for promotion because of reporting a violation of this policy; harassing another Employee for filing a complaint; denying employment opportunities for making a complaint or cooperating in an investigation; changing someone's work assignments; treating people differently such as denying an accommodation; not talking to an Employee when otherwise required by job duties; or otherwise excluding the Employee from job-related activities because of engagement in activities protected under this policy. Actual or threatened retaliation for rejecting sexual advances or complaining about sexual harassment is also unlawful and a violation of this policy.

I. CalOptima shall disseminate the Anti-Harassment Policy to all Employees and require them to acknowledge electronically that each individual has received and understood the Policy. All legally required posters shall be posted in a prominent and accessible location in the workplace.

J. Training Requirements

1. All non-management/non-supervisory Employees are required to attend Harassment prevention training for Employees (1 hour) within the first six (6) months of hire and at least every two (2) years thereafter.

2. All management/supervisory Employees must complete the Harassment prevention training for leaders (2 hours) within the first six (6) months of hire and at least every two (2) years thereafter. These trainings shall include prevention of abusive conduct in the workplace.

K. Addressing and Reporting Violations

1. Any Employee or applicant who experiences or witnesses behavior that they believe violates this policy is encouraged to immediately tell the offending individual that the behavior is inappropriate and, if they feel comfortable doing so, to tell the offending individual to stop the behavior. The applicant or Employee should also immediately report the alleged violation to his/her supervisor, manager, or the Human Resources Department. Employees are free to contact the Human Resources Department and are not required to request supervisor or manager approval to do this. If the alleged offender is the Employee's supervisor or manager, the Employee should report the conduct to any other supervisor or manager or the Human Resources Department. A complaint may be brought forward verbally or in writing. Written complaints can be made using, but not limited to, the Employee Complaint Intake Form.

2. Supervisors or managers who learn of any potential violation of this policy are required to immediately report the matter to Human Resources and must follow instructions provided by

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Human Resources as to how best to proceed.

3. CalOptima shall promptly look into the facts and circumstances of any alleged violation, as appropriate. Even in the absence of a formal complaint, CalOptima may initiate an investigation where it has reason to believe that conduct that violates this policy has occurred. Moreover, even where a complainant conveys a request to withdraw their initial formal complaint, CalOptima may continue the investigation to ensure that the workplace is free from Harassment. Anonymous complaints shall also be investigated. The method will depend on the details provided in the anonymous complaint. If the complaint is sufficiently detailed, the investigation may be able to proceed in the same manner as any other complaint. If the information is more general, CalOptima may need to do an environmental assessment or survey to try to determine if misconduct has occurred. All investigations will be fair, impartial, timely, and completed by qualified personnel.

4. To the extent possible, CalOptima shall endeavor to keep the reporting of the applicant or Employee's concerns confidential; however, complete confidentiality cannot be guaranteed when it interferes with CalOptima's ability to fulfill its obligations under this policy. All Employees are required to cooperate fully with any investigation. This includes, but is not limited to, maintaining an appropriate level of discretion regarding the investigation, and disclosing any and all information that may be pertinent to the investigation. Upon completion of the investigation, if misconduct is substantiated, CalOptima shall take appropriate corrective and preventive action calculated to end the conduct up to and including formal corrective action where warranted.

L. Filing of Complaints Outside of CalOptima

1. Employees and applicants may file formal complaints of Discrimination, Harassment, or Retaliation with the agencies listed below. Individuals who wish to pursue filing with these agencies should contact them directly to obtain further information about their processes and time limits.

a. **California Department of Fair Employment and Housing (DFEH)**
2218 Kausen Drive, Suite 100
Elk Grove, CA 95758
800-884-1684 (voice), 800-700-2320 (TTY) or California's Relay Service at 711
contact.center@dfeh.ca.gov
https://www.dfeh.ca.gov

b. **U.S. Equal Employment Opportunity Commission**
450 Golden Gate Avenue 5 West,
P.O Box 36025
San Francisco, CA 94102-3661
1-800-669-4000 or 510-735-8909 (Deaf/hard-of-hearing callers only)
http://www.eeoc.gov/employees

2. Employees or applicants who believe they have been the subject of discrimination, harassment or retaliation for making a complaint or participating in an investigation of discrimination or harassment may file a complaint with the DFEH within three (3) years of the last act of discrimination, harassment or retaliation. DFEH serves as a neutral factfinder and attempts to help the parties voluntarily resolve disputes. DFEH may also file a civil complaint and seek court orders changing the employer's policies and practices, punitive damages, and attorney's fees and costs. Employees can also pursue the matter through a private lawsuit in civil court

after a complaint has been filed and a Right-to-Sue Notice has been issued. Training developed by DFEH can be accessed at the following link: https://www.dfeh.ca.gov/shpt/.

~~A. Gender Expression, Transitioning status, age, color, National Origin, immigration status, ancestry, mental or physical disability, sexual orientation, religion, religious creed, exercise of rights under Family and Medical Leave Act (FMLA), marital status, military and veteran status, medical condition, genetic information, or any other protected characteristic is a violation of state and federal law and is strictly prohibited by CalOptima. Any person who commits such a violation may be subject to personal liability as well as corrective action up to and including termination of employment.~~

~~B. This policy applies to all of CalOptima's agents, persons providing services pursuant to a contract, volunteers, unpaid interns, temporary employees, and employees, including supervisors and non-supervisory employees, and to non-employees who engage in unlawful harassment in the workplace.~~

~~C. Prohibited harassment includes verbal, physical, and/or visually perceived conduct in any form that is based on a protected characteristic and which creates an intimidating, offensive, or hostile work environment (must be severe or pervasive) or that interferes with work performance. Such conduct constitutes harassment when:~~

~~1. Submission to the conduct is made either an explicit, or implicit, condition of employment;~~

~~2. Submission to or rejection of the conduct is used as the basis for an employment decision; or~~

~~3. The harassment unreasonably interferes with an employee's work performance or creates an intimidating, hostile, or offensive work environment.~~

~~D. Prohibited unlawful harassment includes, but is not limited to, the following behaviors:~~

~~1. Verbal conduct such as epithets, stereotypes based on protected characteristic, derogatory or sexual jokes or comments, slurs or unwanted sexual advances, invitations, or comments;~~

~~2. Visual displays, such as derogatory and/or sexually-oriented posters, photography, cartoons, drawings, or gestures;~~

~~3. Physical conduct including assault, unwanted touching, intentionally blocking normal movement, or interfering with work because of sex, race, or any other protected characteristic; and/or~~

~~4. Threats and demands to submit to sexual requests as a condition of continued employment, or to avoid some other loss and offers of employment benefits in return for sexual favors.~~

~~E. CalOptima encourages reporting of all perceived or actual incidents of discrimination or harassment. An employee, temporary employee, volunteer, or unpaid intern who believes he or she is being, or has been, harassed or discriminated against based on a protected characteristic in any way, should report the facts of the incident or incidents immediately to his or her supervisor, manager, or, if he or she prefers, to the Human Resources (HR) Department. Supervisors and managers must report the incidents, or claims, immediately to the HR Department. An HR representative, or its designee, shall investigate any and all complaints of unlawful harassment based on a protected characteristic and take appropriate preventive and/or corrective action, when it is warranted. Reported complaints of unlawful harassment based on protected characteristic will be~~

~~investigated fairly, thoroughly, promptly, and in a confidential manner to the extent possible, involving only the parties who have a need to know. If a complaint is not resolved to the employee's or complainant's satisfaction, the employee or complainant may submit a request for review of the complaint via email to CalOptima's Executive Director of Human Resources.~~

~~F. CalOptima will not tolerate retaliation against an employee, temporary employee, volunteer, unpaid intern, or persons providing services pursuant to a contract for reporting harassment and/or discrimination, for cooperating in an investigation, for making compliance complaints, or for engaging in similar protected activity. Employees, temporary employees, volunteers, unpaid interns, or persons providing services pursuant to a contract engaging in any actions which are retaliatory against another employee, temporary employee, volunteer, unpaid intern, or persons providing services pursuant to a contract will be subjected to disciplinary action, up to and including termination of employment or contract.~~

~~G. CalOptima encourages all employees, temporary employees, volunteers, and unpaid interns to report any incidents of harassment prohibited by this policy immediately so that complaints can be quickly and fairly resolved. Employees, temporary employees, volunteers, and unpaid interns should be aware that the Federal Equal Employment Opportunity Commission and the California Department of Fair Employment and Housing investigate and prosecute complaints of prohibited harassment in employment. If an individual believes that CalOptima has failed to adequately address a complaint of harassment, that person may file a complaint with one of these agencies.~~

III. PROCEDURE

Responsible Party	Action
Employee	▪ Assume responsibility for a work environment free from Discrimination, Harassment and Retaliation. ▪ Report the facts of any incident(s) of ~~harassment~~Discrimination or ~~discrimination~~Harassment based on a protected characteristic or ~~retaliation~~Retaliation based on a protected activity immediately to your supervisor, manager, or~~, if you prefer,~~ the Human Resources (HR) Department. ▪ Cooperate in a reasonable inquiry or investigation into allegation(s) of Discrimination, Harassment or Retaliation.
Supervisor	▪ Gather all relevant facts from reporting ~~employee~~Employee and report it immediately to the HR Department. ▪ Cooperate in a reasonable inquiry or investigation into allegation(s) of Discrimination, Harassment or Retaliation. ▪ Keep reports or complaints of Discrimination, Harassment, or Retaliation confidential, to the extent possible, and follow HR's direction and guidance.

Responsible Party	Action
Human Resources	~~▪ Disseminate the Unlawful Harassment Policy to all employees, temporary employees, volunteers and unpaid interns and require all employees, temporary employees, volunteers, and unpaid interns to acknowledge electronically that each individual has received and understood the Policy.~~ ▪ Upon receipt of a complaint, ~~gather sufficient facts to~~ evaluate the reported misconduct and determine what level of review or investigation is needed and appropriate for the circumstances. ▪ Request supporting documentation and/or additional statements from employees and potential witnesses, where applicable. ▪ If a determination is made that no further investigation is required, ~~documenta~~ a closure notice shall be issued to the complainant documenting the decision ~~and the reasoning and inform the complainant of the decision.~~. ▪ ~~Complete~~If a determination is made that an investigation is required, complete an impartial ~~and~~, timely, and thorough investigation of the complaint, ~~document and track the investigation, take appropriate~~ which may include interviewing the complaining party, responding party, and relevant witnesses. Review collected documents, exhibits or other evidence. Analyze the information, make credibility determinations when needed, reach reasonable conclusions based on the evidence collected, and make findings based on a preponderance of the evidence standard. ▪ If misconduct is found, recommend appropriate remedial measures, along with preventive and/or corrective action, ~~including disciplinary action,~~ when it is warranted, ~~and~~to department leadership. ▪ Timely inform the complainant of the conclusion of the investigation and any findings. ▪ Timely inform the ~~complainant and/or offender of the decision. Every reported complaint of unlawful harassment based on a protected characteristic will be investigated thoroughly, promptly, and in a confidential manner to the extent possible.~~ responding party of the conclusion of the investigation, any findings, and the final decision, if applicable, of remedial measures or preventive and/or corrective action. ▪ HR will strive to maintain confidentiality during the investigation, but there is no guarantee of complete confidentiality. Only the parties who need to know ~~will~~shall be involved.

IV. ATTACHMENT(S)

~~Not Applicable~~

A. Employee Complaint Intake Form

V. REFERENCE(S)

A. CalOptima Policy HH.1104: Complaints of Discrimination

~~A.~~B. California Government Code, §§12926, 12935 ~~and~~, 12940 *et seq*, 12950, and 12950.1.

~~B. CalOptima Employee Handbook~~

C. Title 2, California Code of Regulations (C.C.R.), §§11008 *et seq.*, 11023, 11027.1(a) and (b), and 1030(a)-(f)

D. Title VII of the Civil Rights Act of 1964 (42, U.S.C., 2000e *et seq*.)
E. CA Labor Code §§230 and 230.1 Rights of Victims of Domestic Violence, Sexual Assault, and Stalking

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

Date	Meeting
01/05/2012	Regular Meeting of the CalOptima Board of Directors
05/01/2014	Regular Meeting of the CalOptima Board of Directors
11/03/2016	Regular Meeting of the CalOptima Board of Directors
09/06/2018	Regular Meeting of the CalOptima Board of Directors
TBD	Regular Meeting of the CalOptima Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	01/05/2012	GA.8027	Unlawful Harassment	Administrative
Revised	04/01/2014	GA.8027	Unlawful Harassment	Administrative
Revised	11/03/2016	GA.8027	Unlawful Harassment	Administrative
Revised	09/06/2018	GA.8027	Unlawful Harassment	Administrative
Revised	TBD	GA.8027	Anti-Harassment	Administrative

IX. GLOSSARY

Term	Definition
Discrimination	~~Adverse employment action against an employee, volunteer, intern,~~Unequal treatment of a person or ~~individual performing services pursuant to a contract~~group on the basis of a protected ~~characteristic~~category.
~~Harassment~~Employee	~~Unwelcome conduct or comments, based on a protected characteristic, that are so severe or pervasive as to create an abusive working environment. .~~Any and all employees of CalOptima, including all permanent and temporary employees, volunteers, and other employed personnel.
Gender Expression~~Retaliation~~	~~Adverse employment action against an employee because he or she filed a complaint or engaged in a protected activity.~~ A person's gender-related appearance or behavior, whether or not stereotypically associated with the person's sex assigned at birth.
Gender ~~Expression~~Identity	~~A~~Each person's internal understanding of their gender~~-related appearance or behavior~~, or the ~~perception of such appearance or behavior, whether or not stereotypically associated with~~perceptions of a person's gender identity, which may include male, female, a combination of male and female, neither male nor female, a gender different from the person's sex assigned at birth, or transgender.
~~Gender Identity~~Harassment	~~Each person's internal understanding of their gender, or the perceptions of a person's gender identity, which may include as male, female, a combination of male and female, neither male nor female, a gender different from the person's sex assigned at birth, or transgender.~~Unwelcome verbal, written or physical conduct that denigrates or shows hostility or aversion toward an individual, based on a protected characteristic, that is so severe or pervasive as to create an intimidating, hostile, or offensive working environment.
National Origin	Includes, but is not limited to, the individual's or ancestors' actual or perceived: (1) physical, cultural, or linguistic characteristics associated with a national origin group; (2) marriage to or association with persons of a national origin group; (3) tribal affiliation; (4) membership in or association with an organization identified with or seeking to promote the interests of a national origin group; (5) attendance or participation in schools, churches, temples, mosques, or other religious institutions generally used by persons of a national origin group; (6) name that is associated with a national origin group; and (7) the basis of possessing a driver's license granted under Section 12801.9 of the Vehicle ~~code~~Code.
National Origin Group	Includes, but is not limited to, ethnic groups, geographic places of origin, and countries that are not presently in existence.
Retaliation	Adverse employment action against an Employee because the Employee filed a complaint or engaged in a protected activity.
Sex	Includes the same definition as provided in Government Code section 12926 and Title 42 of the United States Code section 2000 e(k), which includes, but is not limited to, pregnancy, childbirth~~;~~, breastfeeding, medical conditions related to pregnancy, childbirth, or breastfeeding, gender, gender identity, and gender expression~~, or a perception by a third party of any of the aforementioned.~~.

Term	Definition
Sex Stereotype	Includes, but is not limited to, an assumption about a person's appearance or behavior, gender roles, gender expression, or gender identity, or about an individual's ability or inability to perform certain kinds of work based on a myth, social expectation, or generalization about the individual's sex.
Sexual Harassment	Harassment based on sex (including pregnancy, childbirth, breastfeeding, or related medical conditions, sex stereotype, gender, gender identity or gender expression) or conduct of a sexual nature.
Transgender	A general term that refers to a person whose gender identity differs from the person's sex assigned at birth. A transgender person may or may not have a gender expression that is different from the social expectations of the sex assigned at birth. A transgender person may or may not identify as "transsexual."
Transitioning	A process some transgender people go through to begin living as the gender with which they identify, rather than the sex assigned to them at birth. This process may include, but is not limited to, changes in name and pronoun usage, facility usage, participation in employer-sponsored activities (*e.g.,* sports teams, team-building projects, or volunteering), or undergoing hormone therapy, surgeries, or other medical procedures.

Policy:	GA.8027
Title:	**Anti-Harassment**
Department:	CalOptima Administrative
Section:	Human Resources
CEO Approval:	*/s/*
Effective Date:	01/05/2012
Revised Date:	TBD
Applicable to:	☐ Medi-Cal ☐ OneCare ☐ OneCare Connect ☐ PACE ☒ Administrative

I. PURPOSE

This policy outlines CalOptima's zero tolerance for Discrimination, Harassment, and Retaliation and sets forth a procedure for promptly investigating complaints thereof.

II. POLICY

A. CalOptima is committed to providing a professional work environment that is free of Discrimination and Harassment based on one or more protected category(ies), and an environment free from Retaliation for participating in any protected activity(ies) covered by this policy. CalOptima is committed to providing equal employment opportunities to all Employees and applicants for employment. Accordingly, CalOptima has adopted and shall maintain this Anti-Harassment Policy designed to encourage professional and respectful behavior and prevent discriminating, harassing, or retaliatory conduct in our workplace. CalOptima shall implement appropriate corrective action(s), up to and including termination, in response to any violation of CalOptima's Anti-Harassment Policy, even if the violation does not rise to the level of unlawful conduct.

B. CalOptima prohibits Discrimination and Harassment based on the following categories: race, color, hairstyle, religion, religious creed (including religious dress and grooming practices), national origin, ancestry, citizenship, physical or mental disability, medical condition (including cancer and genetic characteristics), genetic information, marital status, registered domestic partner status, sex (including pregnancy, childbirth, breastfeeding, or related medical conditions), sex stereotype, gender, transitioning status, gender identity, gender expression, age (40 years and over), sexual orientation, veteran and/or military status, protected medical leaves (requesting or approved for leave under the Family and Medical Leave Act or the California Family Rights Act), domestic violence victim status, political affiliation, and any other status protected by state or federal law. In addition, CalOptima prohibits Retaliation against a person who engages reasonably and in good faith in activities protected under this policy. Reporting or assisting in reporting suspected violations of this policy and cooperating in investigations or proceedings arising out of an alleged violation of this policy are protected activities.

C. All Employees are expected to assume responsibility for maintaining a work environment that is free from Discrimination, Harassment and Retaliation. The law prohibits supervisors, managers, and co-workers, as well as third parties with whom CalOptima employees come into contact in the

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workplace, from engaging in unlawful Discrimination, Harassment and Retaliation. Employees are encouraged to promptly report conduct that they reasonably believe violates this policy so that CalOptima shall have an opportunity to address and resolve any concerns. Managers and supervisors are required to promptly report conduct that they believe violates this policy. CalOptima is committed to responding to alleged violations of this policy in a timely and fair manner and to taking appropriate action aimed at ending the prohibited conduct.

D. Complaints/reports under this policy must be based on a reasonable belief of misconduct and made in good faith. CalOptima will not tolerate intentional false accusations of Discrimination, Harassment, or Retaliation. A finding of any intentional false accusations is considered a violation of this policy and may result in corrective action up to and including termination.

E. This policy applies to agents, contractors, volunteers, job applicants, and employees. In addition, this policy extends to conduct with a connection to an Employee's work, even when the conduct takes place away from CalOptima's premises, such as a business trip or business-related social function. CalOptima's policy prohibiting discrimination against CalOptima Members is addressed in CalOptima Policy HH.1104: Complaints of Discrimination.

F. CalOptima shall take appropriate steps and implement processes to protect Employees from unlawful Discrimination, Harassment and Retaliation in the workplace, including:

1. Employees are encouraged to timely report and file a complaint regarding suspected or actual inappropriate conduct in violation of this policy and/or applicable laws, and, whenever possible, to put the complaint or concern in writing. Employees may designate the report or complaint as confidential, which may remain confidential to the extent possible based on the circumstances and applicable laws, except with respect to the investigation, which may not be completely confidential. Employees can file complaints directly with their immediate supervisor, manager, or the Human Resources Department.

2. Supervisors and managers are required to forward all complaints, oral and/or written, alleging violation(s) of this policy to the Human Resources Department.

3. The Human Resources Department or designee will review any report or complaint of inappropriate conduct in violation of this policy and will complete a timely, thorough, and impartial review and/or investigation, when appropriate, that provides all parties appropriate due process and reaches reasonable conclusions based on the evidence collected.

4. Impacted parties are required to reasonably participate in the review and/or investigation of complaints alleging inappropriate conduct in violation of this policy.

5. The complainant and respondent will be timely informed of appropriate information related to the progress of the review or investigation, including the findings and closure of an investigation.

6. If, at the end of the investigation, inappropriate conduct or violation(s) of this policy or applicable law are found, CalOptima shall take appropriate remedial measures.

7. Employees reporting inappropriate conduct, along with employees participating in the investigation as witnesses, shall not be retaliated against for filing a complaint or participating in the investigation process.

G. Employees may also file a complaint directly with the United States Equal Employment Opportunity Commission (EEOC) or California Department of Fair Employment and Housing

(DFEH), or other appropriate state or federal agency(ies). They may also file a civil action in the appropriate court, subject to applicable laws.

H. Prohibited Conduct

1. Discrimination: CalOptima prohibits discrimination based on any one or more protected characteristics as described in Section II.B. of this policy. Prohibited discrimination includes unequal treatment based upon the Employee or applicant's association with a member of these protected classes. Discrimination may include but is not necessarily limited to: allowing the applicant's or Employee's protected category to be a factor in hiring, promotion, compensation, or other employment related decision, unless otherwise permitted by applicable law; and providing unwarranted assistance or withholding work-related assistance, cooperation, and/or information to applicants or Employees because of their protected category.

2. Harassment: CalOptima prohibits harassing, disrespectful or unprofessional conduct, including harassing, disrespectful or unprofessional conduct based on any one or more protected characteristics as described in Section II.B. of this policy. Prohibited harassment can be verbal (such as slurs, jokes, insults, epithets, gestures, or teasing), visual (such as the posting or distribution of offensive posters, symbols, cartoons, drawings, computer displays, or emails), or physical (such as physically threatening another person, blocking someone's way, making physical contact in an unwelcome manner, etc.).

3. Sexual Harassment: CalOptima prohibits Discrimination and Harassment based on sex (including pregnancy, childbirth, breastfeeding, or related medical conditions), sex stereotype, sexual orientation, gender, gender identity, or gender expression. Sexually harassing conduct need not be motivated by sexual desire and may include situations that began as reciprocal relationships, but that later cease to be reciprocal. Sexual harassment may involve harassment of a person of the same gender as the harasser, regardless of either person's sexual orientation or gender identity. Prohibited Sexual Harassment falls into two categories: (1) "*quid pro quo*" ("this for that") when someone conditions a job, promotion, or other work benefit based on submission to sexual advances or other conduct based on sex; or (2) "hostile work environment" when unwelcome comments or conduct based on sex unreasonably interferes with your work performance or creates an intimidating, hostile, or offensive work environment. Prohibited Sexual Harassment may include all the actions described above as Harassment, as well as other unwelcome sex-based conduct, such as, but not limited to:

   a. Unwelcome or unsolicited sexual advances;

   b. Offering employment benefits in exchange for sexual favors;

   c. Leering or gestures;

   d. Displaying sexually suggestive objects, pictures, cartoons, or posters;

   e. Derogatory comments, epithets, slurs, or jokes;

   f. Graphic comments, sexually degrading words, conversations regarding sexual activities, or suggestive or obscene messages or invitations; or

   g. Physical touching or assault, as well as impeding or blocking movements, or other verbal or physical conduct of a sexual nature.

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4. Retaliation: CalOptima prohibits retaliation against an Employee because the Employee has engaged in protected activity. Protected activities may include, but are not limited to, reporting or assisting in reporting suspected violations of this policy or other applicable laws and/or cooperating in investigations or proceedings arising out of an alleged violation of this policy or other applicable laws. CalOptima shall not take any adverse employment action, based on the Employee's protected activity, that materially affects the terms and conditions of the Employee's employment status or is reasonably likely to deter the Employee from engaging in protected activity. Examples of Retaliation under this policy include, but are not limited to: demotion; suspension; reduction in pay; termination; denial of a merit salary increase; failure to hire or consider for hire; refusing to promote or consider for promotion because of reporting a violation of this policy; harassing another Employee for filing a complaint; denying employment opportunities for making a complaint or cooperating in an investigation; changing someone's work assignments; treating people differently such as denying an accommodation; not talking to an Employee when otherwise required by job duties; or otherwise excluding the Employee from job-related activities because of engagement in activities protected under this policy. Actual or threatened retaliation for rejecting sexual advances or complaining about sexual harassment is also unlawful and a violation of this policy.

I. CalOptima shall disseminate the Anti-Harassment Policy to all Employees and require them to acknowledge electronically that each individual has received and understood the Policy. All legally required posters shall be posted in a prominent and accessible location in the workplace.

J. Training Requirements

1. All non-management/non-supervisory Employees are required to attend Harassment prevention training for Employees (1 hour) within the first six (6) months of hire and at least every two (2) years thereafter.

2. All management/supervisory Employees must complete the Harassment prevention training for leaders (2 hours) within the first six (6) months of hire and at least every two (2) years thereafter. These trainings shall include prevention of abusive conduct in the workplace.

K. Addressing and Reporting Violations

1. Any Employee or applicant who experiences or witnesses behavior that they believe violates this policy is encouraged to immediately tell the offending individual that the behavior is inappropriate and, if they feel comfortable doing so, to tell the offending individual to stop the behavior. The applicant or Employee should also immediately report the alleged violation to his/her supervisor, manager, or the Human Resources Department. Employees are free to contact the Human Resources Department and are not required to request supervisor or manager approval to do this. If the alleged offender is the Employee's supervisor or manager, the Employee should report the conduct to any other supervisor or manager or the Human Resources Department. A complaint may be brought forward verbally or in writing. Written complaints can be made using, but not limited to, the Employee Complaint Intake Form.

2. Supervisors or managers who learn of any potential violation of this policy are required to immediately report the matter to Human Resources and must follow instructions provided by Human Resources as to how best to proceed.

3. CalOptima shall promptly look into the facts and circumstances of any alleged violation, as appropriate. Even in the absence of a formal complaint, CalOptima may initiate an investigation

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where it has reason to believe that conduct that violates this policy has occurred. Moreover, even where a complainant conveys a request to withdraw their initial formal complaint, CalOptima may continue the investigation to ensure that the workplace is free from Harassment. Anonymous complaints shall also be investigated. The method will depend on the details provided in the anonymous complaint. If the complaint is sufficiently detailed, the investigation may be able to proceed in the same manner as any other complaint. If the information is more general, CalOptima may need to do an environmental assessment or survey to try to determine if misconduct has occurred. All investigations will be fair, impartial, timely, and completed by qualified personnel.

4. To the extent possible, CalOptima shall endeavor to keep the reporting of the applicant or Employee's concerns confidential; however, complete confidentiality cannot be guaranteed when it interferes with CalOptima's ability to fulfill its obligations under this policy. All Employees are required to cooperate fully with any investigation. This includes, but is not limited to, maintaining an appropriate level of discretion regarding the investigation, and disclosing any and all information that may be pertinent to the investigation. Upon completion of the investigation, if misconduct is substantiated, CalOptima shall take appropriate corrective and preventive action calculated to end the conduct up to and including formal corrective action where warranted.

L. Filing of Complaints Outside of CalOptima

1. Employees and applicants may file formal complaints of Discrimination, Harassment, or Retaliation with the agencies listed below. Individuals who wish to pursue filing with these agencies should contact them directly to obtain further information about their processes and time limits.

   a. **California Department of Fair Employment and Housing (DFEH)**
   2218 Kausen Drive, Suite 100
   Elk Grove, CA 95758
   800-884-1684 (voice), 800-700-2320 (TTY) or California's Relay Service at 711
   contact.center@dfeh.ca.gov
   https://www.dfeh.ca.gov

   b. **U.S. Equal Employment Opportunity Commission**
   450 Golden Gate Avenue 5 West,
   P.O Box 36025
   San Francisco, CA 94102-3661
   1-800-669-4000 or 510-735-8909 (Deaf/hard-of-hearing callers only)
   http://www.eeoc.gov/employees

2. Employees or applicants who believe they have been the subject of discrimination, harassment or retaliation for making a complaint or participating in an investigation of discrimination or harassment may file a complaint with the DFEH within three (3) years of the last act of discrimination, harassment or retaliation. DFEH serves as a neutral factfinder and attempts to help the parties voluntarily resolve disputes. DFEH may also file a civil complaint and seek court orders changing the employer's policies and practices, punitive damages, and attorney's fees and costs. Employees can also pursue the matter through a private lawsuit in civil court after a complaint has been filed and a Right-to-Sue Notice has been issued. Training developed by DFEH can be accessed at the following link: https://www.dfeh.ca.gov/shpt/.

III. PROCEDURE

Responsible Party	Action
Employee	▪ Assume responsibility for a work environment free from Discrimination, Harassment and Retaliation. ▪ Report the facts of any incident(s) of Discrimination or Harassment based on a protected characteristic or Retaliation based on a protected activity immediately to your supervisor, manager, or the Human Resources (HR) Department. ▪ Cooperate in a reasonable inquiry or investigation into allegation(s) of Discrimination, Harassment or Retaliation.
Supervisor	▪ Gather all relevant facts from reporting Employee and report it immediately to the HR Department. ▪ Cooperate in a reasonable inquiry or investigation into allegation(s) of Discrimination, Harassment or Retaliation. ▪ Keep reports or complaints of Discrimination, Harassment, or Retaliation confidential, to the extent possible, and follow HR's direction and guidance.
Human Resources	▪ Upon receipt of a complaint, evaluate the reported misconduct and determine what level of review or investigation is needed and appropriate for the circumstances. ▪ Request supporting documentation and/or additional statements from employees and potential witnesses, where applicable. ▪ If a determination is made that no further investigation is required, a closure notice shall be issued to the complainant documenting the decision. ▪ If a determination is made that an investigation is required, complete an impartial, timely, and thorough investigation of the complaint, which may include interviewing the complaining party, responding party, and relevant witnesses. Review collected documents, exhibits or other evidence. Analyze the information, make credibility determinations when needed, reach reasonable conclusions based on the evidence collected, and make findings based on a preponderance of the evidence standard. ▪ If misconduct is found, recommend appropriate remedial measures, along with preventive and/or corrective action, when it is warranted, to department leadership. ▪ Timely inform the complainant of the conclusion of the investigation and any findings. ▪ Timely inform the responding party of the conclusion of the investigation, any findings, and the final decision, if applicable, of remedial measures or preventive and/or corrective action. ▪ HR will strive to maintain confidentiality during the investigation, but there is no guarantee of complete confidentiality. Only the parties who need to know shall be involved.

IV. ATTACHMENT(S)

A. Employee Complaint Intake Form

V. REFERENCE(S)

A. CalOptima Policy HH.1104: Complaints of Discrimination

B. California Government Code, §§12926, 12935, 12940 *et seq*, 12950, and 12950.1.
C. Title 2, California Code of Regulations (C.C.R.), §§11008 *et seq*., 11023, 11027.1(a) and (b), and 1030(a)-(f)
D. Title VII of the Civil Rights Act of 1964 (42, U.S.C., 2000e *et seq*.)
E. CA Labor Code §§230 and 230.1 Rights of Victims of Domestic Violence, Sexual Assault, and Stalking

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

Date	Meeting
01/05/2012	Regular Meeting of the CalOptima Board of Directors
05/01/2014	Regular Meeting of the CalOptima Board of Directors
11/03/2016	Regular Meeting of the CalOptima Board of Directors
09/06/2018	Regular Meeting of the CalOptima Board of Directors
TBD	Regular Meeting of the CalOptima Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	01/05/2012	GA.8027	Unlawful Harassment	Administrative
Revised	04/01/2014	GA.8027	Unlawful Harassment	Administrative
Revised	11/03/2016	GA.8027	Unlawful Harassment	Administrative
Revised	09/06/2018	GA.8027	Unlawful Harassment	Administrative
Revised	TBD	GA.8027	Anti-Harassment	Administrative

IX. GLOSSARY

Term	Definition
Discrimination	Unequal treatment of a person or group on the basis of a protected category.
Employee	Any and all employees of CalOptima, including all permanent and temporary employees, volunteers, and other employed personnel.
Gender Expression	A person's gender-related appearance or behavior, whether or not stereotypically associated with the person's sex assigned at birth.
Gender Identity	Each person's internal understanding of their gender, or the perceptions of a person's gender identity, which may include male, female, a combination of male and female, neither male nor female, a gender different from the person's sex assigned at birth, or transgender.
Harassment	Unwelcome verbal, written or physical conduct that denigrates or shows hostility or aversion toward an individual, based on a protected characteristic, that is so severe or pervasive as to create an intimidating, hostile, or offensive working environment.
National Origin	Includes, but is not limited to, the individual's or ancestors' actual or perceived: (1) physical, cultural, or linguistic characteristics associated with a national origin group; (2) marriage to or association with persons of a national origin group; (3) tribal affiliation; (4) membership in or association with an organization identified with or seeking to promote the interests of a national origin group; (5) attendance or participation in schools, churches, temples, mosques, or other religious institutions generally used by persons of a national origin group; (6) name that is associated with a national origin group; and (7) the basis of possessing a driver's license granted under Section 12801.9 of the Vehicle Code.
National Origin Group	Includes, but is not limited to, ethnic groups, geographic places of origin, and countries that are not presently in existence.
Retaliation	Adverse employment action against an Employee because the Employee filed a complaint or engaged in a protected activity.
Sex	Includes the same definition as provided in Government Code section 12926 and Title 42 of the United States Code section 2000 e(k), which includes, but is not limited to, pregnancy, childbirth, breastfeeding, medical conditions related to pregnancy, childbirth, or breastfeeding, gender, gender identity, and gender expression.
Sex Stereotype	Includes, but is not limited to, an assumption about a person's appearance or behavior, gender roles, gender expression, or gender identity, or about an individual's ability or inability to perform certain kinds of work based on a myth, social expectation, or generalization about the individual's sex.
Sexual Harassment	Harassment based on sex (including pregnancy, childbirth, breastfeeding, or related medical conditions, sex stereotype, gender, gender identity or gender expression) or conduct of a sexual nature.
Transgender	A general term that refers to a person whose gender identity differs from the person's sex assigned at birth. A transgender person may or may not have a gender expression that is different from the social expectations of the sex assigned at birth. A transgender person may or may not identify as "transsexual."

Term	Definition
Transitioning	A process some transgender people go through to begin living as the gender with which they identify, rather than the sex assigned to them at birth. This process may include, but is not limited to, changes in name and pronoun usage, facility usage, participation in employer-sponsored activities (*e.g.,* sports teams, team-building projects, or volunteering), or undergoing hormone therapy, surgeries, or other medical procedures.

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2

HUMAN RESOURCES

EMPLOYEE COMPLAINT INTAKE FORM

Complainant Name:		**Employee ID#:**	
Department:		**Contact #:**	
Supervisor:		**Today's Date:**	

WHAT IS THE SPECIFIC SITUATION THAT BROUGHT YOU TO CONTACT HUMAN RESOURCES TODAY? PLEASE INCLUDE INCIDENT AND DATE:
NAME(S) AND POSITION OF EMPLOYEE(S) CONTRIBUTING OR INVOLVED IN THE REPORTED INCIDENT:
GIVE SPECIFIC EXAMPLES OF THEIR BEHAVIOR/ACTIONS? PLEASE INCLUDE DATES AND LOCATION:

WHO ARE THE POTENTIAL WITNESSES TO THESE EVENTS? PLEASE PROVIDE NAME(S) AND POSITIONS:
DO YOU HAVE ANY DOCUMENTS OR OTHER EVIDENCE TO SUPPORT YOUR CLAIM(S)?
WHO IN YOUR LEADERSHIP TEAM HAVE YOU DISCUSSED THIS WITH?

ADDITIONAL INFORMATION YOU WOULD LIKE TO SHARE?

EMPLOYEE SIGNATURE TYPE-WRITTEN "SIGNATURE" ACCEPTED WHEN SUBMITTING FROM YOUR CALOPTIMA EMAIL:
DATE:

Please submit this form for review: employeerelations@caloptima.org

Policy:	GA.8036
Title:	**Education Reimbursement**
Department:	CalOptima Administrative
Section:	Human Resources
CEO Approval:	*/s/*
Effective Date:	01/05/2012
Revised Date:	TBD
Applicable to:	☐ Medi-Cal ☐ OneCare ☐ OneCare Connect ☐ PACE ☒ Administrative

I. PURPOSE

This policy describes CalOptima's pre-approval process for the educational reimbursement program established to offer repayment of reasonable educational and professional development expenses to eligible employees for work-related courses and/or programs, including courses offering credits towards professional licensure or certification requirements.

II. POLICY

A. CalOptima encourages and assists its employees to enhance their professional skills and knowledge through continued education in areas that will contribute to the improvement of their present job function, or potential advancement. Full-time and regular Part-Time employees who have completed their initial one-hundred-eighty (180) calendar days of continuous employment and are in Good Standing, are eligible to participate.

B. Courses eligible for education reimbursement must be either part of an accredited college degree program, or provided by credible institutions that meet the following conditions:

1. Educate the employee in concepts and methods in their present assignment; and/or

2. Help prepare the employee for advancement to other positions available within CalOptima.

Note: While continuing education courses that provide credit towards renewal of a licensure and/or certification may be eligible for reimbursement under this Policy, seminars, conferences, or business meetings that do not result in certification or credit towards a licensure and/or certification are not covered under this Policy. Seminars, conferences, and business meetings may be eligible for reimbursement through CalOptima's Travel and Training program. The costs of new or renewed licensures or certifications are not covered under this Policy. Separately, individual Departments may budget and pay for the costs of new and/or renewed licensures or certifications required for a job position if budgeted funds are available through the Department and at the discretion of the head of the Department.

C. An employee must submit a request in advance for both supervisor and Human Resources (HR) approval. CalOptima will reimburse eligible full-time employees for qualifying courses ~~that are part of an undergraduate or graduate degree program up to three~~ up to five thousand ~~five~~two hundred fifty dollars ($~~3,500~~5,250.00) per fiscal year for tuition expenses only. ~~For all other~~

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~~qualifying courses and programs that are not tied to an accredited college degree program,~~ CalOptima will reimburse eligible ~~full~~part-time employees ~~up to two thousand dollars ($2,000.00) per fiscal year and eligible Part-Time employees~~ for qualifying courses up to ~~one~~two thousand six hundred dollars ($~~1,000~~2,600.00) per fiscal year for tuition expenses only. Reimbursement for books, parking, exams, education subscriptions, and other miscellaneous fees are not covered under this policy. Reimbursement will not be made until the employee has successfully completed the course with a grade of "C" or better for undergraduate and graduate programs, a "Pass" for courses that are Pass/Fail, or a certificate of successful completion. Employees must still be employed at CalOptima after completing the course or program to qualify for reimbursement. No reimbursement shall be made for courses, or other programs, involving sports, games, or hobbies.

1. According to current Internal Revenue Service (IRS) guidelines, reimbursement of up to $5,250 per calendar year is not considered to be taxable earnings. Reimbursement that exceeds IRS Guidelines for a specific calendar year is considered taxable earnings and is subject to federal and state income and payroll tax withholdings in accordance with federal and state law. Employees are responsible for any tax liability arising from the receipt of education reimbursement under this policy.

D. Employees are required to manage time for classes outside of scheduled hours and classes must not interfere with their regular job duties.

E. As a condition of reimbursement and as part of an employee's request for education expense reimbursement, an employee must agree that if the employee voluntarily terminates employment with CalOptima within one year of the date of the completion of the course for which the employee has been reimbursed, the employee shall return a pro rata portion of such reimbursement to CalOptima by way of a deduction from the employee's last paycheck and/or submit payment directly to CalOptima, to the extent permitted by applicable state and federal laws.

F. Education reimbursement is provided in accordance with this Policy on a first-come, first-served basis, and only to the extent that budget funds are available. Annual maximum for education reimbursement is calculated for each fiscal year (July 1 – June 30). The education reimbursement program is not required to be funded.

III. PROCEDURE

Responsible Party	Action
Employee	1. Complete the Request for Education Expense Reimbursement form and submit to immediate supervisor prior to start of the course, or certification. a. Recommend submission no less than three (3) weeks prior to start date. ~~1.~~2. Declare major, or certification. ~~2.~~3. Obtain approval from direct supervisor and Director, or Chief, and submit completed form to HR. ~~3.~~4. Obtain notification from HR of preliminary approval, or denial, of request. a. Request form MUST be received prior to the start of the course in order to be considered. b. Applicant should allow sufficient time for review and preliminary approval prior to start of course or choose to continue to enroll with the understanding it may not be approved by HR. ~~4.~~5. Within sixty (60) calendar days of course completion, submit: a. Proof of completion – Transcript, or other official notification showing grades for each course, or a copy of the certification. b. A copy of the tuition receipt from the college, university, or certifying board. c. Proof of payment - Canceled check, credit card receipt, or cash receipt that clearly demonstrates the method of payment made by the employee. d. Additional documentation may be requested to verify eligibility.
Supervisor	1. Provide statement on the Form to confirm applicability of course and benefit to CalOptima. 2. Certify employee is in Good Standing with CalOptima and will complete the education outside scheduled hours. 3. Approve, or deny, request. 4. Forward to Director, or Chief.
Director/Chief	1. Approve, or deny, request. 2. Forward to HR.

Responsible Party	Action
Human Resources	1. Evaluate request for compliance with this Policy, and if applicable, provide preliminary approval. 2. Notify the employee if the request is approved or denied. 3. Hold form until proof of completion is submitted. ~~4.~~ Upon verification of satisfactory completion consistent with this Policy, ~~prepare check request~~follow Accounting current procedures for approval and payment of reimbursement. ~~5.~~ ~~Forward to the Accounting Department.~~ ~~6.~~4. ~~Issue payment check to employee upon receipt from Accounting.~~
Accounting	1. Issue reimbursement ~~check to HR~~payment.

IV. ATTACHMENT(S)

~~A. Education Expense Reimbursement Prior Authorization Request~~
Not applicable

V. REFERENCE(S)

A. CalOptima Employee Handbook
B. Title 26, United States Code, §127
Sample: Education Expense Reimbursement Prior Authorization Request
~~B.~~C.

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

Date	Meeting
10/05/2012	Regular Meeting of the CalOptima Board of Directors
06/04/2015	Regular Meeting of the CalOptima Board of Directors
02/02/2017	Regular Meeting of the CalOptima Board of Directors
02/07/2019	Regular Meeting of the CalOptima Board of Directors
12/20/2021	Special Meeting of the CalOptima Board of Directors
TBD	Regular Meeting of the CalOptima Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	01/05/2012	GA.8036	Education Reimbursement	Administrative
Revised	06/04/2015	GA.8036	Education Reimbursement	Administrative
Revised	02/02/2017	GA.8036	Education Reimbursement	Administrative
Revised	02/07/2019	GA.8036	Education Reimbursement	Administrative
Revised	12/20/2021	GA.8036	Education Reimbursement	Administrative

Action	Date	Policy	Policy Title	Program(s)
Revised	TBD	GA.8036	Education Reimbursement	Administrative

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IX. GLOSSARY

Term	Definition
Good Standing	The employee has at least a satisfactory level of performance on their most recent evaluation and has not received written corrective action within the last six (6) months.
Part-Time Employees	Employees that regularly work less than thirty (30) hours per week.

Policy:	GA.8036
Title:	**Education Reimbursement**
Department:	CalOptima Administrative
Section:	Human Resources
CEO Approval:	*/s/*
Effective Date:	01/05/2012
Revised Date:	TBD
Applicable to:	☐ Medi-Cal ☐ OneCare ☐ OneCare Connect ☐ PACE ☒ Administrative

I. PURPOSE

This policy describes CalOptima's pre-approval process for the educational reimbursement program established to offer repayment of reasonable educational and professional development expenses to eligible employees for work-related courses and/or programs, including courses offering credits towards professional licensure or certification requirements.

II. POLICY

A. CalOptima encourages and assists its employees to enhance their professional skills and knowledge through continued education in areas that will contribute to the improvement of their present job function, or potential advancement. Full-time and regular Part-Time employees who have completed their initial one-hundred-eighty (180) calendar days of continuous employment and are in Good Standing, are eligible to participate.

B. Courses eligible for education reimbursement must be either part of an accredited college degree program, or provided by credible institutions that meet the following conditions:

1. Educate the employee in concepts and methods in their present assignment; and/or

2. Help prepare the employee for advancement to other positions available within CalOptima.

Note: While continuing education courses that provide credit towards renewal of a licensure and/or certification may be eligible for reimbursement under this Policy, seminars, conferences, or business meetings that do not result in certification or credit towards a licensure and/or certification are not covered under this Policy. Seminars, conferences, and business meetings may be eligible for reimbursement through CalOptima's Travel and Training program. The costs of new or renewed licensures or certifications are not covered under this Policy. Separately, individual Departments may budget and pay for the costs of new and/or renewed licensures or certifications required for a job position if budgeted funds are available through the Department and at the discretion of the head of the Department.

C. An employee must submit a request in advance for both supervisor and Human Resources (HR) approval. CalOptima will reimburse eligible full-time employees for qualifying courses up to five thousand two hundred fifty dollars ($5,250.00) per fiscal year for tuition expenses only. CalOptima will reimburse eligible part-time employees for qualifying courses up to two thousand six hundred

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dollars ($2,600.00) per fiscal year for tuition expenses only. Reimbursement for books, parking, exams, education subscriptions, and other miscellaneous fees are not covered under this policy. Reimbursement will not be made until the employee has successfully completed the course with a grade of "C" or better for undergraduate and graduate programs, a "Pass" for courses that are Pass/Fail, or a certificate of successful completion. Employees must still be employed at CalOptima after completing the course or program to qualify for reimbursement. No reimbursement shall be made for courses, or other programs, involving sports, games, or hobbies.

1. According to current Internal Revenue Service (IRS) guidelines, reimbursement of up to $5,250 per calendar year is not considered to be taxable earnings. Reimbursement that exceeds IRS Guidelines for a specific calendar year is considered taxable earnings and is subject to federal and state income and payroll tax withholdings in accordance with federal and state law. Employees are responsible for any tax liability arising from the receipt of education reimbursement under this policy.

D. Employees are required to manage time for classes outside of scheduled hours and classes must not interfere with their regular job duties.

E. As a condition of reimbursement and as part of an employee's request for education expense reimbursement, an employee must agree that if the employee voluntarily terminates employment with CalOptima within one year of the date of the completion of the course for which the employee has been reimbursed, the employee shall return a pro rata portion of such reimbursement to CalOptima by way of a deduction from the employee's last paycheck and/or submit payment directly to CalOptima, to the extent permitted by applicable state and federal laws.

F. Education reimbursement is provided in accordance with this Policy on a first-come, first-served basis, and only to the extent that budget funds are available. Annual maximum for education reimbursement is calculated for each fiscal year (July 1 – June 30). The education reimbursement program is not required to be funded.

III. PROCEDURE

Responsible Party	Action
Employee	1. Complete the Request for Education Expense Reimbursement form and submit to immediate supervisor prior to start of the course, or certification. a. Recommend submission no less than three (3) weeks prior to start date. 2. Declare major, or certification. 3. Obtain approval from direct supervisor and Director, or Chief, and submit completed form to HR. 4. Obtain notification from HR of preliminary approval, or denial, of request. a. Request form MUST be received prior to the start of the course in order to be considered. b. Applicant should allow sufficient time for review and preliminary approval prior to start of course or choose to continue to enroll with the understanding it may not be approved by HR. 5. Within sixty (60) calendar days of course completion, submit: a. Proof of completion – Transcript, or other official notification showing grades for each course, or a copy of the certification. b. A copy of the tuition receipt from the college, university, or certifying board. c. Proof of payment - Canceled check, credit card receipt, or cash receipt that clearly demonstrates the method of payment made by the employee. d. Additional documentation may be requested to verify eligibility.
Supervisor	1. Provide statement on the Form to confirm applicability of course and benefit to CalOptima. 2. Certify employee is in Good Standing with CalOptima and will complete the education outside scheduled hours. 3. Approve, or deny, request. 4. Forward to Director, or Chief.
Director/Chief	1. Approve, or deny, request. 2. Forward to HR.

Responsible Party	Action
Human Resources	1. Evaluate request for compliance with this Policy, and if applicable, provide preliminary approval. 2. Notify the employee if the request is approved or denied. 3. Hold form until proof of completion is submitted. 4. Upon verification of satisfactory completion consistent with this Policy, follow Accounting current procedures for approval and payment of reimbursement.
Accounting	1. Issue reimbursement payment.

IV. ATTACHMENT(S)

Not applicable

V. REFERENCE(S)

A. CalOptima Employee Handbook
B. Title 26, United States Code, §127
C. Sample: Education Expense Reimbursement Prior Authorization Request

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

Date	Meeting
10/05/2012	Regular Meeting of the CalOptima Board of Directors
06/04/2015	Regular Meeting of the CalOptima Board of Directors
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TBD	Regular Meeting of the CalOptima Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	01/05/2012	GA.8036	Education Reimbursement	Administrative
Revised	06/04/2015	GA.8036	Education Reimbursement	Administrative
Revised	02/02/2017	GA.8036	Education Reimbursement	Administrative
Revised	02/07/2019	GA.8036	Education Reimbursement	Administrative
Revised	12/20/2021	GA.8036	Education Reimbursement	Administrative
Revised	TBD	GA.8036	Education Reimbursement	Administrative

IX. GLOSSARY

Term	Definition
Good Standing	The employee has at least a satisfactory level of performance on their most recent evaluation and has not received written corrective action within the last six (6) months.
Part-Time Employees	Employees that regularly work less than thirty (30) hours per week.

Policy:	GA.8042
Title:	**Supplemental Compensation**
Department:	CalOptima Administrative
Section:	Human Resources
CEO Approval:	*/s/*
Effective Date:	01/01/2011
Revised Date:	TBD

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

I. PURPOSE

This policy establishes general guidelines concerning the use of supplemental compensation above regular base pay to compensate for business needs and to identify items to be reported to CalPERS as "Special Compensation."

II. POLICY

A. CalOptima considers the following as Special Compensation pursuant to Title 2, Section 571 of the California Code of Regulations (CCR):

1. Bilingual Pay/Bilingual Premium;
2. Holiday Premium Pay;
3. Night Shift Premium/Shift Differential;
4. Active Certified Case Manager (CCM) Pay/Educational Incentive; and
5. Executive Incentive Program/Bonus Pay.

B. Overtime Pay: As a public agency, CalOptima follows Federal wage and hour laws. Overtime pay for non-exempt employees will be provided for all ~~hours~~time worked in excess of forty (40) in any one (1) ~~workweek~~ federal Fair Labor Standards Act (FLSA) Workweek at the rate of one and one half (1.5) times the employee's regular rate of pay, as defined by ~~the federal Fair Labor Standards Act (FLSA).~~FLSA. Employees should obtain prior authorization from their supervisors or managers prior to working overtime or incurring overtime pay. Exempt employees are not covered by the overtime provisions and do not receive overtime pay.

C. Holiday Premium Pay: All regular, non-exempt, full-time employees who are eligible for paid holidays but who may be required to work on a holiday observed by CalOptima under GA.8056 Paid Holidays will be paid at two (2) times their regular base pay for the hours worked in addition to the holiday pay. Flex Holiday is not eligible for Holiday Premium Pay. This is considered Holiday

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Pay pursuant to Title 2, CCR, Section 571(a) and is to be reported to CalPERS as Special Compensation.

D. Bilingual Pay: CalOptima provides supplemental bilingual pay for qualified exempt and non-exempt employees who are fluent in at least one (1) of CalOptima's threshold languages. This is considered a Bilingual Premium pursuant to Title 2, CCR, Section 571(a) and is to be reported to CalPERS as Special Compensation. The rate for Bilingual Pay is based on the following schedule:

Proficiency	Rate Per Pay Period
Bilingual language usage with members is required in the job description and used more than fifty percent (50%) of the time in the performance of the employee's job duties.	$60.00
Bilingual language usage with members is preferred in the job description and used less than fifty percent (50%) of the time in the performance of the employee's job duties.	$40.00

E. Translation Pay: In certain circumstances when, for business reasons and for the benefit of CalOptima members, there is a need to translate documents and other written material into languages other than English, the Exempt Employee providing such service will be paid supplemental pay. Non-exempt employees are not eligible for translation pay.

1. Exempt Employees, who do not work in the Cultural & Linguistic Services Department (C&L) and who are not required as part of their regular job responsibilities to translate but are qualified to translate based on successfully passing the CalOptima Bilingual Screening Process, may be eligible for translation pay for performing translation work. Eligible employees, who are interested in performing translation work during non-work hours, may elect to provide translation services during their own personal time based on the rates indicated below. The C&L Department shall assign the work to qualified Exempt Employees on an occasional, as-needed basis.

2. There are two (2) key activities in providing translation services:

   a. Translation of materials from English into the desired language, or from another language into English; and

   b. Review and revision of the translation to ensure quality and consistency in usage of terms.

3. Translating is more difficult and time-consuming than reviewing and editing of the already translated materials, and as a result, translation of materials will be reimbursed at a higher rate. CalOptima will reimburse for services at the following rates:

   a. Translation – Thirty-five dollars ($35.00) per page; and

   b. Review and revision of translated materials – Twenty-five dollars ($25.00) per page.

4. The use of this supplemental pay is limited to situations where the use of professional translation services is either not available or unfeasible due to business constraints.

F. Night Shift: CalOptima provides supplemental pay for work performed as part of a Night Shift. Assignments for Night Shift are subject to business needs and are at the discretion of CalOptima management. This is considered a Shift Differential pursuant to Title 2, CCR, Section 571(a) and is to be reported to CalPERS as Special Compensation. The rate for Night Shift is based on the following schedule:

Definition	Eligibility	Rates (per hour)
Night Shift – Seven (7) consecutive hours or more of work between 3 p.m. and 8 a.m.	Non-exempt employees	$2.00 per hour.

G. Call Back and On Call: CalOptima provides supplemental pay for work performed as part of a Call Back and On Call requirement. Assignments for Call Back and On Call are subject to business needs and are at the discretion of CalOptima management. The rates for Call Back and On Call Pay are based on the following schedule:

Definition	Eligibility	Rates (per hour)
Call Back – Employees must physically return to work within one (1) hour when requested by a Supervisor. A Supervisor may assign employees other work until the guaranteed four (4) hour time elapses.	Non-exempt employees	One and one half (1.5) times of regular base pay with a minimum of four (4) hours of pay.
On Call – Employees must remain accessible after normally scheduled work hours and be available to fix problems or report to work, if necessary. Employees will be informed of the need for their availability to work either from home or at the work site. Employees on call are waiting to be engaged and are free to use their On Call time as they deem appropriate, so long as they are fit to respond when called. Employees must respond within one (1) hour, as required.	Non-exempt employees	$3.00 per hour for being on-call. If a call is taken, employee is paid one and one half (1.5) times the regular base pay with a thirty (30) minute minimum call.
On Call Medical Case Managers (RN or LVN) and Clinical Pharmacists - Must remain accessible to accept or respond to calls within a reasonable time designated by employee's supervisors. In no event shall employees' supervisors require a response time less than thirty (30) minutes. Employees will be informed of the need for their availability to work either from home or at the work site. Employees on call are waiting to be engaged and are free to use their On Call time as they deem appropriate, so long as they are fit to respond when called.	Exempt Employees, excluding those in supervisory positions	Twenty five percent (25%) of the employee's base pay as an hourly equivalent multiplied by the number of hours on call.

H. Commuter Allowance: Effective April 24, 2022 through July 1, 2023, CalOptima shall provide a Commuter Allowance in an amount of one hundred fifty dollars ($150.00) per pay period to full-time employees designated as Full Office Workers, and seventy-five dollars ($75.00) per pay period to full-time employees designated as Partial Teleworkers. The Commuter Allowance begins the first full pay period as a Full Office Worker or Partial Teleworker. Eligible full-time employees will continue to receive the Commuter Allowance until the first full pay period in which an employee is not assigned to partial telework or full office work. The Commuter Allowance will be provided only for full pay periods in which employees are designated a Full Office Worker or Partial Teleworker and will not be prorated for being designated as a Full Office Worker or Partial Teleworker for a portion of the pay period. Executive Level Positions and Full Teleworkers are not eligible for the Commuter Allowance. With approval of the Chief Executive Officer, the Commuter Allowance may continue beyond July 1, 2023, and/or be reinstated after July 1, 2023.

I. Internet Stipend: CalOptima shall provide an Internet Stipend in an amount of twenty-five dollars ($25.00) per pay period to full-time employees designated as Full Teleworkers, Partial Teleworkers or Community Workers. The Internet Stipend begins the first full pay period as a Full or Partial Teleworker or Community Worker. Eligible full-time employees will continue to receive the stipend until the first, full pay period in which an employee is not assigned to full or partial telework or community work. The Internet Stipend will be provided only for full pay periods and will not be prorated for a change in designation for a portion of a pay period. Executive Level Positions and Full Office Workers are not eligible for the Internet Stipend.

~~I.~~J. Active Certified Case Manager (CCM) Pay: CalOptima may recognize supplemental pay of one hundred dollars ($100.00) per pay period to an RN who holds an active CCM certification when such certification is required or preferred in the job description and used regularly in performance of the employee's job duties. This is considered as an Educational Incentive pursuant to Title 2 CCR Section 571(a) and is to be reported to CalPERS as Special Compensation.

~~J.~~K. Executive Incentive Program: The Chief Executive Officer (CEO) may recognize Executive Level Positions, including interim appointments, using incentive compensation as described in this Policy. For employees in Executive Level Positions who achieve outstanding performance, the incentive compensation is considered bonus pay pursuant to Title 2 CCR Section 571(a) and is to be reported to CalPERS as Special Compensation for CalPERS classic members.

~~K.~~L. Sales Incentive Program: The OneCare/OneCare Connect Community Partner and Senior (Sr.) Community Partner staff in the Member Outreach & Education Department shall have an active Resident Insurance Producer license to enroll eligible members into the OneCare and OneCare Connect programs.

1. The licensed Community Partner and Sr. Community Partner staff will receive a monthly Sales Incentive based on the number of eligible members enrolled into the OneCare and OneCare Connect program in accordance with the table in Paragraph II.I.2. below. No incentive will be paid for the first thirty (30) enrollments each month, regardless of how many enrollments are made under, at or over thirty (30). For enrollments over thirty (30), licensed Community Partner and Sr. Community Partner staff will be eligible to receive the incentive payment of one hundred sixty-five dollars ($165.00) for each new enrollment within that tier between thirty-one (31) – fifty (50). In other words, each tier is independent and does not alter the amount paid per enrollment in any other tier. For example, eligible staff who enroll fifty-three (53) members in a month will be eligible to receive payment based on the following calculation (from tier thirty-one (31) – fifty(50)) twenty (20) members multiplied by one hundred sixty-five dollars ($165), plus (from tier fifty-one (51) – sixty-five (65)) three (3) members multiplied by one hundred seventy-five ($175), which equals an incentive of three thousand eight hundred twenty-five dollars ($3,825) for that month.

2. Enrollment is paid per eligible member above the minimum tier at the rate specified within each tier as follows:

Tier Min	Tier Max	Payout for Enrollment within Each Tier
1	30	**$0.00**
31	50	**$165.00**
51	65	**$175.00**
66+		**$200.00**

3 The sales incentive for the Manager, Member Outreach & Education shall be based on the number of eligible members enrolled into the OneCare and OneCare Connect programs by the

Community Partner and Sr. Community Partner in the Member Outreach & Education Department. The Manager, Member Outreach & Education will receive ten dollars ($10.00) per member enrolled, if and only if, the Community Partner or Sr. Community Partner reporting to the Manager, Member Outreach & Education, enrolls thirty-six (36) or more members per month. If a Community Partner or Sr. Community Partner fails to enroll at least thirty-six (36) members per month, the Manager, Member Outreach & Education, would not be eligible for the sales incentive for that Community Partner or Sr. Community Partner.

~~L.~~M. Employee Incentive Program: At the discretion of the CEO, specific employees may be recognized through incentive compensation, when doing so is consistent with CalOptima's business needs and mission, vision, and values.

~~M.~~N. Retention Incentive: In order to preserve organizational talent and to maintain business continuity when the loss of key personnel may cause risk or damage to operational efficiency, regulatory compliance, and/or strategic imperatives, CalOptima may, at the discretion of the CEO, and on an exception basis, award a retention incentive.

~~N.~~O. Recruitment Incentive: At the discretion of the CEO, a recruitment incentive of up to fifteen percent (15%) of the midpoint of base pay for the applicable position may be offered to entice an individual to join CalOptima. Recruitment incentives offered for Executive Director and Chief positions, to a maximum of $50,000, require informing the Board of Directors after approved.

~~O.~~P. Incentive programs may be modified or withdrawn, at any time. An award of incentive compensation is entirely at the discretion of the CEO and/or Board of Directors, as applicable. It is not intended to be a binding contract between Executive Level Positions or employees and CalOptima.

~~P.~~Q. Employer-Paid Member Contribution (EPMC): CalOptima contributes seven percent (7%) of compensation earnable, on behalf of eligible employees who hold management staff positions as identified in the CalOptima salary schedule, and who qualify based on all of the following:

1. Hired, promoted, or transferred into a management staff position, including interim appointments; and

2. Included in one (1) of the following categories:

   a. A CalPERS Classic Member; or

   b. A member prior to January 1, 2013, of another California public retirement system that is eligible for reciprocity with CalPERS.

~~Q.~~R. Annual Performance Lump Sum Bonus: Employees paid at or above the pay range maximum are not eligible for future base pay increases. As a result, in lieu of future base pay increases, these employees may be eligible for merit bonus pay delivered as a lump sum bonus in accordance with Section III.J of this Policy, provided that their performance meets the goals and objectives set forth by their managers.

~~R.~~S. Automobile Allowance: CalOptima may, at the discretion of the CEO, provide employees in Executive Level Positions, including interim appointments, with a monthly automobile allowance in an amount not to exceed five hundred dollars ($500.00) for the use of their personal vehicle for CalOptima business.

~~S.~~T. Supplemental Retirement Benefit: Consistent with applicable Board actions, the CEO is authorized to determine CalOptima's contribution rate for employees to the supplemental retirement benefit (SRB) plan administered by the Public Agency Retirement System (PARS) within the limits of the budget and subject to contribution limits established by applicable laws. With the exception of employees in Executive Level Positions, the contribution rate shall be uniform for all employees. Executive Level Positions will also receive the same uniform contribution rate applicable to all employees. However, for employees in Executive Level Positions who earn more than the applicable compensation limits, the CEO is authorized to provide additional supplemental contributions to PARS, subject to the limitations of applicable laws. An employee in an Executive Level Position must still be employed by CalOptima at the time the additional supplemental contribution to PARS is distributed in order to be eligible to receive the additional supplemental contributions. These SRB contributions to the PARS retirement plan shall continue from year to year, unless otherwise adjusted or discontinued.

III. PROCEDURE

A. Overtime Pay: Overtime must be approved in advance by an employee's manager. Adjustments for overtime pay cannot be calculated until the completion of an employee's workweek. This may result in one (1) pay period's delay in the employee receiving the additional compensation.

B. Holiday Premium Pay: Working on a CalOptima observed holiday must be approved in advance by the employee's manager. Unauthorized work that occurs on an observed holiday is not eligible for Holiday Premium Pay and will be paid at the employee's regular base pay~~. Holiday Premium Pay is not to be considered~~. Actual hours worked ~~in the computation~~on a holiday will be used for purposes of calculating overtime.

C. Bilingual Pay: An employee or potential employee shall undergo a written and verbal bilingual evaluation when bilingual proficiency is a part of the employee's or potential employee's job description and used in the performance of the employee's job duties with members. If the employee or potential employee passes the evaluations, the bilingual pay shall be established.

D. Translation Pay: If an eligible exempt employee elects to provide translation services, and such services are not part of the employee's regular job duties, the employee shall submit their interest to the C&L Department. If selected, the translation pay identified above, will be provided depending on the variables noted above, taking into account whether professional translation services are either not available or unfeasible due to business constraints.

E. Night Shift:

1. Night Shift differential is automatically calculated for those employees regularly working a night shift, defined as seven (7) consecutive hours or more of work between 3 p.m. and 8 a.m.

2. Employees who, at their own request and for their own convenience, adjust their work schedule, such as requesting make up time or alternative hours, and as a result, would be eligible for night shift pay, shall be deemed as having waived their right to same. When appropriate, a new Action Form should be submitted, removing the employee from the night shift.

F. Call Back and On Call Pay:

1. If employees are on call or get called back to work, the employees are responsible for adding this time to their schedules through CalOptima's time keeping system, which is then approved by their supervisors.

G. Commuter Allowance

1. Commuter Allowance is automatically calculated for eligible employees based on system designation of Full Office Worker or Partial Teleworker. Employees and leaders are responsible for maintaining accurate designations in the timekeeping system. Designation changes require a request and approval per the Telework Program Guidelines. CalOptima may periodically audit and validate employee Office/Telework designations.

H. Internet Stipend

1. Internet Stipend is automatically calculated for eligible employees based on system designation of Full Teleworker, Partial Teleworker, or Community Worker. Employees and leaders are responsible for maintaining accurate designations in the timekeeping system. Telework designation changes require a request and approval per the Telework Program Guidelines. Community Worker designation is determined by the position. CalOptima may periodically audit and validate employee Office/Telework designations.

~~H.~~I. Active Certified Case Manager (CCM) Pay:

1. To receive CCM supplemental pay, an employee is responsible for providing a copy of the employee's case management certification issued by the Case Management Society of America to the Human Resources Department.

~~I.~~J. Incentive Compensation

1. The Board of Directors approves CalOptima's strategic plan for each fiscal year, and the CEO is expected to meet the goals set forth in the strategic plan. The CEO in turn sets goals for the Executive Level Positions.

2. The CEO may establish an incentive compensation program for Executive Level Positions based on the Executive Incentive Program attached within budgeted parameters in accomplishing specific results according to the department and individual goals set forth by the CEO and the level of achievement. Executive Level Positions will receive a performance evaluation based on the Performance Review of Executives Template attached, which measures their performance against the established goals. Based on the level of performance, the executive staff member may be eligible for a lump sum bonus payment. The executive staff member must still be employed by CalOptima and in good standing at the time the bonus is distributed in order to be eligible to receive the bonus payment. For eligible Executive Level Positions who achieve outstanding performance, CalOptima will report the bonus payment to CalPERS as Special Compensation. The CEO is authorized to make minor revisions to the Executive Incentive Program and Performance Review of Executives Template from time to time, as appropriate.

3. As circumstances warrant and at the discretion of the CEO, employees not in Executive Level Positions, whose accomplishments have provided extraordinary results, may be considered for incentive compensation.

~~J.~~K. Sales Incentive Program

1. The OneCare/OneCare Connect Community Partner and Sr. Community Partner staff, in the Member Outreach & Education Department, shall have an active Resident Insurance Producer license to enroll eligible members into the OneCare and OneCare Connect Programs.

2. The Community Partner and Sr. Community Partner staff shall be eligible to receive sales incentive pay as described in Section II.I.1 of this Policy for successfully enrolling new members into the OneCare and OneCare Connect Programs. Sales incentive pay for the Manager, Member Outreach & Education, shall be based on the number of members enrolled into the OneCare and OneCare Connect Programs by the Community Partner and Sr. Community Partner as described in Section II.I.2 of this Policy.

    a. CalOptima shall follow the Medicare Marketing Guidelines (MMGs) charge-back guidelines of ninety (90) calendar day rapid disenrollment and recouping the sales incentive with the exceptions as specified under the guidelines and applicable CalOptima policies.

3. CalOptima shall advance the sales incentive to the eligible employee on a monthly basis approximately one and a half (1 ½) months after the month in which the eligible employee enrolled the new member. However, the sales incentive is not earned until the member has been enrolled in the respective program for ninety-one (91) days.

    a. In the event a OneCare or OneCare Connect member disenrolls from their respective program within ninety (90) calendar days for reasons other than the exceptions specified under the guidelines and applicable CalOptima policies, the sales incentive previously paid will be deducted from a future sales incentive.

4. The Chief Operating Officer, Executive Director of Network Operations, and Director Network Management who oversee the Member Outreach & Education Department shall approve the sales incentive payout.

5. Enrollment goals for the Community Partner and Community Partner Sr. staff will be pro-rated for the month if the employee misses one (1) or more full weeks due to vacations, sick days, or a leave of absence.

6. The Director, Network Management, Executive Director of Network Operations, and the Chief Operations Officer will review the sales incentive structure on an annual basis.

~~K.~~L. Retention Incentive: As circumstances warrant, the CEO may award an employee a retention incentive to prevent or delay departures that may adversely impact business operations. The employee offered a retention incentive must be in good standing and accept and sign a retention agreement which contains the condition(s) to be met ~~in order~~ to receive payment. Payment of the incentive will be made when the terms of the agreement have been fully met and at the conclusion of the retention period. The CEO has the authority to offer retention incentives for up to twenty-five (25) employees per fiscal year in an amount not to exceed twenty ~~-~~percent (20%) of the employee's current base annual salary. Retention incentives that exceed twenty~~-~~ percent (20%) of the employee's current base annual salary require Board of Directors approval.

~~L.~~M. Recruitment Incentive: As circumstances warrant, the CEO may offer a recruitment incentive based on the Compensation Administration Guidelines managed by the Human Resources Department to entice an individual to join CalOptima. Board of Director approval is required for recruitment incentives offered for Executive Level Positions. ~~In order to~~To receive the recruitment incentive, the individual offered the incentive is required to accept and sign an offer letter which contains a "claw-back" provision obligating the recipient of a recruitment incentive to return the full amount of the recruitment incentive if the recipient voluntarily terminates employment with CalOptima within twenty-four (24) months of the date of hire.

~~M.~~N. Annual Performance Lump Sum Bonus: Once employees have reached the pay range maximum, employees may be eligible for merit bonus pay delivered as a lump sum bonus, provided that their annual performance evaluations meet the established goals and objectives set forth by their managers. Merit bonus pay will not exceed the maximum percentage of the merit increase matrix and reflects employees' superior performance measured against established objectives. Annual performance lump sum bonuses are paid out in two (2) incremental amounts – the first half when merit salary increases are normally distributed and the second half six (6) months later. The employee must still be employed by CalOptima ~~in order~~ to be eligible to receive the lump sum bonus payments.

~~N.~~O. Automobile Allowance: As circumstances warrant, the CEO may offer employees in Executive Level Positions an automobile allowance in lieu of the IRS standard mileage reimbursement rate that would otherwise apply for the use of their personal vehicle in the performance of their duties. Such automobile allowance will be identified on the employees' W-2 forms as taxable income. In addition, as a condition of receiving such allowance, the employee must comply with the following requirements:

1. Maintain adequate levels of personal vehicle insurance coverage;
2. Purchase their own fuel for the vehicle; and
3. Ensure the vehicle is properly maintained.

IV. ATTACHMENT(S)

A. Executive Incentive Program
B. Performance Review of Executives Template

V. REFERENCE(S)

A. CalOptima Employee Handbook
B. Compensation Administration Guidelines
C. Government Code, §20636 and 20636.1
D. Telework Program Guidelines
~~D.~~E. Title 2, California Code of Regulations (CCR), §571

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

Date	Meeting
01/05/2012	Regular Meeting of the CalOptima Board of Directors
05/01/2014	Regular Meeting of the CalOptima Board of Directors
12/03/2015	Regular Meeting of the CalOptima Board of Directors
09/07/2017	Regular Meeting of the CalOptima Board of Directors
06/07/2018	Regular Meeting of the CalOptima Board of Directors
02/07/2019	Regular Meeting of the CalOptima Board of Directors
04/02/2020	Regular Meeting of the CalOptima Board of Directors
04/07/2022	Regular Meeting of the CalOptima Board of Directors
TBD	Regular Meeting of the CalOptima Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	01/01/2011	GA.8042	Pay Differentials	Administrative
Revised	01/05/2012	GA.8042	Pay Differentials	Administrative
Revised	05/20/2014	GA.8042	Supplemental Compensation	Administrative
Revised	12/03/2015	GA.8042	Supplemental Compensation	Administrative
Revised	09/07/2017	GA.8042	Supplemental Compensation	Administrative
Revised	06/07/2018	GA.8042	Supplemental Compensation	Administrative
Revised	02/07/2019	GA.8042	Supplemental Compensation	Administrative
Revised	04/02/2020	GA.8042	Supplemental Compensation	Administrative
Revised	04/07/2022	GA.8042	Supplemental Compensation	Administrative
Revised	TBD	GA.8042	Supplemental Compensation	Administrative

IX. GLOSSARY

Term	Definition
Bilingual Certified Employee	An employee who has passed CalOptima's Bilingual Screening Process either upon hire or any time during their employment.
Bilingual Screening Process	Prospective staff translators are identified by Cultural and Linguistic (C&L) Services Department based on qualifications obtained through CalOptima's bilingual screening process. The screening is either conducted as part of their initial hiring process or later during their employment. All staff translators must possess a strong ability to read, write and understand the target language. Once identified as potential staff translators, they are required to take a proficiency test created by C&L Services Department. They are evaluated on their vocabulary, grammar, orthography, flow, accuracy, cultural sensitivity, as well as consistency in usage of translated terms. The selection is based on their overall score.
Bonus Pay	Compensation to employees for superior performance such as "annual performance bonus" and "merit pay." If provided only during a member's final compensation period, it shall be excluded from final compensation as "final settlement" pay. A program or system must be in place to plan and identify performance goals and objectives to count as Special Compensation for CalPERS purposes.
CalPERS	California Public Employees Retirement System
CalPERS Classic Member	A member enrolled in CalPERS prior to January 1, 2013.
Classic Director	A Management Staff who is either a CalPERS Classic Member or a member prior to January 1, 2013, of another California public retirement system who is eligible for reciprocity with CalPERS.
Classic Executive	An Executive Staff who is either a CalPERS Classic Member or a member prior to January 1, 2013, of another California public retirement system who is eligible for reciprocity with CalPERS.
Compensation Earnable	The pay rate and Special Compensation as defined in Government Code sections 20636 and 20636.1.
Central Worksite	CalOptima's primary physical location of business applicable to the employee, which is either CalOptima's administration building at 505 City Parkway West, the PACE building or other CalOptima operated location.
Community Worker	An employee in a position that performs fifty-one percent (51%) or more of their duties in field locations such as provider offices, members' homes, and at community outreach events.~~designated to work primarily in the field.~~
Executive Level Position	The position of Executive Director or above.
Exempt Employee	Employees who are exempt from the overtime provisions of the federal Fair Labor Standards Act (FLSA) and state regulations governing wages and salaries. Exempt status is determined by the duties and responsibilities of the position and is defined by Human Resources for each position.
Full Office Worker	An employee who is assigned to work their full schedule at the Central Worksite.
Full Teleworker	An eligible employee who is approved to routinely work their entire regularly scheduled work hours from a Remote Work Location unless business needs require otherwise.
Leave of Absence (LOA)	A term used to describe a scheduled period of time off longer than five (5) days that employees are to be away from their primary jobs, while maintaining the status of employee.

Term	Definition
Management Staff	Staff holding positions at or above Director level.
Partial Teleworker	An eligible employee who is approved to work a pre-established consistent weekly work schedule split between two (2) or more full days per week at the Central Worksite, and the remainder of full days at the Remote Work Location.
Sales Incentive	An amount of money paid, in addition to base pay, to an employee for successfully enrolling a member into the OneCare or/ OneCare Connect Program.
Special Compensation	Payment of additional compensation earned separate from an employee's base pay that meets the criteria listed in Title 2, California Code of Regulations (CCR) section 571(a).
Threshold Language	For purposes of this policy, a threshold language as defined by the Centers for Medicare & Medicaid Services (CMS) for Medicare programs, or Department of Health Care Services for the Medi-Cal program.

1

Policy:	GA.8042
Title:	**Supplemental Compensation**
Department:	CalOptima Administrative
Section:	Human Resources
CEO Approval:	*/s/*
Effective Date:	01/01/2011
Revised Date:	TBD
Applicable to:	☐ Medi-Cal ☐ OneCare ☐ OneCare Connect ☐ PACE ☒ Administrative

I. PURPOSE

This policy establishes general guidelines concerning the use of supplemental compensation above regular base pay to compensate for business needs and to identify items to be reported to CalPERS as "Special Compensation."

II. POLICY

A. CalOptima considers the following as Special Compensation pursuant to Title 2, Section 571 of the California Code of Regulations (CCR):

1. Bilingual Pay/Bilingual Premium;
2. Holiday Premium Pay;
3. Night Shift Premium/Shift Differential;
4. Active Certified Case Manager (CCM) Pay/Educational Incentive; and
5. Executive Incentive Program/Bonus Pay.

B. Overtime Pay: As a public agency, CalOptima follows Federal wage and hour laws. Overtime pay for non-exempt employees will be provided for all time worked in excess of forty (40) in any one (1) federal Fair Labor Standards Act (FLSA) Workweek at the rate of one and one half (1.5) times the employee's regular rate of pay, as defined by FLSA. Employees should obtain prior authorization from their supervisors or managers prior to working overtime or incurring overtime pay. Exempt employees are not covered by the overtime provisions and do not receive overtime pay.

C. Holiday Premium Pay: All regular, non-exempt, full-time employees who are eligible for paid holidays but who may be required to work on a holiday observed by CalOptima under GA.8056 Paid Holidays will be paid at two (2) times their regular base pay for the hours worked in addition to the holiday pay. Flex Holiday is not eligible for Holiday Premium Pay. This is considered Holiday

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Pay pursuant to Title 2, CCR, Section 571(a) and is to be reported to CalPERS as Special Compensation.

D. Bilingual Pay: CalOptima provides supplemental bilingual pay for qualified exempt and non-exempt employees who are fluent in at least one (1) of CalOptima's threshold languages. This is considered a Bilingual Premium pursuant to Title 2, CCR, Section 571(a) and is to be reported to CalPERS as Special Compensation. The rate for Bilingual Pay is based on the following schedule:

Proficiency	Rate Per Pay Period
Bilingual language usage with members is required in the job description and used more than fifty percent (50%) of the time in the performance of the employee's job duties.	$60.00
Bilingual language usage with members is preferred in the job description and used less than fifty percent (50%) of the time in the performance of the employee's job duties.	$40.00

E. Translation Pay: In certain circumstances when, for business reasons and for the benefit of CalOptima members, there is a need to translate documents and other written material into languages other than English, the Exempt Employee providing such service will be paid supplemental pay. Non-exempt employees are not eligible for translation pay.

1. Exempt Employees, who do not work in the Cultural & Linguistic Services Department (C&L) and who are not required as part of their regular job responsibilities to translate but are qualified to translate based on successfully passing the CalOptima Bilingual Screening Process, may be eligible for translation pay for performing translation work. Eligible employees, who are interested in performing translation work during non-work hours, may elect to provide translation services during their own personal time based on the rates indicated below. The C&L Department shall assign the work to qualified Exempt Employees on an occasional, as-needed basis.

2. There are two (2) key activities in providing translation services:

   a. Translation of materials from English into the desired language, or from another language into English; and

   b. Review and revision of the translation to ensure quality and consistency in usage of terms.

3. Translating is more difficult and time-consuming than reviewing and editing of the already translated materials, and as a result, translation of materials will be reimbursed at a higher rate. CalOptima will reimburse for services at the following rates:

   a. Translation – Thirty-five dollars ($35.00) per page; and

   b. Review and revision of translated materials – Twenty-five dollars ($25.00) per page.

4. The use of this supplemental pay is limited to situations where the use of professional translation services is either not available or unfeasible due to business constraints.

F. Night Shift: CalOptima provides supplemental pay for work performed as part of a Night Shift. Assignments for Night Shift are subject to business needs and are at the discretion of CalOptima management. This is considered a Shift Differential pursuant to Title 2, CCR, Section 571(a) and is to be reported to CalPERS as Special Compensation. The rate for Night Shift is based on the following schedule:

Definition	Eligibility	Rates (per hour)
Night Shift – Seven (7) consecutive hours or more of work between 3 p.m. and 8 a.m.	Non-exempt employees	$2.00 per hour.

G. Call Back and On Call: CalOptima provides supplemental pay for work performed as part of a Call Back and On Call requirement. Assignments for Call Back and On Call are subject to business needs and are at the discretion of CalOptima management. The rates for Call Back and On Call Pay are based on the following schedule:

Definition	Eligibility	Rates (per hour)
Call Back – Employees must physically return to work within one (1) hour when requested by a Supervisor. A Supervisor may assign employees other work until the guaranteed four (4) hour time elapses.	Non-exempt employees	One and one half (1.5) times of regular base pay with a minimum of four (4) hours of pay.
On Call – Employees must remain accessible after normally scheduled work hours and be available to fix problems or report to work, if necessary. Employees will be informed of the need for their availability to work either from home or at the work site. Employees on call are waiting to be engaged and are free to use their On Call time as they deem appropriate, so long as they are fit to respond when called. Employees must respond within one (1) hour, as required.	Non-exempt employees	$3.00 per hour for being on-call. If a call is taken, employee is paid one and one half (1.5) times the regular base pay with a thirty (30) minute minimum call.
On Call Medical Case Managers (RN or LVN) and Clinical Pharmacists - Must remain accessible to accept or respond to calls within a reasonable time designated by employee's supervisors. In no event shall employees' supervisors require a response time less than thirty (30) minutes. Employees will be informed of the need for their availability to work either from home or at the work site. Employees on call are waiting to be engaged and are free to use their On Call time as they deem appropriate, so long as they are fit to respond when called.	Exempt Employees, excluding those in supervisory positions	Twenty five percent (25%) of the employee's base pay as an hourly equivalent multiplied by the number of hours on call.

H. Commuter Allowance: Effective April 24, 2022 through July 1, 2023, CalOptima shall provide a Commuter Allowance in an amount of one hundred fifty dollars ($150.00) per pay period to full-time employees designated as Full Office Workers, and seventy-five dollars ($75.00) per pay period to full-time employees designated as Partial Teleworkers. The Commuter Allowance begins the first full pay period as a Full Office Worker or Partial Teleworker. Eligible full-time employees will continue to receive the Commuter Allowance until the first full pay period in which an employee is not assigned to partial telework or full office work. The Commuter Allowance will be provided only for full pay periods in which employees are designated a Full Office Worker or Partial Teleworker and will not be prorated for being designated as a Full Office Worker or Partial Teleworker for a portion of the pay period. Executive Level Positions and Full Teleworkers are not eligible for the Commuter Allowance. With approval of the Chief Executive Officer, the Commuter Allowance may continue beyond July 1, 2023, and/or be reinstated after July 1, 2023.

I. Internet Stipend: CalOptima shall provide an Internet Stipend in an amount of twenty-five dollars ($25.00) per pay period to full-time employees designated as Full Teleworkers, Partial Teleworkers or Community Workers. The Internet Stipend begins the first full pay period as a Full or Partial Teleworker or Community Worker. Eligible full-time employees will continue to receive the stipend until the first, full pay period in which an employee is not assigned to full or partial telework or community work. The Internet Stipend will be provided only for full pay periods and will not be prorated for a change in designation for a portion of a pay period. Executive Level Positions and Full Office Workers are not eligible for the Internet Stipend.

J. Active Certified Case Manager (CCM) Pay: CalOptima may recognize supplemental pay of one hundred dollars ($100.00) per pay period to an RN who holds an active CCM certification when such certification is required or preferred in the job description and used regularly in performance of the employee's job duties. This is considered as an Educational Incentive pursuant to Title 2 CCR Section 571(a) and is to be reported to CalPERS as Special Compensation.

K. Executive Incentive Program: The Chief Executive Officer (CEO) may recognize Executive Level Positions, including interim appointments, using incentive compensation as described in this Policy. For employees in Executive Level Positions who achieve outstanding performance, the incentive compensation is considered bonus pay pursuant to Title 2 CCR Section 571(a) and is to be reported to CalPERS as Special Compensation for CalPERS classic members.

L. Sales Incentive Program: The OneCare/OneCare Connect Community Partner and Senior (Sr.) Community Partner staff in the Member Outreach & Education Department shall have an active Resident Insurance Producer license to enroll eligible members into the OneCare and OneCare Connect programs.

1. The licensed Community Partner and Sr. Community Partner staff will receive a monthly Sales Incentive based on the number of eligible members enrolled into the OneCare and OneCare Connect program in accordance with the table in Paragraph II.I.2. below. No incentive will be paid for the first thirty (30) enrollments each month, regardless of how many enrollments are made under, at or over thirty (30). For enrollments over thirty (30), licensed Community Partner and Sr. Community Partner staff will be eligible to receive the incentive payment of one hundred sixty-five dollars ($165.00) for each new enrollment within that tier between thirty-one (31) – fifty (50). In other words, each tier is independent and does not alter the amount paid per enrollment in any other tier. For example, eligible staff who enroll fifty-three (53) members in a month will be eligible to receive payment based on the following calculation (from tier thirty-one (31) – fifty(50)) twenty (20) members multiplied by one hundred sixty-five dollars ($165), plus (from tier fifty-one (51) – sixty-five (65)) three (3) members multiplied by one hundred seventy-five ($175), which equals an incentive of three thousand eight hundred twenty-five dollars ($3,825) for that month.

2. Enrollment is paid per eligible member above the minimum tier at the rate specified within each tier as follows:

Tier Min	Tier Max	Payout for Enrollment within Each Tier
1	30	**$0.00**
31	50	**$165.00**
51	65	**$175.00**
66+		**$200.00**

3 The sales incentive for the Manager, Member Outreach & Education shall be based on the number of eligible members enrolled into the OneCare and OneCare Connect programs by the

Community Partner and Sr. Community Partner in the Member Outreach & Education Department. The Manager, Member Outreach & Education will receive ten dollars ($10.00) per member enrolled, if and only if, the Community Partner or Sr. Community Partner reporting to the Manager, Member Outreach & Education, enrolls thirty-six (36) or more members per month. If a Community Partner or Sr. Community Partner fails to enroll at least thirty-six (36) members per month, the Manager, Member Outreach & Education, would not be eligible for the sales incentive for that Community Partner or Sr. Community Partner.

M. Employee Incentive Program: At the discretion of the CEO, specific employees may be recognized through incentive compensation, when doing so is consistent with CalOptima's business needs and mission, vision, and values.

N. Retention Incentive: In order to preserve organizational talent and to maintain business continuity when the loss of key personnel may cause risk or damage to operational efficiency, regulatory compliance, and/or strategic imperatives, CalOptima may, at the discretion of the CEO, and on an exception basis, award a retention incentive.

O. Recruitment Incentive: At the discretion of the CEO, a recruitment incentive of up to fifteen percent (15%) of the midpoint of base pay for the applicable position may be offered to entice an individual to join CalOptima. Recruitment incentives offered for Executive Director and Chief positions, to a maximum of $50,000, require informing the Board of Directors after approved.

P. Incentive programs may be modified or withdrawn, at any time. An award of incentive compensation is entirely at the discretion of the CEO and/or Board of Directors, as applicable. It is not intended to be a binding contract between Executive Level Positions or employees and CalOptima.

Q. Employer-Paid Member Contribution (EPMC): CalOptima contributes seven percent (7%) of compensation earnable, on behalf of eligible employees who hold management staff positions as identified in the CalOptima salary schedule, and who qualify based on all of the following:

1. Hired, promoted, or transferred into a management staff position, including interim appointments; and

2. Included in one (1) of the following categories:

   a. A CalPERS Classic Member; or

   b. A member prior to January 1, 2013, of another California public retirement system that is eligible for reciprocity with CalPERS.

R. Annual Performance Lump Sum Bonus: Employees paid at or above the pay range maximum are not eligible for future base pay increases. As a result, in lieu of future base pay increases, these employees may be eligible for merit bonus pay delivered as a lump sum bonus in accordance with Section III.J of this Policy, provided that their performance meets the goals and objectives set forth by their managers.

S. Automobile Allowance: CalOptima may, at the discretion of the CEO, provide employees in Executive Level Positions, including interim appointments, with a monthly automobile allowance in an amount not to exceed five hundred dollars ($500.00) for the use of their personal vehicle for CalOptima business.

T. Supplemental Retirement Benefit: Consistent with applicable Board actions, the CEO is authorized to determine CalOptima's contribution rate for employees to the supplemental retirement benefit (SRB) plan administered by the Public Agency Retirement System (PARS) within the limits of the budget and subject to contribution limits established by applicable laws. With the exception of employees in Executive Level Positions, the contribution rate shall be uniform for all employees. Executive Level Positions will also receive the same uniform contribution rate applicable to all employees. However, for employees in Executive Level Positions who earn more than the applicable compensation limits, the CEO is authorized to provide additional supplemental contributions to PARS, subject to the limitations of applicable laws. An employee in an Executive Level Position must still be employed by CalOptima at the time the additional supplemental contribution to PARS is distributed in order to be eligible to receive the additional supplemental contributions. These SRB contributions to the PARS retirement plan shall continue from year to year, unless otherwise adjusted or discontinued.

III. PROCEDURE

A. Overtime Pay: Overtime must be approved in advance by an employee's manager. Adjustments for overtime pay cannot be calculated until the completion of an employee's workweek. This may result in one (1) pay period's delay in the employee receiving the additional compensation.

B. Holiday Premium Pay: Working on a CalOptima observed holiday must be approved in advance by the employee's manager. Unauthorized work that occurs on an observed holiday is not eligible for Holiday Premium Pay and will be paid at the employee's regular base pay. Actual hours worked on a holiday will be used for purposes of calculating overtime.

C. Bilingual Pay: An employee or potential employee shall undergo a written and verbal bilingual evaluation when bilingual proficiency is a part of the employee's or potential employee's job description and used in the performance of the employee's job duties with members. If the employee or potential employee passes the evaluations, the bilingual pay shall be established.

D. Translation Pay: If an eligible exempt employee elects to provide translation services, and such services are not part of the employee's regular job duties, the employee shall submit their interest to the C&L Department. If selected, the translation pay identified above, will be provided depending on the variables noted above, taking into account whether professional translation services are either not available or unfeasible due to business constraints.

E. Night Shift:

1. Night Shift differential is automatically calculated for those employees regularly working a night shift, defined as seven (7) consecutive hours or more of work between 3 p.m. and 8 a.m.

2. Employees who, at their own request and for their own convenience, adjust their work schedule, such as requesting make up time or alternative hours, and as a result, would be eligible for night shift pay, shall be deemed as having waived their right to same. When appropriate, a new Action Form should be submitted, removing the employee from the night shift.

F. Call Back and On Call Pay:

1. If employees are on call or get called back to work, the employees are responsible for adding this time to their schedules through CalOptima's time keeping system, which is then approved by their supervisors.

G. Commuter Allowance

1. Commuter Allowance is automatically calculated for eligible employees based on system designation of Full Office Worker or Partial Teleworker. Employees and leaders are responsible for maintaining accurate designations in the timekeeping system. Designation changes require a request and approval per the Telework Program Guidelines. CalOptima may periodically audit and validate employee Office/Telework designations.

H. Internet Stipend

1. Internet Stipend is automatically calculated for eligible employees based on system designation of Full Teleworker, Partial Teleworker, or Community Worker. Employees and leaders are responsible for maintaining accurate designations in the timekeeping system. Telework designation changes require a request and approval per the Telework Program Guidelines. Community Worker designation is determined by the position. CalOptima may periodically audit and validate employee Office/Telework designations.

I. Active Certified Case Manager (CCM) Pay:

1. To receive CCM supplemental pay, an employee is responsible for providing a copy of the employee's case management certification issued by the Case Management Society of America to the Human Resources Department.

J. Incentive Compensation

1. The Board of Directors approves CalOptima's strategic plan for each fiscal year, and the CEO is expected to meet the goals set forth in the strategic plan. The CEO in turn sets goals for the Executive Level Positions.

2. The CEO may establish an incentive compensation program for Executive Level Positions based on the Executive Incentive Program attached within budgeted parameters in accomplishing specific results according to the department and individual goals set forth by the CEO and the level of achievement. Executive Level Positions will receive a performance evaluation based on the Performance Review of Executives Template attached, which measures their performance against the established goals. Based on the level of performance, the executive staff member may be eligible for a lump sum bonus payment. The executive staff member must still be employed by CalOptima and in good standing at the time the bonus is distributed in order to be eligible to receive the bonus payment. For eligible Executive Level Positions who achieve outstanding performance, CalOptima will report the bonus payment to CalPERS as Special Compensation. The CEO is authorized to make minor revisions to the Executive Incentive Program and Performance Review of Executives Template from time to time, as appropriate.

3. As circumstances warrant and at the discretion of the CEO, employees not in Executive Level Positions, whose accomplishments have provided extraordinary results, may be considered for incentive compensation.

K. Sales Incentive Program

1. The OneCare/OneCare Connect Community Partner and Sr. Community Partner staff, in the Member Outreach & Education Department, shall have an active Resident Insurance Producer license to enroll eligible members into the OneCare and OneCare Connect Programs.

2. The Community Partner and Sr. Community Partner staff shall be eligible to receive sales incentive pay as described in Section II.I.1 of this Policy for successfully enrolling new members into the OneCare and OneCare Connect Programs. Sales incentive pay for the Manager, Member Outreach & Education, shall be based on the number of members enrolled into the OneCare and OneCare Connect Programs by the Community Partner and Sr. Community Partner as described in Section II.I.2 of this Policy.

    a. CalOptima shall follow the Medicare Marketing Guidelines (MMGs) charge-back guidelines of ninety (90) calendar day rapid disenrollment and recouping the sales incentive with the exceptions as specified under the guidelines and applicable CalOptima policies.

3. CalOptima shall advance the sales incentive to the eligible employee on a monthly basis approximately one and a half (1 ½) months after the month in which the eligible employee enrolled the new member. However, the sales incentive is not earned until the member has been enrolled in the respective program for ninety-one (91) days.

    a. In the event a OneCare or OneCare Connect member disenrolls from their respective program within ninety (90) calendar days for reasons other than the exceptions specified under the guidelines and applicable CalOptima policies, the sales incentive previously paid will be deducted from a future sales incentive.

4. The Chief Operating Officer, Executive Director of Network Operations, and Director Network Management who oversee the Member Outreach & Education Department shall approve the sales incentive payout.

5. Enrollment goals for the Community Partner and Community Partner Sr. staff will be pro-rated for the month if the employee misses one (1) or more full weeks due to vacations, sick days, or a leave of absence.

6. The Director, Network Management, Executive Director of Network Operations, and the Chief Operations Officer will review the sales incentive structure on an annual basis.

L. Retention Incentive: As circumstances warrant, the CEO may award an employee a retention incentive to prevent or delay departures that may adversely impact business operations. The employee offered a retention incentive must be in good standing and accept and sign a retention agreement which contains the condition(s) to be met to receive payment. Payment of the incentive will be made when the terms of the agreement have been fully met and at the conclusion of the retention period. The CEO has the authority to offer retention incentives for up to twenty-five (25) employees per fiscal year in an amount not to exceed twenty percent (20%) of the employee's current base annual salary. Retention incentives that exceed twenty percent (20%) of the employee's current base annual salary require Board of Directors approval.

M. Recruitment Incentive: As circumstances warrant, the CEO may offer a recruitment incentive based on the Compensation Administration Guidelines managed by the Human Resources Department to entice an individual to join CalOptima. Board of Director approval is required for recruitment incentives offered for Executive Level Positions. To receive the recruitment incentive, the individual offered the incentive is required to accept and sign an offer letter which contains a "claw-back" provision obligating the recipient of a recruitment incentive to return the full amount of the recruitment incentive if the recipient voluntarily terminates employment with CalOptima within twenty-four (24) months of the date of hire.

N. Annual Performance Lump Sum Bonus: Once employees have reached the pay range maximum, employees may be eligible for merit bonus pay delivered as a lump sum bonus, provided that their

annual performance evaluations meet the established goals and objectives set forth by their managers. Merit bonus pay will not exceed the maximum percentage of the merit increase matrix and reflects employees' superior performance measured against established objectives. Annual performance lump sum bonuses are paid out in two (2) incremental amounts – the first half when merit salary increases are normally distributed and the second half six (6) months later. The employee must still be employed by CalOptima to be eligible to receive the lump sum bonus payments.

O. Automobile Allowance: As circumstances warrant, the CEO may offer employees in Executive Level Positions an automobile allowance in lieu of the IRS standard mileage reimbursement rate that would otherwise apply for the use of their personal vehicle in the performance of their duties. Such automobile allowance will be identified on the employees' W-2 forms as taxable income. In addition, as a condition of receiving such allowance, the employee must comply with the following requirements:

1. Maintain adequate levels of personal vehicle insurance coverage;

2. Purchase their own fuel for the vehicle; and

3. Ensure the vehicle is properly maintained.

IV. ATTACHMENT(S)

A. Executive Incentive Program
B. Performance Review of Executives Template

V. REFERENCE(S)

A. CalOptima Employee Handbook
B. Compensation Administration Guidelines
C. Government Code, §20636 and 20636.1
D. Telework Program Guidelines
E. Title 2, California Code of Regulations (CCR), §571

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

Date	Meeting
01/05/2012	Regular Meeting of the CalOptima Board of Directors
05/01/2014	Regular Meeting of the CalOptima Board of Directors
12/03/2015	Regular Meeting of the CalOptima Board of Directors
09/07/2017	Regular Meeting of the CalOptima Board of Directors
06/07/2018	Regular Meeting of the CalOptima Board of Directors
02/07/2019	Regular Meeting of the CalOptima Board of Directors
04/02/2020	Regular Meeting of the CalOptima Board of Directors
04/07/2022	Regular Meeting of the CalOptima Board of Directors
TBD	Regular Meeting of the CalOptima Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	01/01/2011	GA.8042	Pay Differentials	Administrative
Revised	01/05/2012	GA.8042	Pay Differentials	Administrative
Revised	05/20/2014	GA.8042	Supplemental Compensation	Administrative
Revised	12/03/2015	GA.8042	Supplemental Compensation	Administrative
Revised	09/07/2017	GA.8042	Supplemental Compensation	Administrative
Revised	06/07/2018	GA.8042	Supplemental Compensation	Administrative
Revised	02/07/2019	GA.8042	Supplemental Compensation	Administrative
Revised	04/02/2020	GA.8042	Supplemental Compensation	Administrative
Revised	04/07/2022	GA.8042	Supplemental Compensation	Administrative
Revised	TBD	GA.8042	Supplemental Compensation	Administrative

IX. GLOSSARY

Term	Definition
Bilingual Certified Employee	An employee who has passed CalOptima's Bilingual Screening Process either upon hire or any time during their employment.
Bilingual Screening Process	Prospective staff translators are identified by Cultural and Linguistic (C&L) Services Department based on qualifications obtained through CalOptima's bilingual screening process. The screening is either conducted as part of their initial hiring process or later during their employment. All staff translators must possess a strong ability to read, write and understand the target language. Once identified as potential staff translators, they are required to take a proficiency test created by C&L Services Department. They are evaluated on their vocabulary, grammar, orthography, flow, accuracy, cultural sensitivity, as well as consistency in usage of translated terms. The selection is based on their overall score.
Bonus Pay	Compensation to employees for superior performance such as "annual performance bonus" and "merit pay." If provided only during a member's final compensation period, it shall be excluded from final compensation as "final settlement" pay. A program or system must be in place to plan and identify performance goals and objectives to count as Special Compensation for CalPERS purposes.
CalPERS	California Public Employees Retirement System
CalPERS Classic Member	A member enrolled in CalPERS prior to January 1, 2013.
Classic Director	A Management Staff who is either a CalPERS Classic Member or a member prior to January 1, 2013, of another California public retirement system who is eligible for reciprocity with CalPERS.
Classic Executive	An Executive Staff who is either a CalPERS Classic Member or a member prior to January 1, 2013, of another California public retirement system who is eligible for reciprocity with CalPERS.
Compensation Earnable	The pay rate and Special Compensation as defined in Government Code sections 20636 and 20636.1.
Central Worksite	CalOptima's primary physical location of business applicable to the employee, which is either CalOptima's administration building at 505 City Parkway West, the PACE building or other CalOptima operated location.
Community Worker	An employee in a position that performs fifty-one percent (51%) or more of their duties in field locations such as provider offices, members' homes, and at community outreach events.
Executive Level Position	The position of Executive Director or above.
Exempt Employee	Employees who are exempt from the overtime provisions of the federal Fair Labor Standards Act (FLSA) and state regulations governing wages and salaries. Exempt status is determined by the duties and responsibilities of the position and is defined by Human Resources for each position.
Full Office Worker	An employee who is assigned to work their full schedule at the Central Worksite.
Full Teleworker	An eligible employee who is approved to routinely work their entire regularly scheduled work hours from a Remote Work Location unless business needs require otherwise.
Leave of Absence (LOA)	A term used to describe a scheduled period of time off longer than five (5) days that employees are to be away from their primary jobs, while maintaining the status of employee.

Term	Definition
Management Staff	Staff holding positions at or above Director level.
Partial Teleworker	An eligible employee who is approved to work a pre-established consistent weekly work schedule split between two (2) or more full days per week at the Central Worksite, and the remainder of full days at the Remote Work Location.
Sales Incentive	An amount of money paid, in addition to base pay, to an employee for successfully enrolling a member into the OneCare or/ OneCare Connect Program.
Special Compensation	Payment of additional compensation earned separate from an employee's base pay that meets the criteria listed in Title 2, California Code of Regulations (CCR) section 571(a).
Threshold Language	For purposes of this policy, a threshold language as defined by the Centers for Medicare & Medicaid Services (CMS) for Medicare programs, or Department of Health Care Services for the Medi-Cal program.

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CALOPTIMA EXECUTIVE INCENTIVE PROGRAM

The Executive Incentive Plan is an annual plan for the members of CalOptima's executive team that provides a monetary reward for superior performance based on the achievement of predetermined goals and objectives. The amount of incentive awarded to participants is determined based on goal achievement scores and the availability of budget for incentive payments.

A. Purpose: To align the performance of CalOptima's executive staff towards the accomplishment of the agency's long-term strategic plan and to reward outstanding accomplishment of annual key business strategies and initiatives.

B. Eligibility: To be eligible to participate in the Executive Incentive Plan, an employee must be in an executive level position with job titles containing the designation of "Chief" or "Executive."

C. Goals and Objectives: Specific performance goals and objectives are established by the Chief Executive Officer and members of the executive team. Each goal is assigned a weighted percentage, and a description/measure of accomplishment. Goals are established using the following guidelines.

- Linkage to organization strategy
- Stretch objectives with a reasonable probability of attainment
- Consistency in approach across departments
- Encouragement of teamwork among leadership team and the organization, and
- Simple to understand, communicate and administer

D. Performance Period: Accomplishment of goals and objectives will be determined based on performance during the fiscal year (July 1 to June 30).

E. Incentive Opportunity: Goals and objectives are assigned accomplishment points. A minimum score of 50 points is required to be eligible for incentive compensation. The maximum points awarded is 100. The maximum incentive award is ten percent (10%) of the participant's annual base compensation at the time the incentive is calculated. The amount can be prorated based on the number of months of participation in the plan. In order to receive an incentive award, the participant must be an active employee at the time the award is paid out. The range of the potential incentive for Executive Staff is contingent upon a range of performance based upon the goals and objectives established by the Chief Executive Officer. Based upon the total accomplishment points received, the incentive opportunities may be determined based upon a performance matrix, as an example, as follows:

Points	Category	Description	Incentive as Percentage of Base Pay
Below 50	Below Threshold	The minimum level of performance was not achieved	0%

Points	Category	Description	Incentive as Percentage of Base Pay
50-60	Threshold	The minimum level of performance which must be achieved before an incentive is paid	0-4%
60-70	Target	The level of performance which generally equates to the achievement of some but not all goals and objectives	4-6%
70-85	Commendable	The level of performance where the combination of personal effort and business produce an above average return for the organization	6-8%
85-100	Outstanding	The very superior level of performance which occasionally occurs when all circumstances come together to produce very high returns for the organization.	8-10%

F. Modification of Plan: The CEO may modify the plan for business need at any time. Participation in the plan is subject to the approval of the CEO. Participation in any single year does not predict participation in subsequent years.

Sample Form

Executive Incentive Goals for FY____- ___

Strategic Priority	Goals	Weight (%)	Description / Measure(s) of Accomplishment / Points Available	Points Earned	Owner(s)	Comment/Notes
Quality Programs and Services	*Goal XYZ*	*10*	*Implement by Q1. Program rolled out to all users. 0 – 25, 0 if not met, 25 if fully met.*	*15*	*Chief Operating Officer*	*Partial completion.*
Culture, Learning and Innovation						
Financial Stability						
Strong Internal Processes						
Community Outreach						

Strategic Priority	Goals	Weight (%)	Description / Measure(s) of Accomplishment / Points Available	Points Earned	Owner(s)	Comment/Notes
			Total Score			

Performance Review – Executive (Directors and Above)

EMPLOYEE INFORMATION

EMPLOYEE	JOB TITLE	DEPARTMENT
SUPERVISOR/EVALUATOR	REVIEW PERIOD to	

SELF REVIEW: In the following section, provide your responses to the following questions for the review period April 1, 2022, through March 31, 2023.

1) **What did you do well that impacted or demonstrated your performance? (Examples: accomplishments, self-development, projects, productivity, collaboration, customer service)**
2) **What are you continuing to work on that you set as goal(s) from last year?**
3) **What opportunities for growth, future goals or enhancement to your position will sustain and/or improve your performance?**

1)

2)

3)

Manager Review: ***Below are the Core Competencies to be completed by your manager***

CORE BEHAVIORAL COMPETENCIES

This section describes the core competencies required for successful employee performance for this CalOptima position. In the space provided, mark the appropriate rating with an "x" and provide comments as needed. Evaluate the employee on each factor relevant to the job duties and responsibilities by indicating to what degree the employee demonstrates the overall skill or behavior on the job.

Competency Rating Scale Definitions:

Outstanding – Performance **regularly exceeds** job expectations due to **exceptionally high quality** of work in all essential areas of responsibility, resulting in outstanding contribution. Reserved for truly outstanding performance.

Exceeds Expectations - **Often** demonstrates behaviors that go **above and beyond** expectations in order to achieve exceptional performance or intended results.

Fully Meets Expectations - Demonstrates effective and desired behaviors that **consistently** meet **expected** performance standards.

Needs Development - Demonstrates **some** desired behaviors, or uses behaviors **inconsistently**. Requires some development/improvement.

Unacceptable - Rarely demonstrates competency behaviors. **Does not meet** performance standards. Requires **significant** and **immediate** improvement

COMMUNICATION:

- Communicates well with others in both verbal and written form by adapting tone, style and approach based on people's perspectives and situations. Organizes thoughts, expresses them clearly and respectfully.
- Listens attentively to ideas of others; cooperates and builds good working relationships with others.
- Provides colleagues with regular and reliable information, including updates on own activities/decisions, and is well-prepared when speaking in front of a group; presentations are clear and informative.

☐ Outstanding
☐ Exceeds Expectations
☐ Fully Meets Expectations
☐ Needs Development
☐ Unacceptable

List specific examples or details of past performance and self-development

CUSTOMER FOCUS (internal and/or external)

- Actively listens and follows up/through on customer inquiries/requests in a timely, professional, courteous, and sensitive manner; ensures clear and frequent communication with customers about progress, changes and status; takes responsibility for correcting customer problems.
- Demonstrates a good understanding of company/department procedures for handling customer complaints; knows when to bring in help/use the chain of command for problems beyond ability.
- Demonstrates collaborative relationships with others.
- Viewed as a team player. Assists others in achieving their goals.

☐ Outstanding
☐ Exceeds Expectations
☐ Fully Meets Expectations
☐ Needs Development
☐ Unacceptable

List specific examples or details of past performance and self-development

LEADERSHIP:

- Communicates high level priorities and objectives, a compelling and strategic vision, which is innovative and future-oriented, and creates buy-in at various levels of the organization for each fiscal year.
- Manages, inspires, motivates, develops, reviews, and supports the growth of the organization and department staff.

☐ Outstanding
☐ Exceeds Expectations
☐ Fully Meets Expectations
☐ Needs Development
☐ Unacceptable

List specific examples or details of past performance and self-development

STRATEGIC THINKING:

- Applies the SWOT analysis to CalOptima's changing environment to identify opportunities for success in order to redirect the company's course, create realistic and well-balanced strategic plans, and to meet new targets. Understands the players in our industry, both competitors and allies, and is on top of industry shifts and changes.
- Includes key stakeholders in strategic planning.
- Is an innovative strategic partner.

☐ Outstanding
☐ Exceeds Expectations
☐ Fully Meets Expectations
☐ Needs Development
☐ Unacceptable

List specific examples or details of past performance and self-development

DECISION MAKING/PROBLEM SOLVING: • Uses sound and consistent judgment when analyzing situations and making decisions that would impact both the department and the entire organization; able to identify potential problems and offers multiple solutions; is conscientious of the department resources. • Able to make decisions even when conditions are uncertain, or information is not available by using the correct balance of logic and intuition; discusses decision and its impact with those who will be affected; the group benefits from input in problem solving and brainstorming sessions. • Reliable, persistent worker who keeps a positive outlook and does not let unexpected problems stop him/her from successfully completing own work; calm under pressure.	☐ Outstanding ☐ Exceeds Expectations ☐ Fully Meets Expectations ☐ Needs Development ☐ Unacceptable

List specific examples or details of past performance and self-development

PREVIOUS MANAGER'S COMMENTS (if applicable):

List goals that will sustain and/or improve performance, and how they will be measured/evaluated during the next review period:

FINAL OVERALL RATING	Outstanding Exceeds Expectations Fully Meets Expectations Needs Development Unacceptable

Manager's/Evaluator's Comments

Manager's/Evaluator's Signature:

Signature Date

Second Level Manager's Comments and Signature:

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Signature _____ Date _____

Employee's Acknowledgement and Comments:

Signature _____ Date _____

Policy:	GA.8050
Title:	**Confidentiality**
Department:	CalOptima Administrative
Section:	Human Resources
CEO Approval:	*/s/*
Effective Date:	02/01/2014
Revised Date:	TBD
Applicable to:	☐ Medi-Cal ☐ OneCare ☐ OneCare Connect ☐ PACE ☒ Administrative

I. PURPOSE

This policy outlines CalOptima's guidelines for protecting proprietary, private, and confidential information.

II. POLICY

A. CalOptima Board members, executive staff, employees, ~~contractors,~~ interns, volunteers, ~~and~~ temporary employees, and applicable contractors, consultants, and agents (referred to herein collectively as "Employees") shall not disclose, divulge, or make accessible proprietary, private, and/or confidential information belonging to, or obtained through the Employee's affiliation with, CalOptima to any person, including, but not limited to, relatives, friends, and business and professional associates, other than to persons who have a legitimate business need for such information and to whom CalOptima has authorized disclosure in writing. This obligation includes making sure proprietary, private, and/or confidential information is secure (whether maintained in electronic or other format), taking precautions to secure files, and following all federal, state, and local laws and regulations.

B. Proprietary information ~~includes~~is all information owned by CalOptima, obtained, or created by Employees during the course of their work with or at CalOptima, including, but not limited to, intellectual property, computer software, and provider identification numbers. Private information ~~includes, but~~ is ~~not limited~~any personal information for which an individual, group, or entity would reasonably expect to~~,~~ be restricted from public access, including, but not limited to, any information related to a person's health, ~~employment application, residence address, testing scores~~member file, personnel ~~reviews,~~ file, recruitment and application records, workers' compensation file, date of birth, and social security number~~, etc.~~. Confidential information is any information that is not known generally to the public, and is accessible only to those for whom it is intended or directed, including, but not limited to, ~~Protected Health Information (PHI), personnel files,~~ provider rates, the Department of Health Care Services (DHCS) reimbursement rates, ~~and any other information that may exist in~~ Protected Health Information (PHI), procurement requests, vendor proposals or bids, contracts, administrative files, ~~personnel records,~~ computer records, computer programs, and financial data. Information may be one or more of proprietary, private, and/or confidential in nature.

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C. Inappropriate use, unauthorized copy ~~and~~or transfer, attempted destruction, or the destruction or disclosure of proprietary, private, and/or confidential~~, private, or proprietary~~ information obtained through the Employee's affiliation with CalOptima will subject an Employee to discipline, up to and including termination, and possible legal recourse.

III. PROCEDURE

A. ~~CalOptima~~ Employees shall:

1. Use proprietary, private, and/or confidential information solely for the purpose of performing services as a trustee~~,~~ or Employee~~,~~ of CalOptima;

2. Exercise good judgment and care at all times to avoid unauthorized~~,~~ or improper~~,~~ disclosures of proprietary, private, and/or confidential information; and

3. Adhere to all CalOptima compliance and Health Insurance Portability and Accountability Act (HIPAA) policies, ~~in accordance with~~including, but not limited to, CalOptima Policies ~~IS.1101: EPHI Physical Controls,~~ IS.1201: EPHI Technical Safeguards - Access Controls, IS.1202: EPHI Technical Safeguards - Data Controls, GA.5005a: Use of Technology Resources, and IS.1301: Security of Workforce Access to EPHI.

4. Employees are expected to report Confidentiality issues under this policy and can do so anonymously to the Compliance and Ethics hotline at 1-877-837-4417.

B. Conversations in public places, such as restaurants, elevators, restrooms, hallways, lobbies, and while traveling via public transportation, should be limited to matters that do not pertain to information of a sensitive, proprietary, private, and/-or confidential nature. In addition, Employees must be sensitive to the risk of inadvertent disclosure and should refrain from leaving proprietary, private, and/or confidential information on desks, workspaces, personal computers, cars, or otherwise in plain view of unauthorized persons, and Employees shall refrain from the use of speaker phones to discuss proprietary, private, and/or confidential information if the conversation could be heard by unauthorized persons.

C. Employees may ~~receive~~be subject to more specific legal, regulatory, and contractual requirements regarding ~~the confidentiality of the~~proprietary, private, and/or confidential information. In brief summary, Employees and individuals affiliated with CalOptima are subject to various confidentiality provisions such as:

1. Public Assistance Recipients: The identity of an individual receiving public services/assistance is protected by state and federal law. Medi-Cal is a form of public assistance and providing information regarding an individual's eligibility is limited only to purposes of service delivery. Only those designated individuals responsible for verifying eligibility to providers should be providing such information and only to authorized recipients.

2. Medical Records: Medical condition and treatment records are confidential between the treating healthcare Provider and Member. Such information is protected under California and federal law. When authorized, such records may be subject to review by qualified professionals involved in CalOptima's responsibilities related to such functions as claims, utilization review, quality assurance, grievance appeals, etc. Any information obtained in this regard must be kept confidential and may not be disclosed to unauthorized persons.

3. Special Health Conditions: Information related to the identity of individuals receiving treatment with certain health conditions carry further confidentiality protection, e.g., AIDS, substance abuse, mental illness, or venereal disease.

4. Special Categories: Other conditions, or circumstances, are covered by special confidentiality provisions, e.g., minors, victims of abuse, etc.

5. Rates: The rates paid to CalOptima by the Department of Health Care Services (DHCS) and the rates CalOptima pays to its contractors/providers are confidential under state and federal law.

D. HIPAA requires CalOptima, its Employees, and its agents to comply with the following standards to protect the privacy of an individual's PHI. PHI is any individually identifiable health information, including demographic information. CalOptima is committed to ensuring the privacy and security of Member information, and Employees shall comply with applicable laws and CalOptima policies and procedures to protect and maintain the confidentiality of PHI as outlined below:

1. General Use: PHI pertaining to Members may only be used to perform functions, activities, or services for the purpose of treatment, payment, or health care operations, unless otherwise authorized by the Member, or required by law. In addition, use or disclosure of PHI should be limited to the minimum necessary to accomplish the intended purpose of the use, disclosure, or request.

2. Unacceptable Use: PHI shall not be used for personal benefit~~,~~ or for the benefit of any other person or entity. Divulging the Medi-Cal status~~,~~ or other PHI~~,~~ of a Member to unauthorized recipients is prohibited.

3. Privacy and Security Safeguards: CalOptima is required to have in place administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of PHI. These safeguards may include, but are not limited to, physically securing PHI in paper form and encrypting PHI in electronic form.

E. At the end of a Board member's term in office, or upon the termination of an Employee's relationship with CalOptima, he or she shall immediately return all documents, papers, electronic files, and other materials, regardless of medium, which may contain or be derived from proprietary, private and/or confidential~~, private or proprietary~~ information in his or her possession.

F. Any individual covered by this policy who violates its provisions shall be subject to discipline and/or separation from service, or affiliation, with CalOptima as well as possible civil and/or criminal liability. The restrictions of this policy also pertain to any disclosure or use of ~~confidential~~proprietary, private, and/or ~~proprietary~~confidential information after leaving affiliation with CalOptima.

G. CalOptima shall provide new hires with this ~~Policy~~policy.

1. All Employees are required to sign an acknowledgment ~~agreeing~~that they have received and read, and understand, this policy and agree to comply with ~~this Policy.~~ it.

2. Failure to sign such acknowledgment may result in disciplinary action, up to and including ~~possible~~ termination.

H. CalOptima welcomes new ideas related to the security of our proprietary, private, and/or confidential information and encourages Employees to share them with their supervisors and

managers to continually improve existing practices. If any Employee would like to remain anonymous when sharing such ideas, that Employee may contact Human Resources Employee Relations unit.

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

A. CalOptima Code of Conduct
B. CalOptima Compliance Plan
~~C. CalOptima Employee Handbook~~
~~D. CalOptima Policy GA.8000: Glossary of Terms~~
~~E.~~C. CalOptima Policy GA.5005a: Use of Technology Resources
~~F. CalOptima Policy IS.1101: EPHI Physical Controls~~
~~G.~~D. CalOptima Policy IS.1201: ~~EPHI~~Electronic Protected Health Information (EPHI) Technical Safeguards - Access Controls
~~H.~~E. CalOptima Policy IS.1202: ~~EPHI~~Electronic Protected Health Information (EPHI) Technical Safeguards - Data Controls
~~I.~~F. CalOptima Policy IS.1301: Security of Workforce Access to ~~EPHI~~Electronic Protected Health Information (EPHI)
~~J.~~G. Confidentiality Statement

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

Date	Regulatory Agency
12/01/2016	Regular Meeting of the CalOptima Board of Directors
05/01/2014	Regular Meeting of the CalOptima Board of Directors
10/04/2018	Regular Meeting of the CalOptima Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	02/01/2014	GA.8050	Confidentiality	Administrative
Revised	12/01/2016	GA.8050	Confidentiality	Administrative
Revised	10/04/2018	GA.8050	Confidentiality	Administrative
Revised	TBD	GA.8050	Confidentiality	Administrative

IX. GLOSSARY

Term	Definition
~~Employee~~Covered Services	~~For purposes of this policy, include, but are not limited to, all full-time and part-time regular CalOptima employees, all temporary employees, volunteers, interns, CalOptima Board members, and applicable contractors and consultants.~~Medi-Cal: Those services provided in the Fee-For-Service Medi-Cal program (as set forth in Title 22, CCR, Division 3, Subdivision 1, Chapter 3, beginning with Section 51301), the Child Health and Disability Prevention program (as set forth in Title 17, CCR, Division 1, Chapter 4, Subchapter 13, Article 4, beginning with section 6842), and the California Children's Services (as set forth in Title 22, CCR, Division 2, subdivision 7, and Welfare and Institutions Code, Division 9, Part 3, Chapter 7, Article 2.985, beginning with section 14094.4) under the Whole-Child Model program, to the extent those services are included as Covered Services under CalOptima's Medi-Cal Contract with DHCS and are Medically Necessary, along with chiropractic services (as defined in Section 51308 of Title 22, CCR), podiatry services (as defined in Section 51310 of Title 22, CCR), speech pathology services and audiology services (as defined in Section 51309 of Title 22, CCR), and Health Homes Program (HHP) services (as set forth in DHCS All Plan Letter 18-012 and Welfare and Institutions Code, Division 9, Part 3, Chapter 7, Article 3.9, beginning with section 14127) for HHP Members with eligible physical chronic conditions and substance use disorders, or other services as authorized by the CalOptima Board of Directors, which shall be covered for Members not-withstanding whether such benefits are provided under the Fee-For-Service Medi-Cal program. OneCare: Those medical services, equipment, or supplies that CalOptima is obligated to provide to Members under the Centers of Medicare & Medicaid Services (CMS) Contract. OneCare Connect: Those medical services, equipment, or supplies that CalOptima is obligated to provide to Members under the Three-Way Contract with the Department of Health Care Services (DHCS) and Centers for Medicare & Medicaid Services (CMS). PACE: Those services set for the in California Code of Regulations, title 22, chapter 3, article 4, beginning with section 51301, and title 17, division 1, chapter 4, subchapter 13, beginning with Section 6840, unless otherwise specifically excluded under the terms of the DHCS PACE Contract with CalOptima, or other services as authorized by the CalOptima Board of Directors.
Employee	For purposes of this policy, CalOptima Board members, executive staff, employees, contractors, interns, volunteers, temporary employees, and applicable contractors, consultants, and agents.
Health Insurance Portability and Accountability Act (HIPAA)	The Health Insurance Portability and Accountability Act of 1996, Public Law 104-191, enacted on August 21, 1996. Sections 261 through 264 of HIPAA require the Secretary of the U.S. Department of Health and Human Services to publicize standards for the electronic exchange, privacy and security of health information, as amended.

Term	Definition
Medical Record	Any single or complete record kept or required to be kept, that documents all the medical services received by the Member, including, but not limited to, inpatient, outpatient, and emergency care, referral requests, authorizations, or other documentation as indicated by CalOptima policy.
Member	~~An enrollee~~ A beneficiary ~~of~~enrolled in a CalOptima program.
Protected Health Information (PHI)	Has the meaning in 45 Code of Federal Regulations Section 160.103, including the following: individually identifiable health information transmitted by electronic media, maintained in electronic media, or transmitted or maintained in any other form or medium. This information identifies the individual or there is reasonable basis to believe the information can be used to identify the individual. The information was created or received by CalOptima or Business Associates and relates to: 1. The past, present, or future physical or mental health or condition of a Member; 2. The provision of health care to a Member; or 3. Past, present, or future ~~Payment~~payment for the provision of health care to a Member.
Provider	A physician, nurse, nurse mid-wife, nurse practitioner, medical technician, physician assistant, hospital, laboratory, ancillary provider, health maintenance organization, or other person or institution that furnishes Covered Services.

Policy:	GA.8050
Title:	**Confidentiality**
Department:	CalOptima Administrative
Section:	Human Resources
CEO Approval:	*/s/*
Effective Date:	02/01/2014
Revised Date:	TBD
Applicable to:	☐ Medi-Cal ☐ OneCare ☐ OneCare Connect ☐ PACE ☒ Administrative

I. PURPOSE

This policy outlines CalOptima's guidelines for protecting proprietary, private, and confidential information.

II. POLICY

A. CalOptima Board members, executive staff, employees, interns, volunteers, temporary employees, and applicable contractors, consultants, and agents (referred to herein collectively as "Employees") shall not disclose, divulge, or make accessible proprietary, private, and/or confidential information belonging to, or obtained through the Employee's affiliation with, CalOptima to any person, including, but not limited to, relatives, friends, and business and professional associates, other than to persons who have a legitimate business need for such information and to whom CalOptima has authorized disclosure in writing. This obligation includes making sure proprietary, private, and/or confidential information is secure (whether maintained in electronic or other format), taking precautions to secure files, and following all federal, state, and local laws and regulations.

B. Proprietary information is all information owned by CalOptima, obtained, or created by Employees during the course of their work with or at CalOptima, including, but not limited to, intellectual property, computer software, and provider identification numbers. Private information is any personal information for which an individual, group, or entity would reasonably expect to be restricted from public access, including, but not limited to, any information related to a person's health, member file, personnel file, recruitment and application records, workers' compensation file, date of birth, and social security number. Confidential information is any information that is not known generally to the public, and is accessible only to those for whom it is intended or directed, including, but not limited to, provider rates, the Department of Health Care Services (DHCS) reimbursement rates, Protected Health Information (PHI), procurement requests, vendor proposals or bids, contracts, administrative files, computer records, computer programs, and financial data. Information may be one or more of proprietary, private, and/or confidential in nature.

C. Inappropriate use, unauthorized copy or transfer, attempted destruction, or the destruction or disclosure of proprietary, private, and/or confidential information obtained through the Employee's affiliation with CalOptima will subject an Employee to discipline, up to and including termination, and possible legal recourse.

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III. PROCEDURE

A. Employees shall:

1. Use proprietary, private, and/or confidential information solely for the purpose of performing services as a trustee or Employee of CalOptima;

2. Exercise good judgment and care at all times to avoid unauthorized or improper disclosures of proprietary, private, and/or confidential information; and

3. Adhere to all CalOptima compliance and Health Insurance Portability and Accountability Act (HIPAA) policies, including, but not limited to, CalOptima Policies IS.1201: EPHI Technical Safeguards - Access Controls, IS.1202: EPHI Technical Safeguards - Data Controls, GA.5005a: Use of Technology Resources, and IS.1301: Security of Workforce Access to EPHI.

4. Employees are expected to report Confidentiality issues under this policy and can do so anonymously to the Compliance and Ethics hotline at 1-877-837-4417.

B. Conversations in public places, such as restaurants, elevators, restrooms, hallways, lobbies, and while traveling via public transportation, should be limited to matters that do not pertain to information of a sensitive, proprietary, private, and/or confidential nature. In addition, Employees must be sensitive to the risk of inadvertent disclosure and should refrain from leaving proprietary, private, and/or confidential information on desks, workspaces, personal computers, cars, or otherwise in plain view of unauthorized persons, and Employees shall refrain from the use of speaker phones to discuss proprietary, private, and/or confidential information if the conversation could be heard by unauthorized persons.

C. Employees may be subject to more specific legal, regulatory, and contractual requirements regarding proprietary, private, and/or confidential information. In brief summary, Employees and individuals affiliated with CalOptima are subject to various confidentiality provisions such as:

1. Public Assistance Recipients: The identity of an individual receiving public services/assistance is protected by state and federal law. Medi-Cal is a form of public assistance and providing information regarding an individual's eligibility is limited only to purposes of service delivery. Only those designated individuals responsible for verifying eligibility to providers should be providing such information and only to authorized recipients.

2. Medical Records: Medical condition and treatment records are confidential between the treating healthcare Provider and Member. Such information is protected under California and federal law. When authorized, such records may be subject to review by qualified professionals involved in CalOptima's responsibilities related to such functions as claims, utilization review, quality assurance, grievance appeals, etc. Any information obtained in this regard must be kept confidential and may not be disclosed to unauthorized persons.

3. Special Health Conditions: Information related to the identity of individuals receiving treatment with certain health conditions carry further confidentiality protection, e.g., AIDS, substance abuse, mental illness, or venereal disease.

4. Special Categories: Other conditions, or circumstances, are covered by special confidentiality provisions, e.g., minors, victims of abuse, etc.

5. Rates: The rates paid to CalOptima by the Department of Health Care Services (DHCS) and the rates CalOptima pays to its contractors/providers are confidential under state and federal law.

D. HIPAA requires CalOptima, its Employees, and its agents to comply with the following standards to protect the privacy of an individual's PHI. PHI is any individually identifiable health information, including demographic information. CalOptima is committed to ensuring the privacy and security of Member information, and Employees shall comply with applicable laws and CalOptima policies and procedures to protect and maintain the confidentiality of PHI as outlined below:

1. General Use: PHI pertaining to Members may only be used to perform functions, activities, or services for the purpose of treatment, payment, or health care operations, unless otherwise authorized by the Member, or required by law. In addition, use or disclosure of PHI should be limited to the minimum necessary to accomplish the intended purpose of the use, disclosure, or request.

2. Unacceptable Use: PHI shall not be used for personal benefit or for the benefit of any other person or entity. Divulging the Medi-Cal status or other PHI of a Member to unauthorized recipients is prohibited.

3. Privacy and Security Safeguards: CalOptima is required to have in place administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of PHI. These safeguards may include, but are not limited to, physically securing PHI in paper form and encrypting PHI in electronic form.

E. At the end of a Board member's term in office, or upon the termination of an Employee's relationship with CalOptima, he or she shall immediately return all documents, papers, electronic files, and other materials, regardless of medium, which may contain or be derived from proprietary, private and/or confidential information in his or her possession.

F. Any individual covered by this policy who violates its provisions shall be subject to discipline and/or separation from service, or affiliation, with CalOptima as well as possible civil and/or criminal liability. The restrictions of this policy also pertain to any disclosure or use of proprietary, private, and/or confidential information after leaving affiliation with CalOptima.

G. CalOptima shall provide new hires with this policy.

1. All Employees are required to sign an acknowledgment that they have received and read, and understand, this policy and agree to comply with it.

2. Failure to sign such acknowledgment may result in disciplinary action, up to and including termination.

H. CalOptima welcomes new ideas related to the security of our proprietary, private, and/or confidential information and encourages Employees to share them with their supervisors and managers to continually improve existing practices. If any Employee would like to remain anonymous when sharing such ideas, that Employee may contact Human Resources Employee Relations unit.

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

A. CalOptima Code of Conduct
B. CalOptima Compliance Plan
C. CalOptima Policy GA.5005a: Use of Technology Resources
D. CalOptima Policy IS.1201: Electronic Protected Health Information (EPHI) Technical Safeguards - Access Controls
E. CalOptima Policy IS.1202: Electronic Protected Health Information (EPHI) Technical Safeguards - Data Controls
F. CalOptima Policy IS.1301: Security of Workforce Access to Electronic Protected Health Information (EPHI)
G. Confidentiality Statement

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

Date	Regulatory Agency
12/01/2016	Regular Meeting of the CalOptima Board of Directors
05/01/2014	Regular Meeting of the CalOptima Board of Directors
10/04/2018	Regular Meeting of the CalOptima Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	02/01/2014	GA.8050	Confidentiality	Administrative
Revised	12/01/2016	GA.8050	Confidentiality	Administrative
Revised	10/04/2018	GA.8050	Confidentiality	Administrative
Revised	TBD	GA.8050	Confidentiality	Administrative

IX. GLOSSARY

Term	Definition
Covered Services	Medi-Cal: Those services provided in the Fee-For-Service Medi-Cal program (as set forth in Title 22, CCR, Division 3, Subdivision 1, Chapter 3, beginning with Section 51301), the Child Health and Disability Prevention program (as set forth in Title 17, CCR, Division 1, Chapter 4, Subchapter 13, Article 4, beginning with section 6842), and the California Children's Services (as set forth in Title 22, CCR, Division 2, subdivision 7, and Welfare and Institutions Code, Division 9, Part 3, Chapter 7, Article 2.985, beginning with section 14094.4) under the Whole-Child Model program, to the extent those services are included as Covered Services under CalOptima's Medi-Cal Contract with DHCS and are Medically Necessary, along with chiropractic services (as defined in Section 51308 of Title 22, CCR), podiatry services (as defined in Section 51310 of Title 22, CCR), speech pathology services and audiology services (as defined in Section 51309 of Title 22, CCR), and Health Homes Program (HHP) services (as set forth in DHCS All Plan Letter 18-012 and Welfare and Institutions Code, Division 9, Part 3, Chapter 7, Article 3.9, beginning with section 14127) for HHP Members with eligible physical chronic conditions and substance use disorders, or other services as authorized by the CalOptima Board of Directors, which shall be covered for Members not-withstanding whether such benefits are provided under the Fee-For-Service Medi-Cal program. OneCare: Those medical services, equipment, or supplies that CalOptima is obligated to provide to Members under the Centers of Medicare & Medicaid Services (CMS) Contract. OneCare Connect: Those medical services, equipment, or supplies that CalOptima is obligated to provide to Members under the Three-Way Contract with the Department of Health Care Services (DHCS) and Centers for Medicare & Medicaid Services (CMS). PACE: Those services set for the in California Code of Regulations, title 22, chapter 3, article 4, beginning with section 51301, and title 17, division 1, chapter 4, subchapter 13, beginning with Section 6840, unless otherwise specifically excluded under the terms of the DHCS PACE Contract with CalOptima, or other services as authorized by the CalOptima Board of Directors.
Employee	For purposes of this policy, CalOptima Board members, executive staff, employees, contractors, interns, volunteers, temporary employees, and applicable contractors, consultants, and agents.
Health Insurance Portability and Accountability Act (HIPAA)	The Health Insurance Portability and Accountability Act of 1996, Public Law 104-191, enacted on August 21, 1996. Sections 261 through 264 of HIPAA require the Secretary of the U.S. Department of Health and Human Services to publicize standards for the electronic exchange, privacy and security of health information, as amended.

Term	Definition
Medical Record	Any single or complete record kept or required to be kept, that documents all the medical services received by the Member, including, but not limited to, inpatient, outpatient, and emergency care, referral requests, authorizations, or other documentation as indicated by CalOptima policy.
Member	A beneficiary enrolled in a CalOptima program.
Protected Health Information (PHI)	Has the meaning in 45 Code of Federal Regulations Section 160.103, including the following: individually identifiable health information transmitted by electronic media, maintained in electronic media, or transmitted or maintained in any other form or medium. This information identifies the individual or there is reasonable basis to believe the information can be used to identify the individual. The information was created or received by CalOptima or Business Associates and relates to: 1. The past, present, or future physical or mental health or condition of a Member; 2. The provision of health care to a Member; or 3. Past, present, or future payment for the provision of health care to a Member.
Provider	A physician, nurse, nurse mid-wife, nurse practitioner, medical technician, physician assistant, hospital, laboratory, ancillary provider, health maintenance organization, or other person or institution that furnishes Covered Services.

Policy:	GA.8058
Title:	**Salary Schedule**
Department:	CalOptima Administrative
Section:	Human Resources
CEO Approval:	*/s/*
Effective Date:	05/01/2014
Revised Date:	06/02/2022
Applicable to:	☐ Medi-Cal ☐ OneCare ☐ OneCare Connect ☐ PACE ☒ Administrative

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;

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7. Retained by the employer and available for public inspection for not less than five (5) years; and
8. Does not reference another document in lieu of disclosing the pay rate.

B. The Chief Executive Officer (CEO) is authorized and directed to take all steps necessary and proper to implement the salary schedule for all other employees not inconsistent therewith.

III. PROCEDURE

A. The Human Resources Department (HR) will ensure that the salary schedule meets the requirements above and is available at CalOptima's offices, immediately accessible for public review during normal business hours and posted on CalOptima's internal and external websites.

B. HR shall retain the salary schedule for not less than five (5) years.

C. HR shall review the salary schedule and provide recommendations to maintain the competitiveness of the salary schedule to market pay levels.

D. Any adjustments to the salary schedule will require the Executive Director of HR to make a recommendation to the CEO for approval, with the CEO taking the recommendation to the CalOptima Board of Directors for final approval. No changes to the salary schedule, or CEO compensation, shall be effective unless and until approved by the CalOptima Board of Directors.

IV. ATTACHMENT(S)

A. CalOptima - Annual Base Salary Schedule (Revised: ~~03/03~~06/02/2022)

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

Date	Meeting
10/06/2016	Regular Meeting of the CalOptima Board of Directors
11/03/2016	Regular Meeting of the CalOptima Board of Directors
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03/02/2017	Regular Meeting of the CalOptima Board of Directors
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09/07/2017	Regular Meeting of the CalOptima Board of Directors
11/02/2017	Regular Meeting of the CalOptima Board of Directors
02/01/2018	Regular Meeting of the CalOptima Board of Directors
09/06/2018	Regular Meeting of the CalOptima Board of Directors
10/04/2018	Regular Meeting of the CalOptima Board of Directors
02/07/2019	Regular Meeting of the CalOptima Board of Directors
08/01/2019	Regular Meeting of the CalOptima Board of Directors
09/03/2020	Regular Meeting of the CalOptima Board of Directors
03/04/2021	Regular Meeting of the CalOptima Board of Directors
08/05/2021	Regular Meeting of the CalOptima Board of Directors
09/02/2021	Regular Meeting of the CalOptima Board of Directors
03/03/2022	Regular Meeting of the CalOptima Board of Directors
06/02/2022	Regular Meeting of the CalOptima Board of Directors

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

Action	Date	Policy	Policy Title	Program(s)
Revised	05/04/2017	GA.8058	Salary Schedule	Administrative
Revised	06/01/2017	GA.8058	Salary Schedule	Administrative
Revised	08/03/2017	GA.8058	Salary Schedule	Administrative
Revised	09/07/2017	GA.8058	Salary Schedule	Administrative
Revised	11/02/2017	GA.8058	Salary Schedule	Administrative
Revised	02/01/2018	GA.8058	Salary Schedule	Administrative
Revised	09/06/2018	GA.8058	Salary Schedule	Administrative
Revised	10/04/2018	GA.8058	Salary Schedule	Administrative
Revised	02/07/2019	GA.8058	Salary Schedule	Administrative
Revised	08/01/2019	GA.8058	Salary Schedule	Administrative
Revised	09/03/2020	GA.8058	Salary Schedule	Administrative
Revised	03/04/2021	GA.8058	Salary Schedule	Administrative
Revised	08/05/2021	GA.8058	Salary Schedule	Administrative
Revised	09/02/2021	GA.8058	Salary Schedule	Administrative
Revised	03/03/2022	GA.8058	Salary Schedule	Administrative
Revised	06/02/2022	GA.8058	Salary Schedule	Administrative

IX. 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:	06/02/2022
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 - Annual Base Salary Schedule (Revised: 06/02/2022)

V. REFERENCE(S)

A. Title 2, California Code of Regulations, §570.5

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

Date	Meeting
05/01/2014	Regular Meeting of the CalOptima Board of Directors
08/07/2014	Regular Meeting of the CalOptima Board of Directors
11/06/2014	Regular Meeting of the CalOptima Board of Directors
12/04/2014	Regular Meeting of the CalOptima Board of Directors
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08/04/2016	Regular Meeting of the CalOptima Board of Directors
09/01/2016	Regular Meeting of the CalOptima Board of Directors

Date	Meeting
10/06/2016	Regular Meeting of the CalOptima Board of Directors
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VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	05/01/2014	GA.8057	Compensation Program and Salary Schedule	Administrative
Revised	08/07/2014	GA.8057	Compensation Program and Salary Schedule	Administrative
Revised	11/06/2014	GA.8057	Compensation Program and Salary Schedule	Administrative
Revised	12/04/2014	GA.8057	Compensation Program and Salary Schedule	Administrative
Revised	03/05/2015	GA.8057	Compensation Program and Salary Schedule	Administrative
Revised	06/04/2015	GA.8058	Salary Schedule	Administrative
Revised	10/01/2015	GA.8058	Salary Schedule	Administrative
Revised	12/03/2015	GA.8058	Salary Schedule	Administrative
Revised	03/03/2016	GA.8058	Salary Schedule	Administrative
Revised	06/02/2016	GA.8058	Salary Schedule	Administrative
Revised	08/04/2016	GA.8058	Salary Schedule	Administrative
Revised	09/01/2016	GA.8058	Salary Schedule	Administrative
Revised	10/06/2016	GA.8058	Salary Schedule	Administrative
Revised	11/03/2016	GA.8058	Salary Schedule	Administrative
Revised	12/01/2016	GA.8058	Salary Schedule	Administrative
Revised	03/02/2017	GA.8058	Salary Schedule	Administrative

Action	Date	Policy	Policy Title	Program(s)
Revised	05/04/2017	GA.8058	Salary Schedule	Administrative
Revised	06/01/2017	GA.8058	Salary Schedule	Administrative
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Revised	09/07/2017	GA.8058	Salary Schedule	Administrative
Revised	11/02/2017	GA.8058	Salary Schedule	Administrative
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Revised	10/04/2018	GA.8058	Salary Schedule	Administrative
Revised	02/07/2019	GA.8058	Salary Schedule	Administrative
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Revised	09/02/2021	GA.8058	Salary Schedule	Administrative
Revised	03/03/2022	GA.8058	Salary Schedule	Administrative
Revised	06/02/2022	GA.8058	Salary Schedule	Administrative

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IX. GLOSSARY

Not Applicable

CalOptima - Annual Base Salary Schedule - Revised: ~~March 03, 2022~~ June 02, 2022
To be implemented: ~~March 13, 2022~~ June 05, 2022

	Job Title	Pay Grade	Job Code	Min	Proposed Min	Mid	Proposed Mid	Max	Proposed Max	For Approval
	Accountant	H	39	$59,000		$71,850		$84,700		
	Accountant Int	I	634	$61,000		$77,250		$93,500		
	Accountant Sr	K	68	$70,000		$88,900		$107,800		
	Accounting Clerk	D	334	$44,000		$53,900		$63,800		
	Accounting Clerk Sr	E	680	$48,000		$58,100		$68,200		
	Activity Coordinator (PACE)	E	681	$48,000		$58,100		$68,200		
	Actuarial Analyst	K	558	$70,000		$88,900		$107,800		
	Actuarial Analyst Sr	L	559	$77,000		$98,450		$119,900		
	Actuary	O	357	$105,000		$134,450		$163,900		
	Actuary Principal	Q	~~TBD~~ 882	$130,000		$166,200		$202,400		
	Actuary Sr	P	~~TBD~~ 883	$117,000		$149,250		$181,500		
	Administrative Assistant	D	882	$44,000		$53,900		$63,800		
	Administrative Fellow	J	TBD		$65,000		$82,550		$100,100	Add title
	Analyst	H	562	$59,000		$71,850		$84,700		
	Analyst Int	I	563	$61,000		$77,250		$93,500		
	Analyst Sr	J	564	$65,000		$82,550		$100,100		
	Applications Analyst	I	232	$61,000		$77,250		$93,500		
	Applications Analyst Int	J	233	$65,000		$82,550		$100,100		
	Applications Analyst Sr	L	298	$77,000		$98,450		$119,900		
	Associate Director I	P	~~TBD~~ 884	$117,000		$149,250		$181,500		
	Associate Director II	Q	~~TBD~~ 885	$130,000		$166,200		$202,400		
	Associate Director III	R	~~TBD~~ 886	$144,000		$184,200		$224,400		
	Associate Director IV	S	~~TBD~~ 887	$154,000		$204,600		$255,200		
	Auditor	I	565	$61,000		$77,250		$93,500		
	Auditor Sr	J	566	$65,000		$82,550		$100,100		
	Behavioral Health Manager	M	383	$85,000		$109,050		$133,100		
	Biostatistics Manager	M	418	$85,000		$109,050		$133,100		
	Board Services Specialist	E	435	$48,000		$58,100		$68,200		
	Business Analyst	J	40	$65,000		$82,550		$100,100		
	Business Analyst Sr	L	611	$77,000		$98,450		$119,900		
	Business Systems Analyst Sr	K	69	$70,000		$88,900		$107,800		
	Buyer	G	29	$55,000		$66,550		$78,100		
	Buyer Int	H	49	$59,000		$71,850		$84,700		
	Buyer Sr	I	67	$61,000		$77,250		$93,500		
	Care Manager	K	657	$70,000		$88,900		$107,800		
	Care Transition Intervention Coach (RN)	L	417	$77,000		$98,450		$119,900		
	Certified Coder	H	399	$59,000		$71,850		$84,700		
	Certified Coding Specialist	H	639	$59,000		$71,850		$84,700		
	Certified Coding Specialist Sr	J	640	$65,000		$82,550		$100,100		
	Change Control Administrator	I	499	$61,000		$77,250		$93,500		
	Change Control Administrator Int	J	500	$65,000		$82,550		$100,100		
**	Chief Compliance Officer	W	~~TBD~~ 888	$313,000		$414,450		$515,900		
**	Chief Executive Officer	Z	138	$560,000		$700,750		$841,500		
**	Chief Financial Officer	X	134	$368,000		$487,600		$607,200		
**	Chief Health Equity Officer	W	~~TBD~~ 889	$313,000		$414,450		$515,900		
**	Chief Human Resources Officer	W	~~TBD~~ 890	$313,000		$414,450		$515,900		
**	Chief Information Officer	W	131	$313,000		$414,450		$515,900		
**	Chief Medical Officer	X	137	$368,000		$487,600		$607,200		
**	Chief of Staff	U	~~TBD~~ 692	$226,000		$298,900		$371,800		
**	Chief Operating Officer	Y	136	$433,000		$573,450		$713,900		
	Claims - Lead	G	574	$55,000		$66,550		$78,100		
	Claims Examiner	C	9	~~$41,000~~	$43,281	~~$49,650~~	$50,790	$58,300		Increase pay grade minimum to $43,281 and shift pay grade midpoint accordingly
	Claims Examiner - Lead	F	236	$51,000		$62,350		$73,700		
	Claims Examiner Sr	E	20	$48,000		$58,100		$68,200		
	Claims QA Analyst	F	28	$51,000		$62,350		$73,700		
	Claims QA Analyst Sr	G	540	$55,000		$66,550		$78,100		
	Claims Recovery Specialist	F	283	$51,000		$62,350		$73,700		
	Claims Resolution Specialist	F	282	$51,000		$62,350		$73,700		
	Clerk of the Board	O	59	$105,000		$134,450		$163,900		
	Clinical Auditor	L	567	$77,000		$98,450		$119,900		
	Clinical Auditor Sr	M	568	$85,000		$109,050		$133,100		
	Clinical Documentation Specialist (RN)	M	641	$85,000		$109,050		$133,100		
	Clinical Pharmacist	P	297	$117,000		$149,250		$181,500		
	Clinical Systems Administrator	K	607	$70,000		$88,900		$107,800		
	Clinical Trainer	M	TBD		$85,000		$109,050		$133,100	Add title
	Clinical Trainer (LVN)	L	TBD		$77,000		$98,450		$119,900	Add title
	Clinician (Behavioral Health)	K	513	$70,000		$88,900		$107,800		
	Communications Specialist	G	188	$55,000		$66,550		$78,100		
	Communications Specialist - Lead	J	~~TBD~~ 707	$65,000		$82,550		$100,100		
	Communications Specialist Sr	H	~~TBD~~ 708	$59,000		$71,850		$84,700		
	Community Partner	G	575	$55,000		$66,550		$78,100		
	Community Partner Sr	H	612	$59,000		$71,850		$84,700		
	Community Relations Specialist	G	288	$55,000		$66,550		$78,100		
	Community Relations Specialist Sr	I	646	$61,000		$77,250		$93,500		
	Compliance Claims Auditor	G	222	$55,000		$66,550		$78,100		
	Compliance Claims Auditor Sr	H	279	$59,000		$71,850		$84,700		
	Contract Administrator	K	385	$70,000		$88,900		$107,800		
	Contracts Manager	M	207	$85,000		$109,050		$133,100		
	Contracts Manager Sr	N	683	$95,000		$120,650		$146,300		
	Contracts Specialist	I	257	$61,000		$77,250		$93,500		
	Contracts Specialist Int	J	469	$65,000		$82,550		$100,100		
	Contracts Specialist Sr	K	331	$70,000		$88,900		$107,800		
*	Controller	T	464	$182,000		$240,600		$299,200		
	Credentialing Coordinator	E	41	$48,000		$58,100		$68,200		
	Credentialing Coordinator - Lead	F	510	$51,000		$62,350		$73,700		
	Customer Service Coordinator	E	182	$48,000		$58,100		$68,200		
	Customer Service Rep	C	5	~~$41,000~~	$43,281	~~$49,650~~	$50,790	$58,300		Increase pay grade minimum to $43,281 and shift pay grade midpoint accordingly

CalOptima - Annual Base Salary Schedule - Revised: ~~March 03, 2022~~ June 02, 2022
To be implemented: ~~March 13, 2022~~ June 05, 2022

	Job Title	Pay Grade	Job Code	Min	Proposed Min	Mid	Proposed Mid	Max	Proposed Max	For Approval
	Customer Service Rep - Lead	E	482	$48,000		$58,100		$68,200		
	Customer Service Rep Sr	D	481	$44,000		$53,900		$63,800		
	Data Analyst	J	337	$65,000		$82,550		$100,100		
	Data Analyst Int	K	341	$70,000		$88,900		$107,800		
	Data Analyst Sr	L	342	$77,000		$98,450		$119,900		
	Data and Reporting Analyst - Lead	M	654	$85,000		$109,050		$133,100		
	Data Entry Tech	A	3	~~$36,000~~	$41,600	~~$43,300~~	$46,100	$50,600		Increase pay grade minimum to $41,600 and shift pay grade midpoint accordingly
	Data Warehouse Architect	N	363	$95,000		$120,650		$146,300		
	Data Warehouse Programmer/Analyst	N	364	$95,000		$120,650		$146,300		
	Data Warehouse Reporting Analyst	M	412	$85,000		$109,050		$133,100		
	Data Warehouse Reporting Analyst Sr	N	522	$95,000		$120,650		$146,300		
	Database Administrator	L	90	$77,000		$98,450		$119,900		
	Database Administrator Sr	N	179	$95,000		$120,650		$146,300		
**	Deputy Chief Medical Officer	W	561	$313,000		$414,450		$515,900		
	Deputy Clerk of the Board	K	684	$70,000		$88,900		$107,800		
	Designer	K	387	$70,000		$88,900		$107,800		
	Designer Sr	L	~~TBD~~ 901	$77,000		$98,450		$119,900		
*	Director I	Q	~~TBD~~ 891	$130,000		$166,200		$202,400		
*	Director II	R	~~TBD~~ 892	$144,000		$184,200		$224,400		
*	Director III	S	~~TBD~~ 893	$154,000		$204,600		$255,200		
*	Director IV	T	~~TBD~~ 894	$182,000		$240,600		$299,200		
	Enrollment Coordinator (PACE)	F	441	$51,000		$62,350		$73,700		
	Enterprise Analytics Manager	O	582	$105,000		$134,450		$163,900		
	Executive Administrative Services Manager	J	661	$65,000		$82,550		$100,100		
	Executive Assistant	G	339	$55,000		$66,550		$78,100		
	Executive Assistant to CEO	I	261	$61,000		$77,250		$93,500		
**	Executive Director	U	~~TBD~~ 895	$226,000		$298,900		$371,800		
	Facilities & Support Services Coord - Lead	G	631	$55,000		$66,550		$78,100		
	Facilities & Support Services Coordinator	E	10	$48,000		$58,100		$68,200		
	Facilities & Support Services Coordinator Sr	F	511	$51,000		$62,350		$73,700		
	Facilities Coordinator	E	438	$48,000		$58,100		$68,200		
	~~Financial Analyst~~ Financial Analyst I	J	51	$65,000		$82,550		$100,100		Title Change
	~~Financial Analyst Sr~~ Financial Analyst II	L	84	$77,000		$98,450		$119,900		Title Change
	Financial Analyst III	M	TBD		$85,000		$109,050		$133,100	Add Title
	Financial Analyst IV	N	TBD		$95,000		$120,650		$146,300	Add Title
	Financial Reporting Analyst	I	475	$61,000		$77,250		$93,500		
	Grievance & Appeals Nurse Specialist	M	226	$85,000		$109,050		$133,100		
	Grievance Resolution Specialist	F	42	$51,000		$62,350		$73,700		
	Grievance Resolution Specialist - Lead	I	590	$61,000		$77,250		$93,500		
	Grievance Resolution Specialist Sr	H	589	$59,000		$71,850		$84,700		
	Health Coach	K	556	$70,000		$88,900		$107,800		
	Health Educator	H	47	$59,000		$71,850		$84,700		
	Health Educator Sr	I	355	$61,000		$77,250		$93,500		
	Health Network Liaison Specialist (RN)	L	524	$77,000		$98,450		$119,900		
	Health Network Oversight Specialist	K	323	$70,000		$88,900		$107,800		
	HEDIS Case Manager	M	443	$85,000		$109,050		$133,100		
	Help Desk Technician	E	571	$48,000		$58,100		$68,200		
	Help Desk Technician Sr	F	573	$51,000		$62,350		$73,700		
	Human Resources Assistant	D	181	$44,000		$53,900		$63,800		
	Human Resources Business Partner	M	584	$85,000		$109,050		$133,100		
	Human Resources Coordinator	F	316	$51,000		$62,350		$73,700		
	Human Resources Representative	J	278	$65,000		$82,550		$100,100		
	Human Resources Representative Sr	L	350	$77,000		$98,450		$119,900		
	Human Resources Specialist	G	505	$55,000		$66,550		$78,100		
	Human Resources Specialist Sr	H	608	$59,000		$71,850		$84,700		
	Information Technology Services Coordinator	E	365	$48,000		$58,100		$68,200		
	Information Technology Services Project Manager	N	424	$95,000		$120,650		$146,300		
	Information Technology Services Project Manager Sr	O	509	$105,000		$134,450		$163,900		
	Information Technology Services Project Specialist	K	549	$70,000		$88,900		$107,800		
	Information Technology Services Project Specialist Sr	L	550	$77,000		$98,450		$119,900		
	Infrastructure Systems Administrator	F	541	$51,000		$62,350		$73,700		
	Infrastructure Systems Administrator Int	G	542	$55,000		$66,550		$78,100		
	Inpatient Quality Coding Auditor	I	642	$61,000		$77,250		$93,500		
	Intern	A	237	~~$36,000~~	$41,600	~~$43,300~~	$46,100	$50,600		Increase pay grade minimum to $41,600 and shift pay grade midpoint accordingly
	Investigator Sr	I	553	$61,000		$77,250		$93,500		
	Kitchen Assistant	A	585	~~$36,000~~	$41,600	~~$43,300~~	$46,100	$50,600		Increase pay grade minimum to $41,600 and shift pay grade midpoint accordingly
	Licensed Clinical Social Worker	J	598	$65,000		$82,550		$100,100		
	Litigation Support Specialist	K	588	$70,000		$88,900		$107,800		
	LVN (PACE)	K	533	$70,000		$88,900		$107,800		
	LVN Specialist	K	686	$70,000		$88,900		$107,800		
	Mailroom Clerk	A	1	~~$36,000~~	$41,600	~~$43,300~~	$46,100	$50,600		Increase pay grade minimum to $41,600 and shift pay grade midpoint accordingly
	Manager Accounting	O	98	$105,000		$134,450		$163,900		
	Manager Actuary	R	453	$144,000		$184,200		$224,400		
	Manager Audit & Oversight	O	539	$105,000		$134,450		$163,900		
	Manager Behavioral Health	O	633	$105,000		$134,450		$163,900		
	Manager Business Integration	O	544	$105,000		$134,450		$163,900		
	Manager Case Management	P	270	$117,000		$149,250		$181,500		
	Manager Claims	O	92	$105,000		$134,450		$163,900		
	Manager Clinic Operations	N	551	$95,000		$120,650		$146,300		
	Manager Clinical Pharmacist	R	296	$144,000		$184,200		$224,400		
	Manager Coding Quality	N	382	$95,000		$120,650		$146,300		
	Manager Communications	N	398	$95,000		$120,650		$146,300		
	Manager Community Relations	N	384	$95,000		$120,650		$146,300		
	Manager Contracting	O	329	$105,000		$134,450		$163,900		
	Manager Creative Branding	M	430	$85,000		$109,050		$133,100		
	Manager Cultural & Linguistic	M	349	$85,000		$109,050		$133,100		
	Manager Customer Service	M	94	$85,000		$109,050		$133,100		
	Manager Electronic Business	N	422	$95,000		$120,650		$146,300		
	Manager Encounters	N	516	$95,000		$120,650		$146,300		

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To be implemented: ~~March 13, 2022~~ June 05, 2022

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	Manager Environmental Health & Safety	N	495	$95,000		$120,650		$146,300		
	Manager Finance	O	148	$105,000		$134,450		$163,900		
	Manager Financial Analysis	P	356	$117,000		$149,250		$181,500		
	Manager Government Affairs	N	437	$95,000		$120,650		$146,300		
	Manager Grievance & Appeals	O	426	$105,000		$134,450		$163,900		
	Manager Human Resources	O	526	$105,000		$134,450		$163,900		
	Manager Information Technology Services	P	560	$117,000		$149,250		$181,500		
	Manager Long Term Support Services	O	200	$105,000		$134,450		$163,900		
	Manager Marketing & Enrollment (PACE)	N	414	$95,000		$120,650		$146,300		
	Manager Marketing & Outreach	M	687	$85,000		$109,050		$133,100		
	Manager Member Liaison Program	M	354	$85,000		$109,050		$133,100		
	Manager Member Outreach & Education	M	616	$85,000		$109,050		$133,100		
	Manager MSSP	O	393	$105,000		$134,450		$163,900		
	Manager OneCare Clinical	P	359	$117,000		$149,250		$181,500		
	Manager OneCare Customer Service	M	429	$85,000		$109,050		$133,100		
	Manager Outreach & Enrollment	M	477	$85,000		$109,050		$133,100		
	Manager PACE Center	N	432	$95,000		$120,650		$146,300		
	Manager Population Health Management	N	674	$95,000		$120,650		$146,300		
	Manager Process Excellence	O	622	$105,000		$134,450		$163,900		
	Manager Program Implementation	N	488	$95,000		$120,650		$146,300		
	Manager Provider Data Management Services	M	653	$85,000		$109,050		$133,100		
	Manager Provider Network	O	191	$105,000		$134,450		$163,900		
	Manager Provider Relations	M	171	$85,000		$109,050		$133,100		
	Manager Purchasing	O	275	$105,000		$134,450		$163,900		
	Manager QI Initiatives	M	433	$85,000		$109,050		$133,100		
	Manager Quality Analytics	N	617	$95,000		$120,650		$146,300		
	Manager Quality Improvement	N	104	$95,000		$120,650		$146,300		
	Manager Regulatory Affairs and Compliance	O	626	$105,000		$134,450		$163,900		
	Manager Reporting & Financial Compliance	O	572	$105,000		$134,450		$163,900		
	Manager Strategic Development	O	603	$105,000		$134,450		$163,900		
	Manager Utilization Management	P	250	$117,000		$149,250		$181,500		
	Marketing and Outreach Specialist	F	496	$51,000		$62,350		$73,700		
	Medical Assistant	C	535	~~$41,000~~	$43,281	~~$49,650~~	$50,790	$58,300		Increase pay grade minimum to $43,281 and shift pay grade midpoint accordingly
	Medical Authorization Asst	C	11	~~$41,000~~	$43,281	~~$49,650~~	$50,790	$58,300		Increase pay grade minimum to $43,281 and shift pay grade midpoint accordingly
	Medical Case Manager	L	72	$77,000		$98,450		$119,900		
	Medical Case Manager (LVN)	K	444	$70,000		$88,900		$107,800		
*	Medical Director	V	306	$266,000		$351,900		$437,800		
	Medical Records & Health Plan Assistant	B	548	~~$38,000~~	$42,432	~~$46,500~~	$48,716	$55,000		Increase pay grade minimum to $42,432 and shift pay grade midpoint accordingly
	Medical Records Clerk	B	523	~~$38,000~~	$42,432	~~$46,500~~	$48,716	$55,000		Increase pay grade minimum to $42,432 and shift pay grade midpoint accordingly
	Medical Services Case Manager	G	54	$55,000		$66,550		$78,100		
	Member Liaison Specialist	D	353	$44,000		$53,900		$63,800		
	MMS Program Coordinator	G	360	$55,000		$66,550		$78,100		
	Nurse Practitioner (PACE)	O	635	$105,000		$134,450		$163,900		
	Occupational Therapist	L	531	$77,000		$98,450		$119,900		
	Occupational Therapist Assistant	H	623	$59,000		$71,850		$84,700		
	Office Clerk	A	335	~~$36,000~~	$41,600	~~$43,300~~	$46,100	$50,600		Increase pay grade minimum to $41,600 and shift pay grade midpoint accordingly
	OneCare Operations Manager	N	461	$95,000		$120,650		$146,300		
	OneCare Partner - Sales	F	230	$51,000		$62,350		$73,700		
	OneCare Partner - Sales (Lead)	G	537	$55,000		$66,550		$78,100		
	OneCare Partner - Service	C	231	~~$41,000~~	$43,281	~~$49,650~~	$50,790	$58,300		Increase pay grade minimum to $43,281 and shift pay grade midpoint accordingly
	OneCare Partner (Inside Sales)	E	371	$48,000		$58,100		$68,200		
	Outreach Specialist	C	218	~~$41,000~~	$43,281	~~$49,650~~	$50,790	$58,300		Increase pay grade minimum to $43,281 and shift pay grade midpoint accordingly
	Paralegal/Legal Secretary	I	376	$61,000		$77,250		$93,500		
	Payroll Specialist	E	554	$48,000		$58,100		$68,200		
	Payroll Specialist Sr	G	688	$55,000		$66,550		$78,100		
	Performance Analyst	I	538	$61,000		$77,250		$93,500		
	Personal Care Attendant	A	485	~~$36,000~~	$41,600	~~$43,300~~	$46,100	$50,600		Increase pay grade minimum to $41,600 and shift pay grade midpoint accordingly
	Personal Care Attendant - Lead	B	498	~~$38,000~~	$42,432	~~$46,500~~	$48,716	$55,000		Increase pay grade minimum to $42,432 and shift pay grade midpoint accordingly
	Personal Care Coordinator	C	525	~~$41,000~~	$43,281	~~$49,650~~	$50,790	$58,300		Increase pay grade minimum to $43,281 and shift pay grade midpoint accordingly
	Personal Care Coordinator Sr	D	689	$44,000		$53,900		$63,800		
	Pharmacy Resident	G	379	$55,000		$66,550		$78,100		
	Pharmacy Services Specialist	C	23	~~$41,000~~	$43,281	~~$49,650~~	$50,790	$58,300		Increase pay grade minimum to $43,281 and shift pay grade midpoint accordingly
	Pharmacy Services Specialist Int	D	35	$44,000		$53,900		$63,800		
	Pharmacy Services Specialist Sr	E	507	$48,000		$58,100		$68,200		
	Physical Therapist	L	530	$77,000		$98,450		$119,900		
	Physical Therapist Assistant	H	624	$59,000		$71,850		$84,700		
	Policy Advisor Sr	M	580	$85,000		$109,050		$133,100		
	Principal Financial Analyst	O	TBD		$105,000		$134,450		$163,900	Add title
	Privacy Manager	N	536	$95,000		$120,650		$146,300		
	Privacy Officer	O	648	$105,000		$134,450		$163,900		
	Process Excellence Manager	N	529	$95,000		$120,650		$146,300		
	Program Assistant	C	24	~~$41,000~~	$43,281	~~$49,650~~	$50,790	$58,300		Increase pay grade minimum to $43,281 and shift pay grade midpoint accordingly
	Program Coordinator	C	284	~~$41,000~~	$43,281	~~$49,650~~	$50,790	$58,300		Increase pay grade minimum to $43,281 and shift pay grade midpoint accordingly
	Program Development Analyst Sr	K	492	$70,000		$88,900		$107,800		
	Program Manager	L	421	$77,000		$98,450		$119,900		
	Program Manager Sr	M	594	$85,000		$109,050		$133,100		
	Program Specialist	E	36	$48,000		$58,100		$68,200		
	Program Specialist Int	G	61	$55,000		$66,550		$78,100		
	Program Specialist Sr	I	508	$61,000		$77,250		$93,500		
	Program/Policy Analyst	I	56	$61,000		$77,250		$93,500		
	Program/Policy Analyst Sr	K	85	$70,000		$88,900		$107,800		
	Programmer	K	43	$70,000		$88,900		$107,800		
	Programmer Int	M	74	$85,000		$109,050		$133,100		
	Programmer Sr	N	80	$95,000		$120,650		$146,300		
	Project Manager	L	81	$77,000		$98,450		$119,900		
	Project Manager - Lead	M	467	$85,000		$109,050		$133,100		
	Project Manager Sr	N	105	$95,000		$120,650		$146,300		

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To be implemented: ~~March 13, 2022~~ June 05, 2022

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	Project Specialist	E	291	$48,000		$58,100		$68,200		
	Project Specialist Sr	I	503	$61,000		$77,250		$93,500		
	Projects Analyst	G	254	$55,000		$66,550		$78,100		
	Provider Data Management Services Coordinator	D	12	$44,000		$53,900		$63,800		
	Provider Data Management Services Coordinator Sr	F	586	$51,000		$62,350		$73,700		
	Provider Enrollment Manager	G	190	$55,000		$66,550		$78,100		
	Provider Network Rep Sr	I	391	$61,000		$77,250		$93,500		
	Provider Network Specialist	H	44	$59,000		$71,850		$84,700		
	Provider Network Specialist Sr	J	595	$65,000		$82,550		$100,100		
	Provider Office Education Manager	I	300	$61,000		$77,250		$93,500		
	Provider Relations Rep	G	205	$55,000		$66,550		$78,100		
	Provider Relations Rep Sr	I	285	$61,000		$77,250		$93,500		
	Publications Coordinator	G	293	$55,000		$66,550		$78,100		
	QA Analyst	I	486	$61,000		$77,250		$93,500		
	QA Analyst Sr	L	380	$77,000		$98,450		$119,900		
	QI Nurse Specialist	M	82	$85,000		$109,050		$133,100		
	QI Nurse Specialist (LVN)	L	445	$77,000		$98,450		$119,900		
	Receptionist	B	140	~~$38,000~~	$42,432	~~$46,500~~	$48,716	$55,000		Increase pay grade minimum to $42,432 and shift pay grade midpoint accordingly
	Records Manager	Q	~~TBD~~ 778	$130,000		$166,200		$202,400		
	Recreational Therapist	H	487	$59,000		$71,850		$84,700		
	Registered Dietitian	I	57	$61,000		$77,250		$93,500		
	Regulatory Affairs and Compliance - Lead	L	630	$77,000		$98,450		$119,900		
	Regulatory Affairs and Compliance Analyst	I	628	$61,000		$77,250		$93,500		
	Regulatory Affairs and Compliance Analyst Sr	K	629	$70,000		$88,900		$107,800		
	RN (PACE)	M	480	$85,000		$109,050		$133,100		
	Security Analyst Int	M	534	$85,000		$109,050		$133,100		
	Security Analyst Sr	N	474	$95,000		$120,650		$146,300		
	Security Officer	B	311	~~$38,000~~	$42,432	~~$46,500~~	$48,716	$55,000		Increase pay grade minimum to $42,432 and shift pay grade midpoint accordingly
	SharePoint Developer/Administrator Sr	N	397	$95,000		$120,650		$146,300		
	Social Worker	J	463	$65,000		$82,550		$100,100		
	Social Worker Sr	K	690	$70,000		$88,900		$107,800		
*	Sr Director	T	~~TBD~~ 896	$182,000		$240,600		$299,200		
	Sr Manager I	P	~~TBD~~ 897	$117,000		$149,250		$181,500		
	Sr Manager II	Q	~~TBD~~ 898	$130,000		$166,200		$202,400		
	Sr Manager III	R	~~TBD~~ 899	$144,000		$184,200		$224,400		
	Sr Manager IV	S	~~TBD~~ 900	$154,000		$204,600		$255,200		
	Supervisor Accounting	M	434	$85,000		$109,050		$133,100		
	Supervisor Audit and Oversight	M	618	$85,000		$109,050		$133,100		
	Supervisor Behavioral Health	M	659	$85,000		$109,050		$133,100		
	Supervisor Budgeting	N	466	$95,000		$120,650		$146,300		
	Supervisor Case Management	M	86	$85,000		$109,050		$133,100		
	Supervisor Claims	J	219	$65,000		$82,550		$100,100		
	Supervisor Coding Initiatives	M	502	$85,000		$109,050		$133,100		
	Supervisor Credentialing	I	671	$61,000		$77,250		$93,500		
	Supervisor Customer Service	I	34	$61,000		$77,250		$93,500		
	Supervisor Data Entry	H	192	$59,000		$71,850		$84,700		
	Supervisor Day Center (PACE)	H	619	$59,000		$71,850		$84,700		
	Supervisor Dietary Services (PACE)	J	643	$65,000		$82,550		$100,100		
	Supervisor Encounters	I	253	$61,000		$77,250		$93,500		
	Supervisor Facilities	J	162	$65,000		$82,550		$100,100		
	Supervisor Finance	M	419	$85,000		$109,050		$133,100		
	Supervisor Grievance and Appeals	L	620	$77,000		$98,450		$119,900		
	Supervisor Information Technology Services	N	457	$95,000		$120,650		$146,300		
	Supervisor Long Term Support Services	M	587	$85,000		$109,050		$133,100		
	Supervisor Member Outreach and Education	K	592	$70,000		$88,900		$107,800		
	Supervisor MSSP	M	348	$85,000		$109,050		$133,100		
	Supervisor Nursing Services (PACE)	M	662	$85,000		$109,050		$133,100		
	Supervisor OneCare Customer Service	I	408	$61,000		$77,250		$93,500		
	Supervisor Payroll	M	547	$85,000		$109,050		$133,100		
	Supervisor Pharmacist	Q	610	$130,000		$166,200		$202,400		
	Supervisor Population Health Management	M	673	$85,000		$109,050		$133,100		
	Supervisor Provider Data Management Services	K	439	$70,000		$88,900		$107,800		
	Supervisor Provider Relations	L	652	$77,000		$98,450		$119,900		
	Supervisor Quality Analytics	M	609	$85,000		$109,050		$133,100		
	Supervisor Quality Improvement	M	600	$85,000		$109,050		$133,100		
	Supervisor Regulatory Affairs and Compliance	M	627	$85,000		$109,050		$133,100		
	Supervisor Social Work (PACE)	J	636	$65,000		$82,550		$100,100		
	Supervisor Therapy Services (PACE)	M	645	$85,000		$109,050		$133,100		
	Supervisor Utilization Management	M	637	$85,000		$109,050		$133,100		
	Systems Network Administrator Int	L	63	$77,000		$98,450		$119,900		
	Systems Network Administrator Sr	M	89	$85,000		$109,050		$133,100		
	Systems Operations Analyst	F	32	$51,000		$62,350		$73,700		
	Systems Operations Analyst Int	G	45	$55,000		$66,550		$78,100		
	Technical Analyst Int	J	64	$65,000		$82,550		$100,100		
	Technical Analyst Sr	L	75	$77,000		$98,450		$119,900		
	Therapy Aide	E	521	$48,000		$58,100		$68,200		
	Training Administrator	I	621	$61,000		$77,250		$93,500		
	Training Program Coordinator	H	471	$59,000		$71,850		$84,700		
	Translation Specialist	B	241	~~$38,000~~	$42,432	~~$46,500~~	$48,716	$55,000		Increase pay grade minimum to $42,432 and shift pay grade midpoint accordingly
	Web Architect	N	366	$95,000		$120,650		$146,300		

* These positions are identified for the purposes of CalOptima Policy GA. 8042: Supplemental Compensation as Director level and above positions for which eligible employees may qualify for Employer-Paid Member Contribution.

** These positions are identified for the purposes of CalOptima Policy GA. 8042: Supplemental Compensation as Director level and above positions for which eligible

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	Job Title	Pay Grade	Job Code	Min	Mid	Max
	Accountant	H	39	$59,000	$71,850	$84,700
	Accountant Int	I	634	$61,000	$77,250	$93,500
	Accountant Sr	K	68	$70,000	$88,900	$107,800
	Accounting Clerk	D	334	$44,000	$53,900	$63,800
	Accounting Clerk Sr	E	680	$48,000	$58,100	$68,200
	Activity Coordinator (PACE)	E	681	$48,000	$58,100	$68,200
	Actuarial Analyst	K	558	$70,000	$88,900	$107,800
	Actuarial Analyst Sr	L	559	$77,000	$98,450	$119,900
	Actuary	O	357	$105,000	$134,450	$163,900
	Actuary Principal	Q	882	$130,000	$166,200	$202,400
	Actuary Sr	P	883	$117,000	$149,250	$181,500
	Administrative Assistant	D	19	$44,000	$53,900	$63,800
	Administrative Fellow	J	TBD	$65,000	$82,550	$100,100
	Analyst	H	562	$59,000	$71,850	$84,700
	Analyst Int	I	563	$61,000	$77,250	$93,500
	Analyst Sr	J	564	$65,000	$82,550	$100,100
	Applications Analyst	I	232	$61,000	$77,250	$93,500
	Applications Analyst Int	J	233	$65,000	$82,550	$100,100
	Applications Analyst Sr	L	298	$77,000	$98,450	$119,900
	Associate Director I	P	884	$117,000	$149,250	$181,500
	Associate Director II	Q	885	$130,000	$166,200	$202,400
	Associate Director III	R	886	$144,000	$184,200	$224,400
	Associate Director IV	S	887	$154,000	$204,600	$255,200
	Auditor	I	565	$61,000	$77,250	$93,500
	Auditor Sr	J	566	$65,000	$82,550	$100,100
	Behavioral Health Manager	M	383	$85,000	$109,050	$133,100
	Biostatistics Manager	M	418	$85,000	$109,050	$133,100
	Board Services Specialist	E	435	$48,000	$58,100	$68,200
	Business Analyst	J	40	$65,000	$82,550	$100,100
	Business Analyst Sr	L	611	$77,000	$98,450	$119,900
	Business Systems Analyst Sr	K	69	$70,000	$88,900	$107,800
	Buyer	G	29	$55,000	$66,550	$78,100
	Buyer Int	H	49	$59,000	$71,850	$84,700
	Buyer Sr	I	67	$61,000	$77,250	$93,500
	Care Manager	K	657	$70,000	$88,900	$107,800
	Care Transition Intervention Coach (RN)	L	417	$77,000	$98,450	$119,900
	Certified Coder	H	399	$59,000	$71,850	$84,700
	Certified Coding Specialist	H	639	$59,000	$71,850	$84,700
	Certified Coding Specialist Sr	J	640	$65,000	$82,550	$100,100
	Change Control Administrator	I	499	$61,000	$77,250	$93,500
	Change Control Administrator Int	J	500	$65,000	$82,550	$100,100
**	Chief Compliance Officer	W	888	$313,000	$414,450	$515,900
**	Chief Executive Officer	Z	138	$560,000	$700,750	$841,500
**	Chief Financial Officer	X	134	$368,000	$487,600	$607,200
**	Chief Health Equity Officer	W	889	$313,000	$414,450	$515,900
**	Chief Human Resources Officer	W	890	$313,000	$414,450	$515,900
**	Chief Information Officer	W	131	$313,000	$414,450	$515,900
**	Chief Medical Officer	X	137	$368,000	$487,600	$607,200
**	Chief of Staff	U	692	$226,000	$298,900	$371,800
**	Chief Operating Officer	Y	136	$433,000	$573,450	$713,900
	Claims - Lead	G	574	$55,000	$66,550	$78,100
	Claims Examiner	C	9	$43,281	$50,790	$58,300
	Claims Examiner - Lead	F	236	$51,000	$62,350	$73,700

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	Job Title	Pay Grade	Job Code	Min	Mid	Max
	Claims Examiner Sr	E	20	$48,000	$58,100	$68,200
	Claims QA Analyst	F	28	$51,000	$62,350	$73,700
	Claims QA Analyst Sr	G	540	$55,000	$66,550	$78,100
	Claims Recovery Specialist	F	283	$51,000	$62,350	$73,700
	Claims Resolution Specialist	F	262	$51,000	$62,350	$73,700
	Clerk of the Board	O	59	$105,000	$134,450	$163,900
	Clinical Auditor	L	567	$77,000	$98,450	$119,900
	Clinical Auditor Sr	M	568	$85,000	$109,050	$133,100
	Clinical Documentation Specialist (RN)	M	641	$85,000	$109,050	$133,100
	Clinical Pharmacist	P	297	$117,000	$149,250	$181,500
	Clinical Systems Administrator	K	607	$70,000	$88,900	$107,800
	Clincal Trainer	M	TBD	$85,000	$109,050	$133,100
	Clincal Trainer (LVN)	L	TBD	$77,000	$98,450	$119,900
	Clinician (Behavioral Health)	K	513	$70,000	$88,900	$107,800
	Communications Specialist	G	188	$55,000	$66,550	$78,100
	Communications Specialist - Lead	J	707	$65,000	$82,550	$100,100
	Communications Specialist Sr	H	708	$59,000	$71,850	$84,700
	Community Partner	G	575	$55,000	$66,550	$78,100
	Community Partner Sr	H	612	$59,000	$71,850	$84,700
	Community Relations Specialist	G	288	$55,000	$66,550	$78,100
	Community Relations Specialist Sr	I	646	$61,000	$77,250	$93,500
	Compliance Claims Auditor	G	222	$55,000	$66,550	$78,100
	Compliance Claims Auditor Sr	H	279	$59,000	$71,850	$84,700
	Contract Administrator	K	385	$70,000	$88,900	$107,800
	Contracts Manager	M	207	$85,000	$109,050	$133,100
	Contracts Manager Sr	N	683	$95,000	$120,650	$146,300
	Contracts Specialist	I	257	$61,000	$77,250	$93,500
	Contracts Specialist Int	J	469	$65,000	$82,550	$100,100
	Contracts Specialist Sr	K	331	$70,000	$88,900	$107,800
*	Controller	T	464	$182,000	$240,600	$299,200
	Credentialing Coordinator	E	41	$48,000	$58,100	$68,200
	Credentialing Coordinator - Lead	F	510	$51,000	$62,350	$73,700
	Customer Service Coordinator	E	182	$48,000	$58,100	$68,200
	Customer Service Rep	C	5	$43,281	$50,790	$58,300
	Customer Service Rep - Lead	E	482	$48,000	$58,100	$68,200
	Customer Service Rep Sr	D	481	$44,000	$53,900	$63,800
	Data Analyst	J	337	$65,000	$82,550	$100,100
	Data Analyst Int	K	341	$70,000	$88,900	$107,800
	Data Analyst Sr	L	342	$77,000	$98,450	$119,900
	Data and Reporting Analyst - Lead	M	654	$85,000	$109,050	$133,100
	Data Entry Tech	A	3	$41,600	$46,100	$50,600
	Data Warehouse Architect	N	363	$95,000	$120,650	$146,300
	Data Warehouse Programmer/Analyst	N	364	$95,000	$120,650	$146,300
	Data Warehouse Reporting Analyst	M	412	$85,000	$109,050	$133,100
	Data Warehouse Reporting Analyst Sr	N	522	$95,000	$120,650	$146,300
	Database Administrator	L	90	$77,000	$98,450	$119,900
	Database Administrator Sr	N	179	$95,000	$120,650	$146,300
**	Deputy Chief Medical Officer	W	561	$313,000	$414,450	$515,900
	Deputy Clerk of the Board	K	684	$70,000	$88,900	$107,800
	Designer	K	387	$70,000	$88,900	$107,800
	Designer Sr	L	901	$77,000	$98,450	$119,900
*	Director I	Q	891	$130,000	$166,200	$202,400
*	Director II	R	892	$144,000	$184,200	$224,400

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	Job Title	Pay Grade	Job Code	Min	Mid	Max
*	Director III	S	893	$154,000	$204,600	$255,200
*	Director IV	T	894	$182,000	$240,600	$299,200
	Enrollment Coordinator (PACE)	F	441	$51,000	$62,350	$73,700
	Enterprise Analytics Manager	O	582	$105,000	$134,450	$163,900
	Executive Administrative Services Manager	J	661	$65,000	$82,550	$100,100
	Executive Assistant	G	339	$55,000	$66,550	$78,100
	Executive Assistant to CEO	I	261	$61,000	$77,250	$93,500
**	Executive Director	U	895	$226,000	$298,900	$371,800
	Facilities & Support Services Coord - Lead	G	631	$55,000	$66,550	$78,100
	Facilities & Support Services Coordinator	E	10	$48,000	$58,100	$68,200
	Facilities & Support Services Coordinator Sr	F	511	$51,000	$62,350	$73,700
	Facilities Coordinator	E	438	$48,000	$58,100	$68,200
	Financial Analyst I	J	51	$65,000	$82,550	$100,100
	Financial Analyst II	L	84	$77,000	$98,450	$119,900
	Financial Analyst III	M	TBD	$85,000	$109,050	$133,100
	Financial Analyst IV	N	TBD	$95,000	$120,650	$146,300
	Financial Reporting Analyst	I	475	$61,000	$77,250	$93,500
	Grievance & Appeals Nurse Specialist	M	226	$85,000	$109,050	$133,100
	Grievance Resolution Specialist	F	42	$51,000	$62,350	$73,700
	Grievance Resolution Specialist - Lead	I	590	$61,000	$77,250	$93,500
	Grievance Resolution Specialist Sr	H	589	$59,000	$71,850	$84,700
	Health Coach	K	556	$70,000	$88,900	$107,800
	Health Educator	H	47	$59,000	$71,850	$84,700
	Health Educator Sr	I	355	$61,000	$77,250	$93,500
	Health Network Liaison Specialist (RN)	L	524	$77,000	$98,450	$119,900
	Health Network Oversight Specialist	K	323	$70,000	$88,900	$107,800
	HEDIS Case Manager	M	443	$85,000	$109,050	$133,100
	Help Desk Technician	E	571	$48,000	$58,100	$68,200
	Help Desk Technician Sr	F	573	$51,000	$62,350	$73,700
	Human Resources Assistant	D	181	$44,000	$53,900	$63,800
	Human Resources Business Partner	M	584	$85,000	$109,050	$133,100
	Human Resources Coordinator	F	316	$51,000	$62,350	$73,700
	Human Resources Representative	J	278	$65,000	$82,550	$100,100
	Human Resources Representative Sr	L	350	$77,000	$98,450	$119,900
	Human Resources Specialist	G	505	$55,000	$66,550	$78,100
	Human Resources Specialist Sr	H	608	$59,000	$71,850	$84,700
	Information Technology Services Coordinator	E	365	$48,000	$58,100	$68,200
	Information Technology Services Project Manager	N	424	$95,000	$120,650	$146,300
	Information Technology Services Project Manager Sr	O	509	$105,000	$134,450	$163,900
	Information Technology Services Project Specialist	K	549	$70,000	$88,900	$107,800
	Information Technology Services Project Specialist Sr	L	550	$77,000	$98,450	$119,900
	Infrastructure Systems Administrator	F	541	$51,000	$62,350	$73,700
	Infrastructure Systems Administrator Int	G	542	$55,000	$66,550	$78,100
	Inpatient Quality Coding Auditor	I	642	$61,000	$77,250	$93,500
	Intern	A	237	$41,600	$46,100	$50,600
	Investigator Sr	I	553	$61,000	$77,250	$93,500
	Kitchen Assistant	A	585	$41,600	$46,100	$50,600
	Licensed Clinical Social Worker	J	598	$65,000	$82,550	$100,100
	Litigation Support Specialist	K	588	$70,000	$88,900	$107,800
	LVN (PACE)	K	533	$70,000	$88,900	$107,800
	LVN Specialist	K	686	$70,000	$88,900	$107,800
	Mailroom Clerk	A	1	$41,600	$46,100	$50,600
	Manager Accounting	O	98	$105,000	$134,450	$163,900

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Job Title	Pay Grade	Job Code	Min	Mid	Max
Manager Actuary	R	453	$144,000	$184,200	$224,400
Manager Audit & Oversight	O	539	$105,000	$134,450	$163,900
Manager Behavioral Health	O	633	$105,000	$134,450	$163,900
Manager Business Integration	O	544	$105,000	$134,450	$163,900
Manager Case Management	P	270	$117,000	$149,250	$181,500
Manager Claims	O	92	$105,000	$134,450	$163,900
Manager Clinic Operations	N	551	$95,000	$120,650	$146,300
Manager Clinical Pharmacist	R	296	$144,000	$184,200	$224,400
Manager Coding Quality	N	382	$95,000	$120,650	$146,300
Manager Communications	N	398	$95,000	$120,650	$146,300
Manager Community Relations	N	384	$95,000	$120,650	$146,300
Manager Contracting	O	329	$105,000	$134,450	$163,900
Manager Creative Branding	M	430	$85,000	$109,050	$133,100
Manager Cultural & Linguistic	M	349	$85,000	$109,050	$133,100
Manager Customer Service	M	94	$85,000	$109,050	$133,100
Manager Electronic Business	N	422	$95,000	$120,650	$146,300
Manager Encounters	N	516	$95,000	$120,650	$146,300
Manager Environmental Health & Safety	N	495	$95,000	$120,650	$146,300
Manager Finance	O	148	$105,000	$134,450	$163,900
Manager Financial Analysis	P	356	$117,000	$149,250	$181,500
Manager Government Affairs	N	437	$95,000	$120,650	$146,300
Manager Grievance & Appeals	O	426	$105,000	$134,450	$163,900
Manager Human Resources	O	526	$105,000	$134,450	$163,900
Manager Information Technology Services	P	560	$117,000	$149,250	$181,500
Manager Long Term Support Services	O	200	$105,000	$134,450	$163,900
Manager Marketing & Enrollment (PACE)	N	414	$95,000	$120,650	$146,300
Manager Marketing & Outreach	M	687	$85,000	$109,050	$133,100
Manager Member Liaison Program	M	354	$85,000	$109,050	$133,100
Manager Member Outreach & Education	M	616	$85,000	$109,050	$133,100
Manager MSSP	O	393	$105,000	$134,450	$163,900
Manager OneCare Clinical	P	359	$117,000	$149,250	$181,500
Manager OneCare Customer Service	M	429	$85,000	$109,050	$133,100
Manager Outreach & Enrollment	M	477	$85,000	$109,050	$133,100
Manager PACE Center	N	432	$95,000	$120,650	$146,300
Manager Population Health Management	N	674	$95,000	$120,650	$146,300
Manager Process Excellence	O	622	$105,000	$134,450	$163,900
Manager Program Implementation	N	488	$95,000	$120,650	$146,300
Manager Provider Data Management Services	M	653	$85,000	$109,050	$133,100
Manager Provider Network	O	191	$105,000	$134,450	$163,900
Manager Provider Relations	M	171	$85,000	$109,050	$133,100
Manager Purchasing	O	275	$105,000	$134,450	$163,900
Manager QI Initiatives	M	433	$85,000	$109,050	$133,100
Manager Quality Analytics	N	617	$95,000	$120,650	$146,300
Manager Quality Improvement	N	104	$95,000	$120,650	$146,300
Manager Regulatory Affairs and Compliance	O	626	$105,000	$134,450	$163,900
Manager Reporting & Financial Compliance	O	572	$105,000	$134,450	$163,900
Manager Strategic Development	O	603	$105,000	$134,450	$163,900
Manager Utilization Management	P	250	$117,000	$149,250	$181,500
Marketing and Outreach Specialist	F	496	$51,000	$62,350	$73,700
Medical Assistant	C	535	$43,281	$50,790	$58,300
Medical Authorization Asst	C	11	$43,281	$50,790	$58,300
Medical Case Manager	L	72	$77,000	$98,450	$119,900
Medical Case Manager (LVN)	K	444	$70,000	$88,900	$107,800

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	Job Title	Pay Grade	Job Code	Min	Mid	Max
*	Medical Director	V	306	$266,000	$351,900	$437,800
	Medical Records & Health Plan Assistant	B	548	$42,432	$48,716	$55,000
	Medical Records Clerk	B	523	$42,432	$48,716	$55,000
	Medical Services Case Manager	G	54	$55,000	$66,550	$78,100
	Member Liaison Specialist	D	353	$44,000	$53,900	$63,800
	MMS Program Coordinator	G	360	$55,000	$66,550	$78,100
	Nurse Practitioner (PACE)	O	635	$105,000	$134,450	$163,900
	Occupational Therapist	L	531	$77,000	$98,450	$119,900
	Occupational Therapist Assistant	H	623	$59,000	$71,850	$84,700
	Office Clerk	A	335	$41,600	$46,100	$50,600
	OneCare Operations Manager	N	461	$95,000	$120,650	$146,300
	OneCare Partner - Sales	F	230	$51,000	$62,350	$73,700
	OneCare Partner - Sales (Lead)	G	537	$55,000	$66,550	$78,100
	OneCare Partner - Service	C	231	$43,281	$50,790	$58,300
	OneCare Partner (Inside Sales)	E	371	$48,000	$58,100	$68,200
	Outreach Specialist	C	218	$43,281	$50,790	$58,300
	Paralegal/Legal Secretary	I	376	$61,000	$77,250	$93,500
	Payroll Specialist	E	554	$48,000	$58,100	$68,200
	Payroll Specialist Sr	G	688	$55,000	$66,550	$78,100
	Performance Analyst	I	538	$61,000	$77,250	$93,500
	Personal Care Attendant	A	485	$41,600	$46,100	$50,600
	Personal Care Attendant - Lead	B	498	$42,432	$48,716	$55,000
	Personal Care Coordinator	C	525	$43,281	$50,790	$58,300
	Personal Care Coordinator Sr	D	689	$44,000	$53,900	$63,800
	Pharmacy Resident	G	379	$55,000	$66,550	$78,100
	Pharmacy Services Specialist	C	23	$43,281	$50,790	$58,300
	Pharmacy Services Specialist Int	D	35	$44,000	$53,900	$63,800
	Pharmacy Services Specialist Sr	E	507	$48,000	$58,100	$68,200
	Physical Therapist	L	530	$77,000	$98,450	$119,900
	Physical Therapist Assistant	H	624	$59,000	$71,850	$84,700
	Policy Advisor Sr	M	580	$85,000	$109,050	$133,100
	Principal Financial Analyst	O	TBD	$105,000	$134,450	$163,900
	Privacy Manager	N	536	$95,000	$120,650	$146,300
	Privacy Officer	O	648	$105,000	$134,450	$163,900
	Process Excellence Manager	N	529	$95,000	$120,650	$146,300
	Program Assistant	C	24	$43,281	$50,790	$58,300
	Program Coordinator	C	284	$43,281	$50,790	$58,300
	Program Development Analyst Sr	K	492	$70,000	$88,900	$107,800
	Program Manager	L	421	$77,000	$98,450	$119,900
	Program Manager Sr	M	594	$85,000	$109,050	$133,100
	Program Specialist	E	36	$48,000	$58,100	$68,200
	Program Specialist Int	G	61	$55,000	$66,550	$78,100
	Program Specialist Sr	I	508	$61,000	$77,250	$93,500
	Program/Policy Analyst	I	56	$61,000	$77,250	$93,500
	Program/Policy Analyst Sr	K	85	$70,000	$88,900	$107,800
	Programmer	K	43	$70,000	$88,900	$107,800
	Programmer Int	M	74	$85,000	$109,050	$133,100
	Programmer Sr	N	80	$95,000	$120,650	$146,300
	Project Manager	L	81	$77,000	$98,450	$119,900
	Project Manager - Lead	M	467	$85,000	$109,050	$133,100
	Project Manager Sr	N	105	$95,000	$120,650	$146,300
	Project Specialist	E	291	$48,000	$58,100	$68,200
	Project Specialist Sr	I	503	$61,000	$77,250	$93,500

CalOptima - Annual Base Salary Schedule - Revised: June 02, 2022
To be implemented: June 05, 2022

Job Title	Pay Grade	Job Code	Min	Mid	Max
Projects Analyst	G	254	$55,000	$66,550	$78,100
Provider Data Management Services Coordinator	D	12	$44,000	$53,900	$63,800
Provider Data Management Services Coordinator Sr	F	586	$51,000	$62,350	$73,700
Provider Enrollment Manager	G	190	$55,000	$66,550	$78,100
Provider Network Rep Sr	I	391	$61,000	$77,250	$93,500
Provider Network Specialist	H	44	$59,000	$71,850	$84,700
Provider Network Specialist Sr	J	595	$65,000	$82,550	$100,100
Provider Office Education Manager	I	300	$61,000	$77,250	$93,500
Provider Relations Rep	G	205	$55,000	$66,550	$78,100
Provider Relations Rep Sr	I	285	$61,000	$77,250	$93,500
Publications Coordinator	G	293	$55,000	$66,550	$78,100
QA Analyst	I	486	$61,000	$77,250	$93,500
QA Analyst Sr	L	380	$77,000	$98,450	$119,900
QI Nurse Specialist	M	82	$85,000	$109,050	$133,100
QI Nurse Specialist (LVN)	L	445	$77,000	$98,450	$119,900
Receptionist	B	140	$42,432	$48,716	$55,000
Records Manager	Q	778	$130,000	$166,200	$202,400
Recreational Therapist	H	487	$59,000	$71,850	$84,700
Registered Dietitian	I	57	$61,000	$77,250	$93,500
Regulatory Affairs and Compliance - Lead	L	630	$77,000	$98,450	$119,900
Regulatory Affairs and Compliance Analyst	I	628	$61,000	$77,250	$93,500
Regulatory Affairs and Compliance Analyst Sr	K	629	$70,000	$88,900	$107,800
RN (PACE)	M	480	$85,000	$109,050	$133,100
Security Analyst Int	M	534	$85,000	$109,050	$133,100
Security Analyst Sr	N	474	$95,000	$120,650	$146,300
Security Officer	B	311	$42,432	$48,716	$55,000
SharePoint Developer/Administrator Sr	N	397	$95,000	$120,650	$146,300
Social Worker	J	463	$65,000	$82,550	$100,100
Social Worker Sr	K	690	$70,000	$88,900	$107,800
* Sr Director	T	896	$182,000	$240,600	$299,200
Sr Manager I	P	897	$117,000	$149,250	$181,500
Sr Manager II	Q	898	$130,000	$166,200	$202,400
Sr Manager III	R	899	$144,000	$184,200	$224,400
Sr Manager IV	S	900	$154,000	$204,600	$255,200
Supervisor Accounting	M	434	$85,000	$109,050	$133,100
Supervisor Audit and Oversight	M	618	$85,000	$109,050	$133,100
Supervisor Behavioral Health	M	659	$85,000	$109,050	$133,100
Supervisor Budgeting	N	466	$95,000	$120,650	$146,300
Supervisor Case Management	M	86	$85,000	$109,050	$133,100
Supervisor Claims	J	219	$65,000	$82,550	$100,100
Supervisor Coding Initiatives	M	502	$85,000	$109,050	$133,100
Supervisor Credentialing	I	671	$61,000	$77,250	$93,500
Supervisor Customer Service	I	34	$61,000	$77,250	$93,500
Supervisor Data Entry	H	192	$59,000	$71,850	$84,700
Supervisor Day Center (PACE)	H	619	$59,000	$71,850	$84,700
Supervisor Dietary Services (PACE)	J	643	$65,000	$82,550	$100,100
Supervisor Encounters	I	253	$61,000	$77,250	$93,500
Supervisor Facilities	J	162	$65,000	$82,550	$100,100
Supervisor Finance	M	419	$85,000	$109,050	$133,100
Supervisor Grievance and Appeals	L	620	$77,000	$98,450	$119,900
Supervisor Information Technology Services	N	457	$95,000	$120,650	$146,300
Supervisor Long Term Support Services	M	587	$85,000	$109,050	$133,100
Supervisor Member Outreach and Education	K	592	$70,000	$88,900	$107,800

CalOptima - Annual Base Salary Schedule - Revised: June 02, 2022
To be implemented: June 05, 2022

Job Title	Pay Grade	Job Code	Min	Mid	Max
Supervisor MSSP	M	348	$85,000	$109,050	$133,100
Supervisor Nursing Services (PACE)	M	662	$85,000	$109,050	$133,100
Supervisor OneCare Customer Service	I	408	$61,000	$77,250	$93,500
Supervisor Payroll	M	517	$85,000	$109,050	$133,100
Supervisor Pharmacist	Q	610	$130,000	$166,200	$202,400
Supervisor Population Health Management	M	673	$85,000	$109,050	$133,100
Supervisor Provider Data Management Services	K	439	$70,000	$88,900	$107,800
Supervisor Provider Relations	L	652	$77,000	$98,450	$119,900
Supervisor Quality Analytics	M	609	$85,000	$109,050	$133,100
Supervisor Quality Improvement	M	600	$85,000	$109,050	$133,100
Supervisor Regulatory Affairs and Compliance	M	627	$85,000	$109,050	$133,100
Supervisor Social Work (PACE)	J	636	$65,000	$82,550	$100,100
Supervisor Therapy Services (PACE)	M	645	$85,000	$109,050	$133,100
Supervisor Utilization Management	M	637	$85,000	$109,050	$133,100
Systems Network Administrator Int	L	63	$77,000	$98,450	$119,900
Systems Network Administrator Sr	M	89	$85,000	$109,050	$133,100
Systems Operations Analyst	F	32	$51,000	$62,350	$73,700
Systems Operations Analyst Int	G	45	$55,000	$66,550	$78,100
Technical Analyst Int	J	64	$65,000	$82,550	$100,100
Technical Analyst Sr	L	75	$77,000	$98,450	$119,900
Therapy Aide	E	521	$48,000	$58,100	$68,200
Training Administrator	I	621	$61,000	$77,250	$93,500
Training Program Coordinator	H	471	$59,000	$71,850	$84,700
Translation Specialist	B	241	$42,432	$48,716	$55,000
Web Architect	N	366	$95,000	$120,650	$146,300

* These positions are identified for the purposes of CalOptima Policy GA. 8042: Supplemental Compensation as Director level and above positions for which eligible employees may qualify for Employer-Paid Member Contribution.

** These positions are identified for the purposes of CalOptima Policy GA. 8042: Supplemental Compensation as Director level and

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken June 2, 2022
Regular Meeting of the CalOptima Board of Directors

Report Item
Election of Officers of the Board of Directors for Fiscal Year 2022-23

Contact
Michael Hunn, Chief Executive Officer, (657) 900-1481

Recommended Action
Elect Board Chair and Vice Chair for terms effective July 1, 2022, through June 30, 2023, or until the election of a successor(s), unless the Board Chair or Vice Chair shall sooner resign or be removed from office.

Background/Discussion
In accordance with Article VIII, Section 8.1 of CalOptima's Bylaws, the Board shall elect one of its Directors as Chair at an organizational meeting. The Chair shall be the principal officer of the Board and shall preside at all meetings of the Board, shall appoint all members of the Ad Hoc Committees, as well as the chair of the Ad Hoc Committees and all Committees other than the Member and Provider Advisory Committees. The Chair shall perform all duties incident to the office and such other duties as may be prescribed by the Board from time to time.

Section 8.2 of the CalOptima Bylaws states that the Board shall elect one of its Directors to serve as Vice Chair at an organizational meeting. The Vice Chair shall perform the duties of the Chair if the Chair is absent from the meeting or is otherwise unable to act.

The Chair and Vice Chair terms shall commence on the first day of the month after the organizational meeting at which they are elected to their respective positions.

Fiscal Impact
There is no fiscal impact.

Rationale for Recommendation
The recommended actions are in accordance with Article VIII of the CalOptima Bylaws.

Concurrence
Troy R. Szabo, Outside General Counsel, Kennaday Leavitt

Attachments
None

/s/ Michael Hunn — *05/27/2022*
Authorized Signature — **Date**

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Board of Directors Meeting
June 2, 2022

OneCare Connect Cal MediConnect Plan (Medicare-Medicaid Plan)
Member Advisory Committee Update

On April 21, 2022, the OneCare Connect Member Advisory Committee (OCC MAC) held a regular meeting via teleconference using Zoom Webinar technology.

OCC MAC members approved their meeting schedule through December 2022 and approved a recommendation to extend the terms through December 31, 2022, for those members whose term expires on June 30, 2022. The OCC MAC also approved their FY 2021-22 accomplishments.

Michael Hunn, Chief Executive Officer (CEO) provided the committee with a verbal CEO update discussing CalFresh and noted that CalOptima has organized a campaign to make members aware of this benefit. He noted that approximately 247,000 members were already enrolled and that CalOptima is identifying those members who are not enrolled in CalFresh to provide them with this assistance. Mr. Hunn also discussed how CalOptima will be seeking Board approval to enter into the California Exchange (Cover California) at the May Board meeting.

Yunkyung Kim, Chief Operating Officer provided a verbal update and discussed how CalOptima is in the process of the transition from OneCare Connect to OneCare and discussed the additional OneCare benefits with the committee. She asked the committee to help promote the transition to OneCare with the OneCare Connect members.

Richard Pitts, D.O., Chief Medical Officer provided a verbal update on COVID and discussed the category of patients with severe underlying conditions and the various types of medical drugs that were available for treatment.

Kelly Giardina, Executive Director, Clinical Operations with Scott Robinson, Director, Long-Term Services and Supports (LTSS) along with Michelle Findlater, LTSS Manager presented on the Difficulty in Placing Hospice Patients in Skilled Nursing Facilities and Tiffany Kaaiakamanu, Manager, Community Relations along with Amanda Vega, Supervisor, Orange County Social Services Agency presented on CalFresh program.

The OCC MAC appreciates the opportunity to provide the CalOptima Board with input and updates on their activities.

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Provider Advisory Committee Update
Board of Directors Meeting
June 2, 2022

On May 12, 2022, the Provider Advisory Committee (PAC) held its monthly meeting via teleconference using Zoom Webinar technology.

PAC members approved their FY 2022-2023 meeting schedule that will have them meeting bi-monthly and jointly with the Member Advisory Committee. PAC also approved their accomplishments for FY 2021-22 and their proposed slate of candidates as recommended by the nominations ad hoc committee to fill upcoming PAC vacancies. PAC requested that staff prepare the necessary paperwork to forward appointment recommendations to the Board for seats expiring on June 30, 2022.

Michael Hunn, Chief Executive Officer, thanked the PAC for their service to CalOptima by serving on the PAC. Ms. Hunn also discussed CalOptima's receipt of $83 million over two a two year period to assist with homelessness street medicine. These funds would also be used to assist those homeless members navigate into housing. Mr. Hunn also discussed CalOptima's request of the Board to submit a request to the Board of Supervisors to change to the CalOptima Ordinance in order participate in the California Exchange and noted that the Board had approved this request at their June 2, 2022 meeting. He noted that a change to the Ordinance would allow for continuity of care for those members who risk losing coverage at the end of the pandemic emergency by allowing them to continue with CalOptima under Cover California.

Yunkyung Kim, Chief Operating Officer, discussed how on May 1, 2022 that adults 50 years and over regardless of their immigration status were now eligible for full scope Medi-Cal. This resulted in an additional 16K members for CalOptima. She noted that CalOptima continues to identify those who may be eligible for full scope Medi-Cal. Ms. Kim also provided a brief CalAIM update to the committee.

Richard Pitts, D.O., Chief Medical Officer, provided a COVID-19 update and screen shared via Zoom a color coded monthly calendar that showed a seasonal COVID pattern populated over the last two years.

Katie Balderas, Interim Director, Population Health Management presented on Homeless Health Initiatives and Tiffany Kaaiakamanu, Manager, Community Relations along with Taylor Adray, Supervisor, Orange County Social Services Agency presented on CalFresh.

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
June 2, 2022

On May 12, 2022, the Member Advisory Committee (MAC) held its monthly meeting via teleconference using Zoom Webinar technology. MAC members approved their FY 2022-2023 meeting schedule which will be held bi-monthly and jointly with the Provider Advisory Committee (PAC) beginning in August. The MAC also approved a recommended slate of candidates for the seats expiring on June 30, 2022, as recommended by the MAC nominations ad hoc committee. The MAC also approved their accomplishments for the FY 2021-2022.

Michael Hunn, Chief Executive Officer, thanked the MAC for their service to CalOptima and its members and assured the committee that their work in support of CalOptima's mission and vision had not gone unnoticed. Ms. Hunn also discussed CalOptima's receipt of $83 million over a two year period to assist with homelessness street medicine. These funds will also be used to assist those homeless members navigate into housing. Mr. Hunn also discussed CalOptima's request of the Board to submit a request to the Board of Supervisors for a change of Ordinance in order for CalOptima to participate in the California Exchange, and noted that the Board had approved this request at their June 2, 2022 meeting. A change to the Ordinance would allow for continuity of care for those members who risk losing coverage through Medi-Cal at the end of the pandemic emergency by allowing them to continue with CalOptima under Cover California.

Yunkyung Kim, Chief Operating Officer, discussed that on May 1, 2022, adults 50 years and over, regardless of their immigration status, are now eligible for full scope Medi-Cal benefits which resulted in an additional 16K members for CalOptima. She noted that CalOptima continues to identify those who may be eligible for full scope Medi-Cal. Ms. Kim also provided a brief CalAIM update to the committee.

Richard Pitts, D.O., Chief Medical Officer, provided a COVID-19 update and shared with the committee the trends being experienced with the virus noted in the New England Journal of Medicine.

Michael Arnot, Executive Director, Children's Cause OC presented on the Children's Mental Health Access Collaborative Project. Katie Balderas, Interim Director, Population Health Management, briefly discussed the Homeless Health Initiatives and agreed to return to the June meeting and update all of the Board Advisory Committees in order to receive feedback on how best to distribute the $83 million received in support of homeless healthcare initiatives.

MAC also received a CalFresh presentation by Tiffany Kaaiakamanu, Manager, Community Relations, and Angela Carrington, Supervisor, Orange County Social Services.

Once again, the MAC appreciates and thanks the CalOptima Board for the opportunity to provide input and updates on their activities.

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